JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION

Population and Reproductive Health Accountability-related Grants in Nigeria

BASELINE REPORT

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Acronyms

AIDS	acquired immune deficiency syndrome
CHR	Community Health and Research Initiative
CISLAC	Civil Society Legislative Advocacy Centre
CSO	civil society organization
DevComs	Development Communications Network
FCT	Federal Capital Territory
HIV	human immunodeficiency virus
LGA	local government authority
MDR	Maternal Death Review
PATHS2	Partnership for Transforming Health Systems Phase II
PMTCT	preventing mother to child transmission of HIV
SAVI	State Accountability and Voice Initiative
SOGON	Society of Gynecology and Obstetrics of Nigeria
WARD C	Women Advocates Research and Documentation Centre
WHARC	Women's Health Action Research Centre

Executive Summary

PURPOSE

The John D. and Catherine T. MacArthur Foundation funds a portfolio of seven 3-year grants in Nigeria focused on government accountability to maternal and reproductive health. Awarded in 2013, the portfolio focuses on four accountability strategies–budget analysis, community mobilization, legal approaches, and maternal death audits–spans three government levels (federal, state, local), 12 states and the Federal Capital Territory (FCT), and five geopolitical zones.

As part of a series of evaluative activities for this portfolio, the Foundation commissioned EnCompass LLC to refine the portfolio theory of change, conduct a baseline, and build grantee capacity to monitor their grants. The Foundation is prioritizing a learning-focused evaluation over the life of the grants that illuminates aspects of the portfolio strategy that are working well and could be improved to strengthen maternal health accountability in Nigeria. This report provides landscape metrics through the lens of the four accountability strategies that will be used to assess progress and results at midline and endline, and inform the grant portfolio going forward.

METHODOLOGY

The evaluation team, with the MacArthur Foundation and grantees, developed six evaluation questions to guide the evaluation process. For the baseline, the team developed corresponding questions to understand the current landscape prior to full grant implementation.

Key Evaluation Questions	Summary of Baseline Questions
1. In what ways does civil society collaboration and coordination lead to incrased government accountability to maternal health?	1. How are civil society organizations collaborating and coordinating around maternal health accountability? What hinders and supports collaboration and coordination?
2. What enables and constrains Maternal Death Review Committee activation and accurate reporting?	2. What enables and hinders maternal death review committee formation and functioning?
3. In what ways has the grant portfolio contributed to the evidence on maternal health and accountability?	3. What maternal health evidence are media houses, policy makers, and lawyers using to inform their maternal health-related work?
4. To what extent has the grant portfolio led to improved media reporting on maternal health?	4. What is the extent and quality of media coverage of maternal health? What enables and constrains maternal health reporting?
5. How has the grant portfolio contributed to improved maternal health budget perfomance at Federal, State, and local levels?	5. What are 2014 maternal health budget allocations, disbursements, and use rates? What enables and hinders maternal health budget performance at the Federal, State, and local level
6. How has the grant portfolio influenced maternal health policy effectiveness (policy change, effective implementation)?	6. a. What is the state of maternal health litigation? What enables and hinders litigation of maternal health cases? b. What Federal and State maternal health policies exist? Which policies are being implemented?

In April and May 2014, the evaluation team collected data in eight states and the FCT through interviews, focus group discussions, and document review. Respondents included journalists, civil

society representatives, government officials, and Maternal Death Review (MDR) committee members. In October 2014, the evaluation team facilitated a consultation meeting in Abuja with grantees, the MacArthur Foundation, and external stakeholders. Based on their review of the draft baseline report, the meeting allowed participants to validate and interpret the findings, provide input into the conclusions and considerations, and use the findings for learning and adapting.

BASELINE FINDINGS

Civil society collaboration and coordination around maternal health accountability varies and is largely driven by external funding sources, which can fuel competition. Collaboration is enabled by a passion for maternal and reproductive health, partnerships/networks, and development projects.

MDR committee formation and functioning is nascent due in part to confusing directives, staff shortages, and lack of implementation of committee recommendations. The “no name, no blame” policy has mitigated some of the trepidation associated with the process, but suspicion remains.

Maternal health media coverage is infrequent and inaccurate. Media programs are primarily driven by international funding. Reports tend to focus on awareness-raising, lack of government commitment to maternal health, and limited access to services. A key constraint is government censorship and distorted reporting.

Maternal health evidence that is accurate and relevant is scarce in Nigeria. Journalists, government officials, and lawyers tend to rely on the Internet, development projects, health experts, and facilities for accurate information. There is no central “portal” or resource available that is Nigeria-specific.

Federal allocations to health budgets have declined since 2012, as have maternal health-related line items. Declining allocations for maternal health is perceived as a lack of government commitment.

Maternal health litigation is uncommon. The public’s low awareness of health rights, fear of victimization, fatalism, and perceived cost constrain maternal health cases from going to court.

Maternal health policy implementation is perceived as weak, which is exacerbated by verbal policies that tend to fluctuate with government turnover. The Free Maternal Health Policy is well-known, but there is inconsistent understanding of what the policy covers.

CONCLUSIONS

The assumptions on which this grant portfolio was built remain relevant. The seven grants, four accountability strategies, and theory of change respond to the existing challenges and opportunities to advance maternal health and reduce maternal mortality in Nigeria. There is a need, however, for more emphasis in the portfolio on budget performance; one grantee seems insufficient given the importance of this accountability strategy in Nigeria. The general public seems disenfranchised to take action needed to foster change in maternal mortality and the portfolio is addressing this challenge through the community mobilization strategy. Resistance and suspicion from the Federal Ministry of Health down to facilities surround the MDR process and reporting, which the Foundation and grantees need to address stridently.

Introduction

PURPOSE

Nigeria has the second highest maternal mortality globally with 1 in 13 women dying in childbirth.[1] Nigeria reduced maternal mortality by 43 percent--from 1,100 deaths per 100,000 live births in 1990 to 630 per 100,000 live births in 2010--but is still far from the Millennium Development Goal 5 target of a 75 percent reduction by 2015.

Exhibit 1: Accountability Strategies

- Budget analysis
- Community mobilization
- Legal approaches
- Maternal death audits

The John D. and Catherine T. MacArthur Foundation identified reduction in maternal mortality as a priority area in the three Population and Reproductive Health focus countries: India, Mexico and Nigeria. In 2012, the MacArthur Foundation held a meeting in Mexico with grantees from the three focus countries to share experiences in accountability strategies for improving maternal and reproductive health. The meeting generated the following working definition of accountability: *the exercise of power constrained by external means or internal norms.* Discussions at this meeting were organized around four accountability strategies presented in **Exhibit 1**. These strategies became the basis for the MacArthur Foundation's maternal health accountability grant portfolio in Nigeria.

In 2013, the MacArthur Foundation held two meetings in Nigeria to chart a way forward for how organizations could individually and collectively apply different accountability strategies to address maternal health accountability and identify synergies between organizations to increase the impact of the Foundation's investment. Seven grants to civil society organizations resulted from these meetings (see **Exhibit 2**). The grants aim to achieve maternal health accountability by: 1) increasing government commitments at federal, state and local levels to fund maternal health; 2) ensuring government compliance with commitments already made; and 3) ensuring higher quality maternal health services that reflect an understanding of the reasons for maternal deaths in Nigeria and how to prevent them.

Exhibit 2: Timeline Leading to Grant Portfolio

[1] Wairagala Wakabi, "Nigeria aims to boost fight against maternal mortality," *The Lancet*, Volume 381, Issue 9879, (2013): P. 1708.

The MacArthur Foundation is prioritizing learning-focused evaluation that illuminates for the Foundation and its grantees: what is working well to advance maternal health in Nigeria, what could be improved in the current grants and portfolio design and implementation, and what alternative strategies could be considered for increasing government accountability for maternal health. To this end, in 2013 the MacArthur Foundation commissioned EnCompass, LLC (see **Annex 1**) to refine the grant portfolio theory of change, conduct a baseline, and build grantee capacity to monitor their grants as part of a series of evaluative activities for this grant portfolio.

Exhibit 3: Evaluative Activities for Grant Portfolio

This baseline, conducted before grant activities fully began, provides landscape metrics through the lens of the four accountability strategies presented in **Exhibit 1**. Midline and endline evaluations will be conducted in 2015 and 2016 respectively as illustrated in **Exhibit 3**, and will include grantees' monitoring data.

DESIGN, SAMPLE, METHODS

The grant portfolio spans all three levels of government (federal, state, local), 12 states and the FCT, five geopolitical zones, seven grantees, and four accountability strategies as presented in **Exhibit 4**. A list of grantee activities across accountability strategies and states can be found in **Annex 4**.

Exhibit 4: Grantee by Accountability Strategy and State

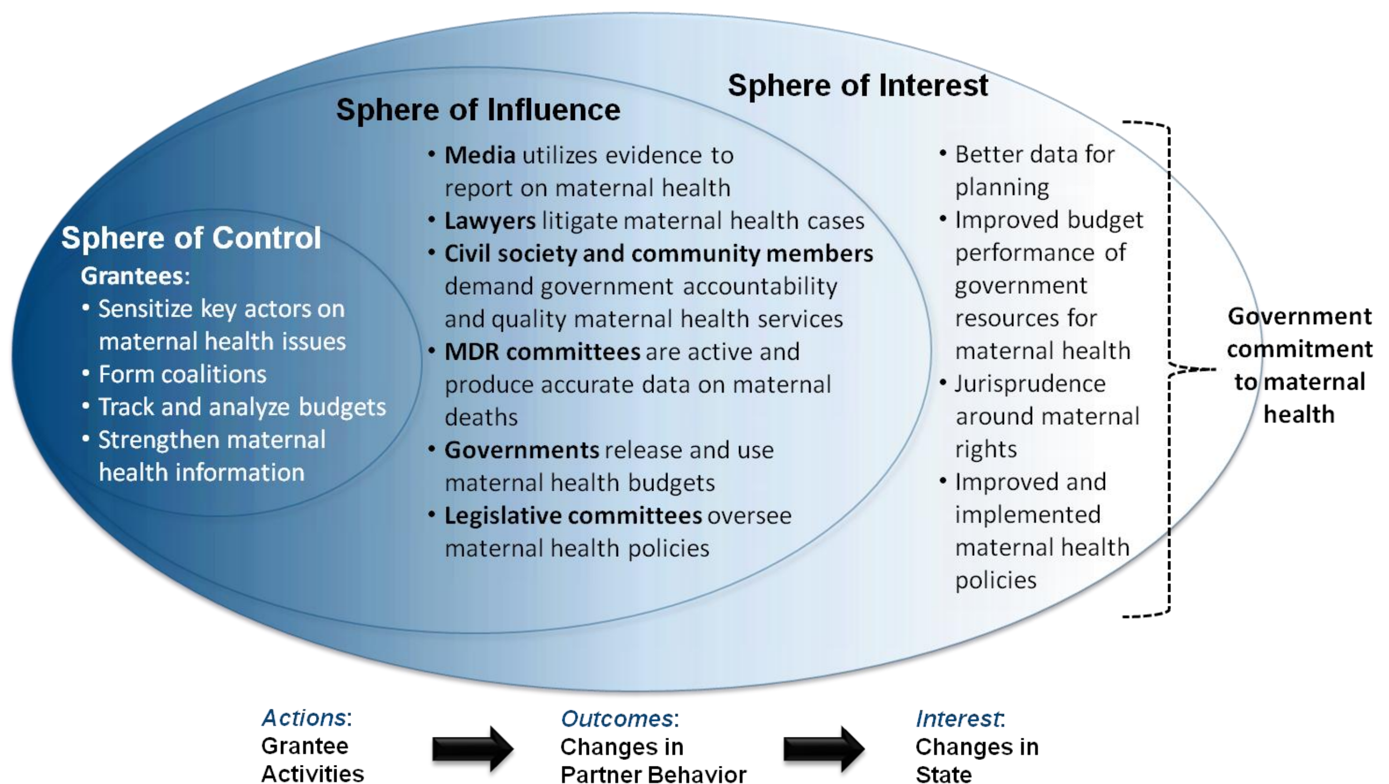
Grantee	Accountability Strategy	States / FCT
Advocacy Nigeria	Community mobilization (policy advocacy)	Adamawa, Gombe, Zamfara
Community Health Research Initiative (CHR)	Community mobilization (policy advocacy), budget analysis	Bauchi, FCT, Jigawa, Kano, Niger, Sokoto
Civil Society Legislative Advocacy Centre (CISLAC)	Community mobilization (policy advocacy)	Jigawa, Kaduna, Kano, Katsina
Development Communications Network (DevComs)	Community mobilization (media), policy advocacy	FCT, Jigawa, Kaduna, Lagos
Society of Gynecology and Obstetrics in Nigeria (SOGON)	Maternal death audits	FCT
Women Advocates Research and Documentation Centre (WARD C)	Community mobilization (policy advocacy), legal approaches	Enugu, Kaduna, Lagos
Women's Health Action Research Centre (WHARC)	Maternal death audits	Lagos

DESIGN

Accountability pathways are complex. The literature acknowledges that the accountability landscape is filled with a broad array of actors with multiple connections creating layered webs of accountability with varying degrees of autonomy and sources of control/oversight. One challenge inherent in evaluating this grant portfolio is establishing direct attributions to changes when multiple grantees, target groups, and interacting factors may have contributed to the end results.

Recognizing the complexity of the multiple pathways to intended outcomes and the geopolitical diversity of the portfolio, EnCompass used a modified outcome mapping framework to make explicit a theory of change for the portfolio, and guide the evaluation design and methodology. Outcome mapping focuses on grantees' direct actions (Sphere of Control); the resulting changes desired among the stakeholders or boundary partners with which the grantees interact (Sphere of Influence); and the resulting changes intended by federal, state and local governments (Sphere of Interest). **Exhibit 5** presents an outcome map for the maternal health accountability grant portfolio in Nigeria. **Annex 2** presents a detailed set of observable actions within each of the three spheres.

Exhibit 5: Theory of Change to Achieve Government Commitment to Maternal Health



The evaluation team worked with the MacArthur Foundation and the seven grantee organizations to develop six evaluation questions to guide the entire evaluative process: baseline, midline, and endline. For the baseline, the evaluation team developed a set of corresponding questions to understand the current landscape in the Sphere of Influence prior to grant implementation. The baseline data will be used to assess progress and results at midline and endline, and inform the grant

portfolio going forward. The baseline questions map to the overall evaluation questions as presented in **Exhibit 6.**

Exhibit 6: Key Evaluation Questions and Baseline Questions

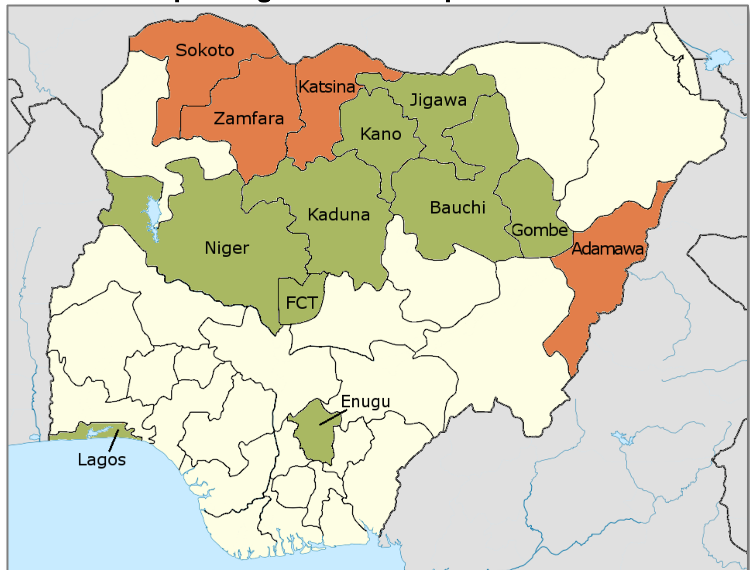
Key Evaluation Questions	Summary of Baseline Questions
1. In what ways does civil society collaboration and coordination lead to incrased government accountability to maternal health? 2. What enables and constrains Maternal Death Review Committee activation and accurate reporting? 3. In what ways has the grant portfolio contributed to the evidence on maternal health and accountability? 4. To what extent has the grant portfolio led to improved media reporting on maternal health? 5. How has the grant portfolio contributed to improved maternal health budget perfomance at Federal, State, and local levels? 6. How has the grant portfolio influenced maternal health policy effectiveness (policy change, effective implementation)?	1. How are civil society organizations collaborating and coordinating around maternal health accountability? What hinders and supports collaboration and coordination? 2. What enables and hinders maternal death review committee formation and functioning? 3. What maternal health evidence are media houses, policy makers, and lawyers using to inform their maternal health-related work? 4. What is the extent and quality of media coverage of maternal health? What enables and constrains maternal health reporting? 5. What are 2014 maternal health budget allocations, disbursements, and use rates? What enables and hinders maternal health budget performance at the Federal, State, and local level 6. a. What is the state of maternal health litigation? What enables and hinders litigation of maternal health cases? b. What Federal and State maternal health policies exist? Which policies are being implemented?

The evaluative process will draw on baseline, midline, and endline data collected by the EnCompass evaluation team, and monitoring data collected by grantees. Together, the data will provide longitudinal comparison of progress and results over time in both the Sphere of Control and Sphere of Influence for formative learning and improvements to the portfolio design and implementation. See **Annex 3** for the key evaluation and baseline questions, sub-questions, indicators, and data sources.

SAMPLE

Collectively, the 3-year grant portfolio covers all four accountability strategies, 12 states and the Federal Capital Territory (FCT). Given available resources, baseline data collection (conducted in April and May 2014) was limited to eight states and the FCT as illustrated in **Exhibit 7** where the states in the sample are indicated in green and entire the grant portfolio represented in green and orange. The list of the eight states, and the FCT, and 16 local government authorities (LGAs) in the

Exhibit 7: Map of Nigeria with Sampled States



sample are presented in **Annex 5**.The criteria used to select the sample states are presented in **Exhibit 8.**

Exhibit 8: State Sampling Criteria

- Accessibility
- Security
- Geographical spread
- Population density
- Breadth of accountability strategies
- Density of grantee activity
- Magnitude of maternal health challenges

The Sphere of Influence, on which the baseline focused, includes a range of maternal health stakeholders. Resource constraints and the learning focus of the baseline made non-probability sampling an appropriate strategy. The evaluation team worked with grantees and the MacArthur Foundation to prioritize key informants based on state, LGA, and grantee activity. The team used two sampling approaches: (1) maximum variation sampling to ensure that a wide variety of perspectives were captured during data collection, and (2) emergent/snowball sampling to allow for changing conditions on the ground, and flexibility to collect data from emerging key informants who have the potential to yield rich evaluative data, but were not initially identified. Based on these approaches a range of stakeholders were reached as listed in **Exhibit 9** and detailed by stakeholder group and state in **Annex 6.**

METHODS

The evaluation team used a mixed-methods data collection approach that included 101 semi-structured interviews with 122 respondents (66 male, 54 female, 2 undocumented), 17 focus group discussions with 159 participants (58 male, 101 female), review of 47 documents provided by the MacArthur Foundation to give context to the accountability pathways, budget analysis of Federal Ministry of Health budget summaries from 2012 to 2014, and a media review of maternal health articles and radio transcripts provided by DevComs (a total of 18) for topical focus, key messages, and mention of grantees. Data collection tools can be found in **Annex 7.** The evaluation team coded and analyzed all qualitative data in Dedoose, a cross-platform application for qualitative and quantitative analysis. Limitations to the evaluation are discussed in **Annex 8**.

Exhibit 9: Stakeholder Groups

- Civil society organizations
- Professional associations
- Government (federal, state, local)
- International organizations/projects
- Lawyers
- Media
- Facilities
- Women using maternal health services or participating in WARD C activities or both

A 2-day data consultation meeting in Abuja was held October 14-15, 2014 with 20 participants from all portfolio grantee organizations, and five representatives from the MacArthur Foundation Nigeria office. The first day also included 16 representatives from a sample of key stakeholders including federal ministries, development partners, professional associations (lawyers and journalists), international organizations/projects, and civil society. Based on their review of the draft baseline report, the participatory meeting allowed for participants to validate and interpret baseline findings, provide input into the conclusions and considerations, and use the findings for learning and adapting. The baseline findings informed portfolio strategies and revisions to some of the grants, for example

how the portfolio is engaging media. Feedback from the meeting is reflected in the conclusions and considerations, and key discussions are summarized in **Annex 9**.

Findings

The baseline findings provide an understanding of the current state of the Sphere of Influence in which grantees are beginning their work (in the Sphere of Control). These findings are presented below by the four desired changes to which the portfolio of grants aims to contribute (Sphere of Interest) as outlined in **Exhibit 10**, as illustrated above in **Exhibit 5**.

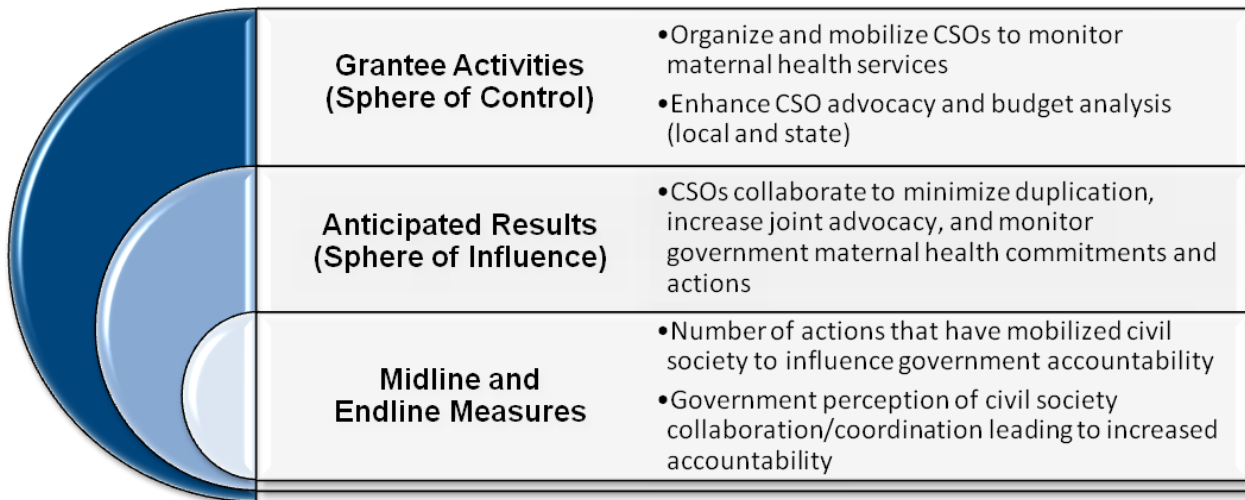
Exhibit 10: Desired Changes in the Sphere of Interest

Desired change	Description
Better data for planning	Governments (federal, state, local) access accurate and timely information on maternal health and use it for maternal health planning and practice. This information is obtained through civil society monitoring of health services, precise media reports, active Maternal Death Review committees that generate accurate reports, and a vibrant civil society that collaborates and coordinates to advocate and monitor government commitments to maternal health. (Baseline questions 1, 2, 3, and 4)
Improved budget performance of government resources for maternal health	Governments (federal, state, local) increase maternal health budget allocations, disbursements and use. (Baseline question 5)
Legal jurisprudence around maternal rights	Maternal health cases use existing laws, and new maternal health laws and policies are formulated to respond to emerging needs. Lawyers use accurate and timely maternal health data for litigation. (Baseline question 6a)
Improved and implemented maternal health policies	Government (federal, state, local) improves and implements existing maternal health policies, especially the Free Maternal Health Policy. (Baseline question 6b)

BETTER DATA FOR PLANNING

This section presents the current state of civil society organizations' (CSOs) collaboration and coordination, MDRs and media reporting on maternal health.

Civil Society Collaboration and Coordination



Grantees will organize and mobilize CSOs to monitor maternal health service delivery to increase the maternal health evidence base in Nigeria. Advocacy Nigeria, CISLAC, and DevComs will work with CSOs in the FCT, and Jigawa, Kaduna, Kano, Katsina, and Lagos states.

Summary of Findings on Civil Society Collaboration and Coordination: Civil society collaboration and coordination around maternal health accountability varies and is largely driven by funding from external sources. Across states, civil society collaboration was enabled by a shared passion for maternal and reproductive health, partnerships/networks, and development projects. Collaboration is currently constrained by competition among organizations largely fueled by funding and shifting funding streams. CSOs are collaborating and coordinating around legislation and budget tracking.

Enablers of and Constraints to Civil Society Collaboration and Coordination for Maternal Health Accountability

Finding 1: CSO collaboration and coordination is fueled by a passion for maternal and reproductive health, partnerships/networks, and development projects.

When asked what supports CSOs to collaborate and coordinate successfully to hold governments accountable to maternal health, CSO respondents in seven states most often cited passion for, and commitment to, maternal and reproductive health, and reducing maternal mortality. Respondents spoke of civil society members volunteering time and money to conduct advocacy; shared mission, goals and objectives for women' s rights and gender equality; a sense of ownership and "team spirit;" and the importance of putting aside personal interests and working transparently and in unity.

> *It is our focus on maternal health and children, and the good understanding among us. We have been doing it individually, but without success. When we teamed up, it yielded.* – CSO respondent, Bauchi state

After passion and commitment, CSO respondents in six states cited the role of development projects, such as Partnership for Transforming Health Systems Phase II (PATHS2), State Accountability and Voice Initiative (SAVI), and Targeted States High Impact Project, in monitoring and supporting joint advocacy through training and financial support, as well as other international organizations and donors "who push the collaboration."

> *One thing that I know that strengthens collaboration in Nigeria is if there is a push, if there is an organization that is pushing the collaboration.* – CSO respondent, Lagos state (Lagos City)

Civil society organization respondents in five states cited maternal and child health networks and partnerships as critical to coordination. Respondents most often spontaneously mentioned the Maternal Newborn Child Health Coalition in Jigawa State, and the Civil Society on HIV/AIDS in Nigeria. Respondents shared stories of loosely structured networks that are successful when they have a core structure of 50-70 organizations that reach out to engage other organizations informally. Networks and partnerships were seen as playing a central coordination and leadership role among CSOs to mobilize resources and build capacity.

Finding 2: CSO collaboration and coordination is constrained by competition and funding.

Competition was most cited by respondents as hindering collaboration, fueled by funding and suspicion. Many respondents spoke of the "selfish interest of CSOs," "unhealthy competition," and "lack of trust and unity." This competition was attributed to several factors including too many CSOs who "want a stake," preference among some to work independently, lack of synergy between "old and new" CSOs, and lack of trust and unity between CSOs. Some noted that the lack of trust or unity was driven by disparate and fragmented values, and organizations specializing in maternal and reproductive health areas. Respondents perceived funding as an underlying factor for either driving collaboration because it is mandated by the donor, or driving division due to fear of being absorbed by bigger organizations or losing funding.

> *Lack of unity and sense of direction. When CSOs come together only when there is funding, they do not work well together.* – CSO respondent, Niger state

CSO respondents mentioned funding as a constraining factor to CSO collaboration almost as frequently as competition. Interviewees mentioned that many CSOs are staffed by volunteers who lack funds to travel to meetings and hold paying jobs elsewhere, which makes it challenging to find time to attend meetings during the day. This makes collaboration difficult because, as one respondent stated, "those people you discuss [with] yesterday will not be the same people today because of their other schedules." Another point CSO respondents raised was that funding was necessary to form and sustain a network that can serve as a coordinating body that fosters collaboration.

> *A lot of coalitions have crashed because of funding issues and sometimes because some members of the coalition spend money and don't involve other members.* – CSO respondent, Kano state (Kano Central)

Other constraints to CSO collaboration that respondents mentioned less frequently were lack of capacity and leadership within CSOs.

How Organizations are Collaborating and Opportunities for Collaboration in the Future

Finding 3: CSO collaboration and coordination is fostered by networks and partnerships.

Networks and partnerships were the most frequently mentioned when respondents were asked how CSOs are collaborating and coordinating around maternal health accountability. These networks and partnerships varied from state to state, but SAVI working in 10 states, and PATHS2 working in five states (Enugu, Jigawa, Kaduna, Kano, Lagos) were mentioned most often.

Respondents reported that CSO collaboration in Kaduna state is strong. Respondents spoke of improved collaboration between maternal and child health CSOs to form the Free Maternal and Child Health Partnership, a group of 10 CSOs working on health that is registered with the Corporate Affairs Commission and supported by SAVI. One respondent mentioned that the Journalists for Better Health emerged from this partnership. The Free Maternal and Child Health Partnership was described as being involved in the Medium Term Sector Strategy processes to ensure that the government continues to fund maternal and child health, and the Partnership pays special attention to budget allocation. The Civil Society for HIV and AIDS in Nigeria, Concerned Civil Society group (a loose network of CSOs), and the Know Your Budget network were also mentioned as CSO networks engaged in budget analysis and advocacy.

> *CSO collaboration on maternal child health is very strong. The Maternal Child Health partnership is supported by SAVI. We collaborate to hold government accountable. Working with SAVI has granted us easy access to the House of Assembly and the Ministry of Health.* – CSO respondent, Kaduna state (Kaduna North)

Respondents in Kano state reported coming together at partners' fora to share achievements and challenges, and collectively advocate to government. The Partnership for the Promotion of Maternal and Child Health was mentioned as a strong coalition of CSOs working on budget tracking and Bill passage in Kano state. The Partnership was created when a number of CSOs formed a network to collaborate on a proposal for the enactment of free maternal and child health. PATHS 2, Community Participation for Action in the Social Sector, and the Centre for Development and Population Activities were mentioned as instrumental in the Partnership's formation, and enabling CSOs to work together towards achieving a common goal and to avoid duplication.

> *There were a number of CSOs that came together to form a coalition/network and the discussions led to the formation of the maternal and child health group: Partnership in Promoting Maternal and Child Health.* – CSO respondent, Kano state (Kano Central)

Respondents in Enugu state also cited SAVI as central to CSO partnership and advocacy for the Free Maternal and Child Health policy. Respondents described the partnership in Enugu state as "a pressure group" to ensure the government provides free maternal and child health, and reduce maternal and infant mortality rates by focusing on three advocacy channels: (1) interest in maternal and child health, (2) health project bodies and medical associations, and (3) representatives of the Ministry of Health. The partnership includes a free maternal and child health steering committee (policy support, broad oversight), and free maternal and child health implementation committee (operational issues) with high-level and influential subjects in government to help steer the program

and ensure political will is retained and attracted to the program. PATHS1 and PATHS2 were also mentioned as leading collaboration and coordination.

> *The SAVI people are doing a lot of work with the CSOs in Enugu.* – CSO respondent, Enugu state (Enugu South)

In Bauchi state, respondents talked about the role of Bauchi State Network of Civil Societies and Advocacy Nigeria in coordinating CSOs for maternal and child health advocacy in the state. Bauchi State Network of Civil Societies was described as a common platform for CSOs working to get a Maternal and Child Health Bill passed. An LGA respondent stated that CSO collaboration in Bauchi mobilizes human and material resources to strengthen the health care system, advocacy, capacity building, and government commitment.

> *We collaborated … to advocate for free maternal health care and for increased budget on maternal health. We took the call up to the State Assembly.* – CSO respondent, Bauchi state

PATHS2, SAVI and Partnership for Reviving Routine Immunization in Northern Nigeria Maternal Newborn and Child Health Initiative were also mentioned by a few CSO respondents in Jigawa state as coordinating CSO collaboration on policy advocacy, budget tracking and analysis, and supporting CSO partnership with the media. In Lagos state, respondents mentioned the Lagos state CSO Partnership that includes maternal health and brings CSOs together to collaborate and discuss maternal health, conduct research, and obtain data for the government "so that they are not just talking."

Finding 4: **CSOs are collaborating and coordinating around the Free Maternal and Child Health Care Bill and maternal health budget tracking.**

Respondents reported that CSOs have started collaborating to hold government accountable. For example, in the FCT the National Population Commission now actively seeks CSO input into its work on the International Conference on Population and Development Platform for Action. A Kano state CSO respondent spoke of improved collaboration amongst CSOs to pressure the government to set up the Accountability Mechanism on Maternal Health, and in Kaduna a CSO respondent said that CSOs come together and push government to focus on priorities.

When asked about successful CSO collaboration, respondents in Bauchi, Jigawa, Kaduna, and Kano states all spoke of CSOs holding state governments responsible for implementing the Free Maternal and Child Health Care Bill. This included CSOs in Jigawa state that advocated to the State House of Assembly for passage into law. The Bill was sent to the Assembly last year and it passed the second reading, but needs to be resent as an Executive Bill. This is yet to be done, but CSOs still consider it a success and feel confident in the outcome. Respondents reported that every CSO working on maternal health in the state participated to make sure "that the Bill has seen the light of the day." PATHS2 was credited with dedicating a lot of time and resources to building capacity of and training CSOs to work hard and articulate their position to the government.

Respondents in Kano state shared the story of how CISLAC organized roundtable discussions attended by all CSOs on maternal health to identify challenges and a positive way forward to pass the Free Maternal and Child Health Care Bill. Respondents said that SAVI also collaborated with CSOs to

advocate for the passage of the Bill and, as a result of their efforts, the former Speaker agreed that the Bill would be passed as soon as it comes to the House. At the time of data collection the Bill was still with the State Ministry of Health.

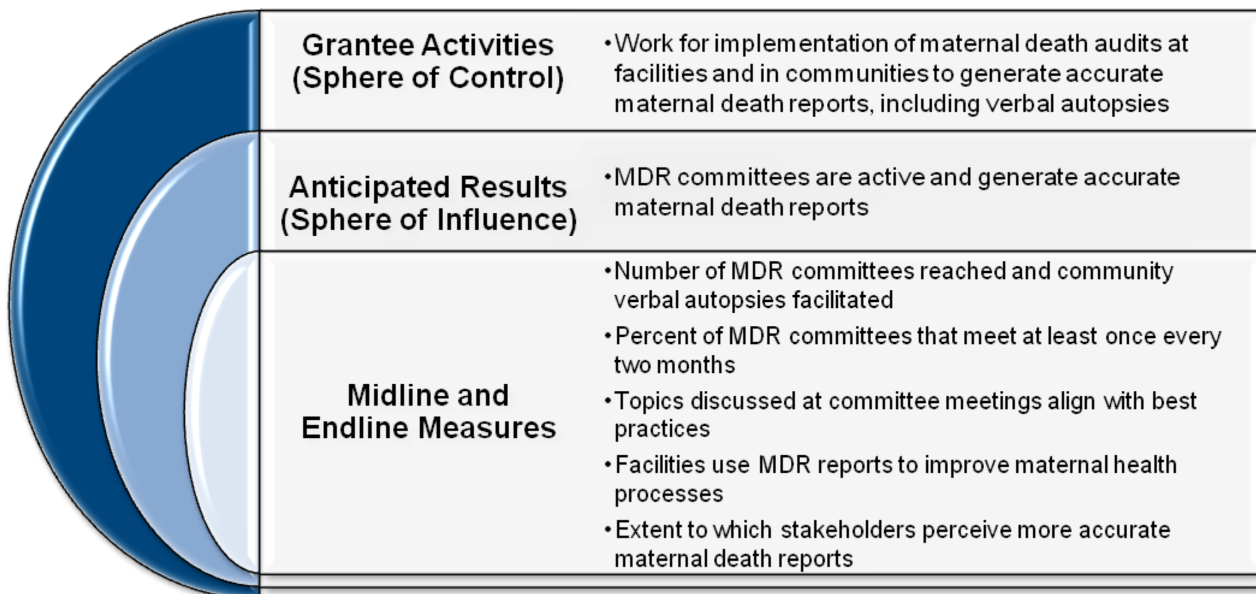
> *We are currently working on a Bill on maternal and child health. All of us are working together to see this Bill passed. All the CSOs went to House of Assembly on an advocacy visit, and we are in touch with all the principal officers at the Assembly. We are expecting the Bill to be passed soon.* – CSO respondent, Bauchi state

Several different stakeholders in Bauchi, Jigawa, Kaduna, Kano, and Niger states and the FCT mentioned spontaneously that CSOs are coordinating and collaborating to track government budgets and funds for health. Respondents mentioned particularly CHR, DevComs, Evidence for Action, and the Jigawa Maternal Health Forum as collaborating with others or leading collaboration on tracking budget effectiveness and advocating for budget transparency through participation in public budget hearings, advocating for increased funding for maternal health, and capacity building and training on budget tracking and analysis.

> *Recently, a group of CSOs came together to advocate for the increase in funding on maternal health at the Bauchi State of Assembly.* – Media respondent, Bauchi state

> *There is good collaboration with CSOs especially on Bills and also during budgeting.* – State government respondent, Kaduna state (Kaduna North)

Enablers of and Constraints to Formation and Functioning[2] of Maternal Death Review Committees



[2] A functional MDR committee is one that meets regularly, generates accurate maternal death reports, and uses those reports to improve maternal health services.

To generate accurate reporting on maternal deaths SOGON and WHARC will work in the FCT and Lagos state to ensure implementation of MDRs at facilities and verbal audits in communities.

Summary of Findings on MDR Formation and Functioning: MDR committee formation and processes are nascent. This is due in part to confusing directives and staff shortages. MDR committee recommendations are largely unused.

Government commitment to reducing maternal deaths (and subsequent budgetary allocations) supports MDR committee formation and functioning. The "no name, no blame" policy has helped mitigate against some of the trepidation, fear and suspicion around the MDR process, and how it will be used. This has enabled health workers to speak more freely about maternal deaths. Strong committee leadership and members appropriately trained on how to carry out the reviews helps MDRS committees succeed, but a fear of indictment is prevalent.

Finding 5: MDR committees are enabled by government commitment to reducing maternal deaths, strong MDR committee leadership, a "no name, no blame" policy, and members trained on how to conduct MDRs.

Facility respondents in Lagos state said that the state government's commitment to reduce the number of maternal deaths and create budget allocations for MDRs has supported MDR committee formation and functioning. Strong leadership was also cited as key to well-functioning committees, especially in terms of delegating MDR tasks effectively, motivating staff to hold review meetings, and ensuring follow-through. Respondents spoke of the role of training in building capacity to carry out successful MDRs, including proper use of the forms.

> *Political will of the present administration to reduce maternal mortality is what actually supports the MDR committee formation.* – Facility respondent, Lagos state (Ajeromi)

> *We also had series of trainings for the Head of Obstetrics and Gynecology, and the MDR Desk Officer. We continue to have training because it's still a new thing. People are still trying to understand the form. And on a regular basis we inform them about any change in what we are doing in the MDRs. So we have carried them along.* – State government respondent, Lagos state (Lagos City)

Respondents also noted that successful MDR committees adopted a "no name, no blame policy" that reassures staff that what is said during the review will not be used to indict them. For example, one respondent described the process whereby MDR reports and all accompanying documentation are destroyed after the investigation is complete. These measures have facilitated more openness about maternal deaths.

> *Due to the fact that it is fact-finding in nature "no name, no blame" attached to it makes it easier and successful. We learn lessons from each maternal death and use it to prevent other occurrences. It is actually going well because of the "no name, no blame, no indictment" slogan.* – Facility respondent, Lagos state (Ajeromi)

Finding 6: MDR committees are constrained by unclear MDR processes, fear of indictment, inadequate funding, staff shortages, and government bureaucratic delays in inaugurating committees.

MDR committee members in Lagos state said that some MDR directives are not clearly stated leading to confusion, the MDR process is unclear, and committees' recommendations are not being implemented perhaps because government and facilities are unsure of how to implement them.

> *Because some of the MDR things are not yet clearly stated; it's a bit fuzzy.* – Facility respondent, Lagos state (Lagos City)

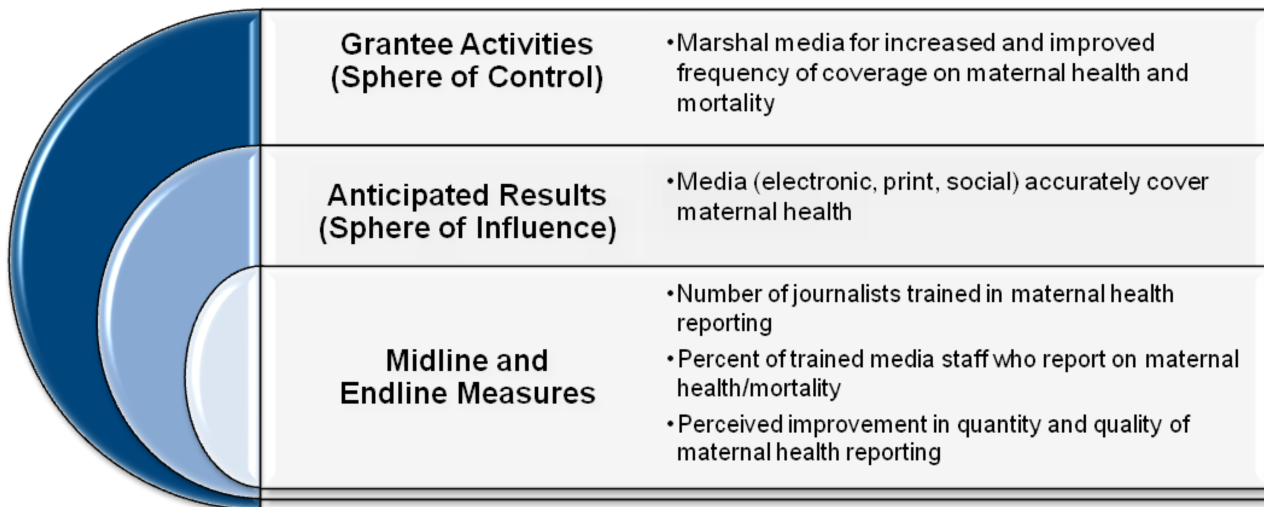
Although some MDR committees perceived the "no name, no blame policy" as a successful approach to MDR committee functioning, others stated that there remains a fear of indictment among h personnel and the perception that the focus of MDRs are to find fault and may be used for litigation.

> *Fear of indictment. People are afraid of investigation and probing on maternal death, this in a nutshell is what hinders it.* – Facility respondent, Lagos state (Ajeromi)

FCT and Lagos state respondents said that MDR committee formation and functioning have been constrained by government bureaucracy leading to delays in inaugurating committees, heavy workloads in hospitals, staff shortages, short timelines, and lack of funds. One respondent shared that MDR committees typically consist of members already employed by the government, thereby minimizing costs.

> *Funding for the committee is nothing to write home about. Sometimes we use our money to photocopy forms so that we can keep meeting. Funding is key, administrative wise.* – Facility respondent, Lagos state (Lagos City)

CURRENT MEDIA REPORTING ON MATERNAL HEALTH



To increase and improve the frequency of coverage on maternal health and mortality Advocacy Nigeria, CISLAC, and DevComs will marshal media in the Federal Capital Territory (FCT), and Jigawa, Kaduna, Kano, Katsina, and Lagos states.

Summary of Findings on Maternal Health Media Reporting: Media coverage of maternal health topics is generally infrequent and inaccurate. Existing maternal health programs and reports are primarily driven by international organization or project funding. For example, media coverage of maternal health seems more frequent in northern states where many international organizations are focusing their maternal health efforts. Existing reports seem to focus on awareness-raising, lack of government commitment to maternal health, and limited access to services.

Journalists are more likely to write on maternal health when they have a passion for the subject, there is accurate information available, and a supportive media house. Journalists' technical capacity and motivation to cover health issues can enable or constrain their ability to report on maternal health

The key constraint to effective media reporting is government censorship that leads to a politicized media environment and distorted reporting. Journalists struggle to access accurate information (although this issue is perceived to be improving due to the Freedom of Information Act).

Extent and Quality of Media Reporting on Maternal Health

Finding 7: Media coverage of maternal health is infrequent and primarily driven by international organizations or projects.

Respondents from all eight states and the FCT said that maternal health reports in the media are generally infrequent and obscure. Although health stories may be as frequent as weekly, maternal health is often overshadowed by other diseases such as HIV and polio. Maternal health stories are viewed as mostly limited to specific times of the year, for example during United Nations-specific maternal health days. Respondents mentioned spontaneously the following maternal health topics they recalled being covered by the media: vesico-vagina fistula, domestic violence, antenatal care (immunizations), child spacing, maternal mortality, and free maternal and child health services. **Exhibit 11** presents media programs associated with maternal health that were spontaneously mentioned by respondents in Jigawa, Kaduna, and Kano states. Maternal health programs and reports that were mentioned were often attributed to international organizations or projects.

Exhibit 11: Media Programs Mentioned Spontaneously in Jigawa and Kaduna States as Covering Maternal Health

Barka da Hantsi

Aikin Likita Fata Na Gari on Freedom Radio

Kiwon lafiya on Kano State Radio Corporation

Kiwo Lafiya on Nigeria Television Authority Kano

Lafiya Uwar Juci on Voice of America Hausa

Riga Kafi Tambarim Lafiya on Voice of America Hausa

Lafiya Iyali on WAZOBIA FM, Kano

Lafiya Jarin Iyali

Shirin Inganta Lafiya (developed by PATHS2)

*Lafiyar Alumma (*developed by the Partnership for Reviving Routine Immunization in Northern Nigeria)

Although they report health matters, about 40 percent only report maternal health when there is a United Nations Day. But now because of the concern it is more polio and HIV reported daily. Maternal and child health is reported when there is an event around it. – Media respondent, Kano state (Kano Central)

The media has been able to help by creating awareness especially through jingles on free maternal and child health services. There is so much visibility on the SURE-P [Subsidy Reinvestment and Empowerment Program] maternal child health program, and the jingles are quite enlightening. – CSO respondent, Niger state

Finding 8: Media reports focused on lack of government commitment to fund maternal health, the role instability plays in limiting access to services, and the need for better media collaboration with CSOs.

The evaluation team's review of 18 news articles and radio transcripts provided by DevComs showed that the media have focused on Nigeria's challenges to achieving the Millennium Development Goals by 2015, health advocates' concern that Nigeria's health providers and government are not following through on their commitment to provide more funding to maternal health services, and experts' perceptions that Nigeria's instability limits families' access to health facilities. Several articles focused on advocates' perception that the media needs to collaborate with CSOs more effectively to increase community awareness of proper health-seeking behaviors by pregnant women.

Several articles summarized a DevComs-led "Not Again Campaign" workshop during which experts stated that the leading causes of death were: delay in accessing emergency care services, lack of vital lifesaving facilities (e.g., blood banks, ambulances), and a general negative attitude of health care providers throughout the country.

Finding 9: Media reporting on maternal health is generally seen as inaccurate.

Respondents in Bauchi, Enugu, Jigawa, Kano, and Lagos states remarked that the quality of media coverage on maternal health is generally low. The majority questioned the accuracy of reports and remarked that most media reporting is distorted by external and internal influences, such as censorship and pressure to report only positive stories. Some respondents in Bauchi and Jigawa states, and the FCT said that the quality of reporting on maternal health was quite high. This difference could be attributed to development partners' focus on the northern states and increased programming there as also indicated in **Exhibit 11** by the number of media programs cited spontaneously in the northern states.

I cannot say that the reports are accurate because sometimes they do it for advertisement or to attract government's attention. – Professional association respondent, Bauchi state

The reports and the stories on our media are accurate and, most of the time, deliver the desired messages. For example, Radio Jigawa and Freedom Radio aired a radio phone-in program called "Barka da Hatsi," and it always featured professionals, and policy makers, and implementers in Jigawa state. And because of this, the messages are most of the time factual. – State government respondent, Jigawa state

Enablers of and Constraints to Media Reporting on Maternal Health

Finding 10: Maternal health coverage is enabled by passion for the topic, availability of accurate information, a supportive media house, the Freedom of Information Act, and collaboration with others.

When asked what supports accurate and effective maternal health reporting, media respondents across several states cited the importance of the availability of precise information. Several journalists and CSO respondents in the FCT, and Enugu, Kaduna, and Kano states mentioned the importance of the Freedom of Information Act in improving access to correct information. There was concern, however, about journalists not taking advantage of the Act, and difficulties in enforcing the rights the Act provides; **Exhibit 12** summarizes the Act.

> *If you want to get information, write formally under the Freedom of Information Act. If you do not get it, that is news*. – Media respondent, FCT

CSO and journalist respondents in Gombe and Kano states also spoke about the importance of collaboration among journalists, and between journalists and CSOs for more accurate reporting. This approach was seen to provide "safety in numbers" when reporting on sensitive topics that might run afoul of government. Journalists also spoke about the importance of a supportive environment within media houses in terms of editors who support maternal health media coverage, a professional and apolitical environment, and the time needed for effective reporting.

Exhibit 12: Freedom of Information Act

After over a decade of advocacy by activists and civil society, President Jonathan Goodluck signed the Nigeria Freedom of Information Act into law on May 28, 2011. The Act allows any individual to, without the need to demonstrate specific interest in the information being applied for, request the records and operational information of any public institution. The Act also requires that all public institutions maintain accurate records of their activities, operations and businesses, as well as make the requested information available to the individual within 7 days of receiving a Freedom of Information Act application. Since it was signed into law, both Ekiti and Lagos states adopted the law, although they allow up to 14 days for state institutions to make the requested information available. This law was hailed by freedom of information activists and civil society as a victory in their fight against corruption. Media Rights Agenda, based in Lagos, recently developed an application for Android devices allowing users to view the legislation on their phone.

http://www.nigeria-law.org/Legislation/LFN/2011/Freedom%20Of%20Information%20Act.pdf

> *If you have investigative reporting that our government is not ready to accept, we liaise with other media houses to get it published.* – Media respondent, Gombe state

Finding 11: Journalists' technical capacity and motivation to cover health issues can enable or constrain their ability to report on maternal health.

Respondents in Bauchi, Enugu, Jigawa, and Kano states, and the FCT mentioned lack of capacity as a constraint to health reporting. In their view, health is a technical area and requires journalists to understand the issues to report correctly. Several respondents in six states and the FCT indicated that journalists often have to link up with subject matter experts to improve accuracy of maternal and child health reports. Respondents said that reports are often more accurate when journalists are able to access relevant information to understand the subject better. Some respondents mentioned that they often embark on self-development to increase their understanding of health issues. Respondents also mentioned that involvement in development programs and activities, including

training and workshops, enhances their capacity to report accurately. A media respondent in Kaduna mentioned that the group, *Journalists for Better Health,* that trains journalists in health reporting. Respondents in Bauchi, Gombe, Jigawa, Kaduna, Kano and Lagos states mentioned journalists' motivation (remuneration and personal interest) as an important factor that influence their choice of topics on which to report.

> *Clearly, media needs to be educated/trained on maternal health issues to increase accuracy and reportage.* – International organization/project respondent, FCT

> *The attitude of the media, who think any issue to be discussed must be accompanied by a brown envelope, meaning that you must appreciate them financially before they present your story.* – State government respondent, Jigawa state

Finding 12: Media reports on maternal health are often distorted by government censorship, victimization of journalists, and information "hoarding".

Media respondents in Enugu, Gombe, and Jigawa states spoke of government's negative reaction to reports that highlight government incompetence because it undermines their efforts to maintain a good media image, such as articles on non-functioning health systems. This issue was especially prevalent among public media houses. Journalists in Gombe and Kaduna states spoke of being "victimized" in the past for reporting on cases that indicted public health facilities. For example, respondents relayed stories of journalists losing their job over a negative report. Others spoke of journalists being asked to explain their actions in writing in advance of potential disciplinary action after investigating and airing health-related cases (a process called querying).

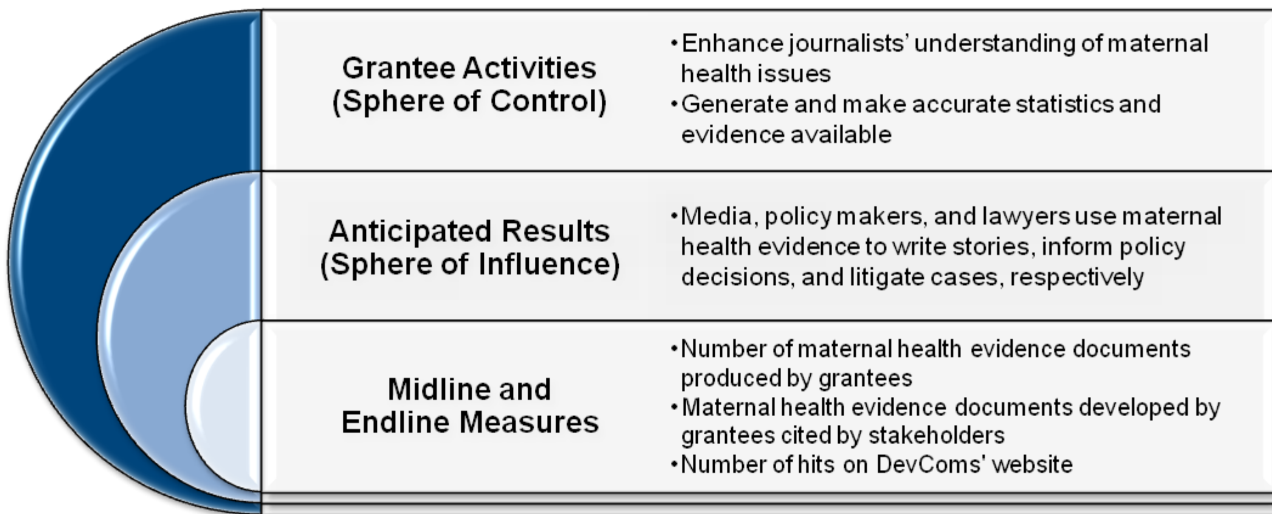
> *..insecurity and fear for our [journalists'] life …you [journalist] might end up to be the story..[laugh]…* – Media respondent, Gombe state

Other journalists spoke of media houses suppressing articles, although the data on cause for such actions were unclear. A journalist in Bauchi state said, "no matter how good a report is, if your producer doesn't want to air it, it would not be aired." This view was corroborated by respondents in the FCT, and Enugu, Gombe, Jigawa, Kaduna, and Kano states.

> *As a reporter that works with the government-owned media, there is censorship. For example, I conducted an investigation … The community was complaining about the lack of health facility. I took the story to my editor and, after a series of questions, the story was aired. We got a phone call that evening followed by a query.* – Media respondent, Kaduna state (Kaduna North)

Several journalists in all eight states and the FCT mentioned that people, especially government employees, tend to "hoard" or limit access to accurate information, which poses a challenge for investigative journalism. Media focus group participants in the FCT, and Kaduna and Kano states discussed the usefulness of the Freedom of Information Act for enhancing access to information. There was consensus that journalists need to study the Freedom of Information Act to understand how to use it to access information.

Maternal Health Evidence Used by Media, Policy Makers, and Lawyers (to Inform Reporting on Maternal Health)



To increase the maternal health evidence-base in Nigeria, Advocacy Nigeria, CISLAC, and DevComs will work in the FCT, and Jigawa, Kaduna, Kano, Katsina, and Lagos states training journalists in maternal health areas and making evidence available to media, policy makers, and lawyers to inform their work.

Summary of Findings on Maternal Health Evidence: There is a dearth of accurate, relevant maternal health information in Nigeria. Journalists, government officials, and lawyers tend to rely on the Internet, maternal health websites, development projects, health experts, and health facilities for accurate information because there is no central "portal" or resource available for Nigeria-specific information.

Finding 13: Journalists turn to the Internet, government, development projects, health facilities, and experts/health professionals to inform their maternal health reports and articles.

Journalists in Bauchi, Gombe, Jigawa, Kaduna, Kano, and Lagos states stated that they regularly get information from the Internet to inform their maternal health reporting, especially the World Health Organization, other United Nations organizations' websites, and Google searches. Some respondents said that they also turn to social media and tweets from leading players in the field. Media practitioners in the FCT spoke about press briefings and press releases as a source of information, while respondents in Bauchi state spoke of using journals and pamphlets.

> *I get most of my information from Google. I look for year-round calendar on issues of health. When the date comes up, I ask Google for the theme of which I use to prepare my questions for different stakeholders, or go to the library if I have time but that is very rare.* – Media respondent, Kano state (Kano Central)

Most respondents cited development partners and health professionals as authentic sources of information to clarify technical issues. Health facilities and parents or relatives of parents were also

mentioned. Some respondents mentioned two challenges regarding information from health facilities: (1) that the information is sometimes said to be "confidential" or "off record" and cannot be cited, and (2) that some individuals are unwilling to share personal experiences with the media.

The kind of information journalists discussed included causes of maternal mortality, and awareness creation/enlightenment talks on maternal health at antenatal clinics. Also mentioned were public pronouncements by public officers such as the Commissioner for Health, free antenatal care, and free drugs. Journalists in Bauchi, Jigawa, Kano, and Lagos states noted that they use this information to determine the focus of articles, where to go for additional information, and what additional questions to ask to complete the stories and, generally, to inform their reporting.

> *Normally, I go to Gunduma Health System Board or the Ministry of Health to obtain fact-based information for their records, for instance on facility delivery they can tell you which facility record the higher number, and which record lower, and from there you know your next call; sometimes from non-governmental organizations, or PATHS2. And if* [you] *come across any issue, you go directly to the person concerned.* – Media respondent, Jigawa state

Finding 14: Government officials obtain maternal health information from a range of sources and use such information for analysis, decision making, policy development, and resource allocation.

Government respondents in Bauchi, Enugu, and Gombe states mentioned the Internet (e.g. Google), newspapers, radio, CSO-led workshops and seminars, media advocacy, monthly maternal child health and family planning reports, and routine supervision as sources of maternal health information. A government respondent in Lagos state mentioned that evidence/best practices on maternal mortality rates from other countries helped inform policy. Others mentioned that information helps gap analyses, determine needs, and inform resource allocation.

Local and state government respondents reported using maternal health information for analysis and decision making, for developing context-specific policy that aligns with needs, and for resource allocation. One state government respondent noted that this information shapes their ideas on how to legislate most effectively.

> *When this information and data are generated, we analyze and interpret them. Thereafter, they are used in resource allocation, monitoring, and evaluation.* – Local government respondent, Bauchi state

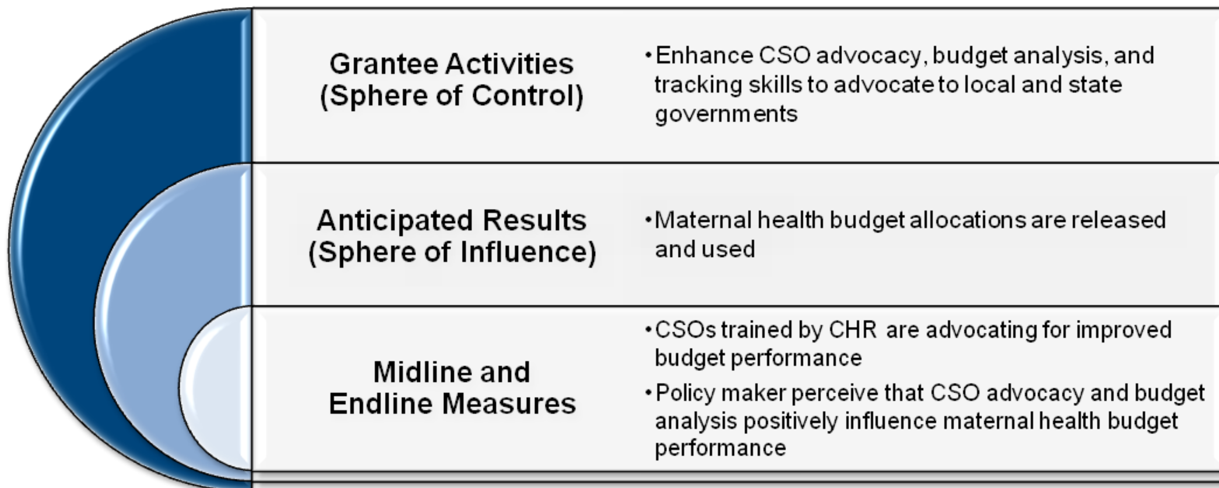
Finding 15: Lawyers in Enugu and Lagos state obtain maternal health evidence from radio, TV, health professionals, the Internet, and antenatal clinics.

Lawyers in Enugu and Lagos states acknowledged that government agencies could serve as sources of evidence, but expressed concerns that they are not good at keeping records and the information is often fraught with confidentiality clauses. In general, these lawyers sought maternal health evidence from radio, TV, health professionals, antenatal clinics, and websites. Overall, lawyers indicated that collating maternal health evidence is difficult.

> *We do research online because agencies are not very good with record keeping and there are confidentiality clauses. There is also a reluctance to part with information. It is not easy collating evidence because of this. – Legal respondent, Lagos state (Lagos City)*

IMPROVED BUDGET PERFORMANCE OF GOVERNMENT RESOURCES FOR MATERNAL HEALTH

This section reports on the current state of maternal health budget allocations, use and disbursement.



To increase federal, state and local government maternal health budget allocations, disbursements and use, CHR will enhance CSO advocacy, budget analysis, and tracking skills to advocate to local and state governments in the FCT, and Bauchi, Jigawa, Kano, Niger and Sokoto states.

Summary of Findings on Budget Performance: Federal allocations to health budgets declined since 2012, as have maternal health-related line items, and budgets often lack earmarks for maternal health line items. These actions are interpreted as lack of Government commitment to maternal health.

Budget performance is constrained by opaque budget processes, delays in releasing allocated funds, disbursements and expenses that are less than expenditures, poor budget planning, lack of transparency, and pressure on government to increase funds, which leads to unrealistic budget allocations.

Finding 16: Federal health and maternal health budget allocations have declined over the last 3 years, and maternal health is not prioritized. Release of allocated funds is often delayed and are sometimes less than allocated, as are expenditures.

Analysis of Federal Budget Summaries from 2012 to 2014 shows an overall reduction in federal budget allocations to health over the past 3 years, as illustrated in **Exhibit 13**. Specifically, there was an overall reduction in allocation for implementing the Integrated Maternal Newborn and Child strategy between 2012 and 2014. In 2012, 100 percent of the funds allocated were spent, yet expenditures reduced by almost half in 2013 (2013 allocation data were not available to the evaluation team). 2014 allocations are less than half the 2012 allocations. Since 2012, allocations to

the National Obstetric Fistula Center, Abakaliki have reduced, and 2012 and 2013 expenditures are approximately half of the allocations. 2012 and 2013 data show Nursing and Midwifery Council expenditures below allocations (see **Exhibit** 14). In 2013, various line item expenditures focused on nursing and midwifery services, such as support for midwifery training schools. A review of 2014 allocations indicated reduced support for these services at the federal level, and in Bayelsa, Eboyi, Enugu, and Yobe states. Some of these reductions might be appropriate. For example, expenditures in Enugu state were to construct training schools so the zero allocation in 2014 could be because construction was completed.

Exhibit 13: Federal Allocations to Health

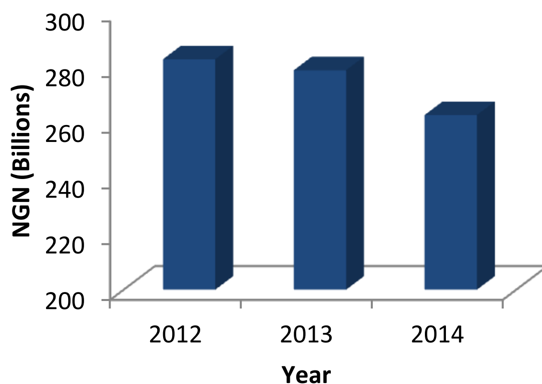
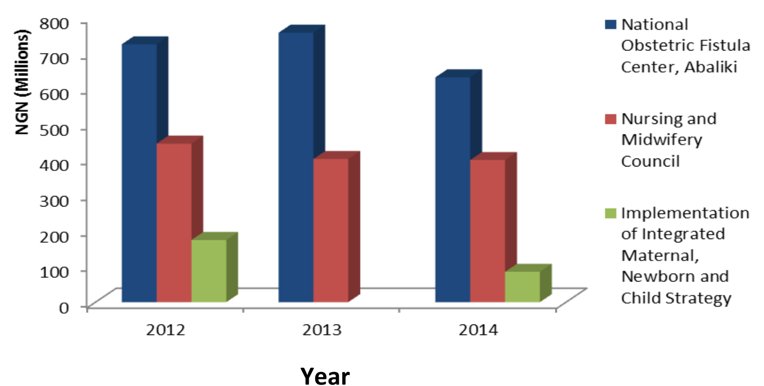


Exhibit 14: Allocations in Three Maternal Health Areas



Respondents in the FCT, and Enugu, Gombe, Kaduna, Kano, and Niger states remarked that government does not allocate enough money to maternal health. Reasons cited included a lack of commitment by leaders to devote resources to maternal health, and a lack of revenue to accommodate need. Some respondents in Kaduna state, however, reported an increase in maternal health allocations there.

> *Women's health* [has been] *neglected for a long time. Maternal health does not get one quarter of the resources allocated to HIV. The number of women dying is colossal, yet the issue does not receive the attention and support it deserves.* – Facility respondent, FCT

Respondents in the FCT and seven states (all except for Jigawa state), said that the government must prioritize increased allocations for maternal health, especially in terms of health worker remuneration.

Even when funds are allocated, respondents in the FCT, and Bauchi, Enugu, Gombe, and Kano states commented on delays in releasing funds, and fewer funds released than were allocated. Several respondents attributed this to the overall lack of revenue, poor budget planning due in part to external pressures, and lack of capacity to plan properly. All of these result in unrealistic budget estimates, compared to government resources.

> *In 2012, our work started late because money was released late. Fifteen billion Naira was earmarked; we only accessed 3.8 billion Naira. In 2013, we had 100 percent budget performance. As we speak, the 2014*

budget is yet to be released. We will end up implementing in a rush when the budget is approved. – Federal government respondent, FCT

We need to be more realistic on our budget estimation. This is very important, speaking from experience. It will require a lot of sincerity, moral prowess, and discipline to be able to do this; integrity is required. There are pressures from all angles. The pressure on government is a lot, but the resources are not available. Budget development should be according to the capacity of what can be generated. – State government respondent, Kano state (Kano Central)

Finding 17: Effective budget allocation is constrained by a lack of earmarks for maternal health-related line items and transparent budget processes.

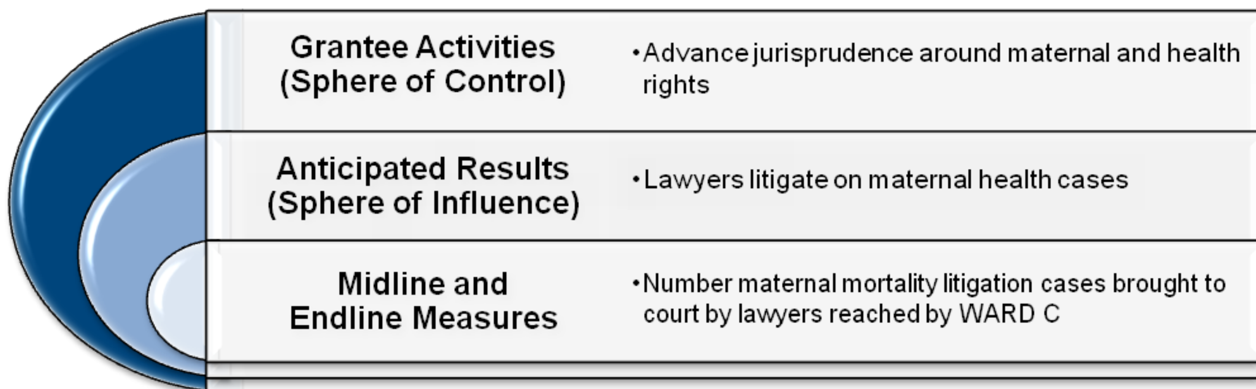
State and local government respondents in Bauchi, Kano, Lagos, and Niger states spoke of challenges to disbursements when budgets do not include maternal health line items. Without line item allocations there is increased risk that funds for maternal health will not be disbursed appropriately. Respondents in Bauchi, Kaduna, and Niger states suggested shifting funds for ongoing expenses (recurrent budgets) to time bound budgets (capital budgets). One consequence of transferring maternal health funds to capital budgets that was mentioned was that funds for maternal health are not separated, which leads to too much discretion in the disbursement process. Respondents said that there ought to be deeper stakeholder participation in budget processes to ensure that budgets are appropriately aligned with needs, and improved budget monitoring.

A major problem is that health budget is usually lumped together. A separate budget for maternal health is desirable. – State government respondent, Niger state

They should identify the needs of stakeholders and involve them. They should involve key stakeholders in developing the budget. 'He who wears the shoes knows where it pinches.' We should be part of it. The LGAs, the grassroots people who are going to access these services should be part of it. The budget should be open to discussion and review. – State government respondent, Enugu state (Enugu South)

JURISPRUDENCE AROUND MATERNAL RIGHTS

This section reports on the current state of maternal health litigation, and factors that enable and hinder such cases.



WARD C will work in Enugu, Kaduna, and Lagos states on policy implementation and jurisprudence for maternal health and rights.

Summary of Findings on Maternal Health Jurisprudence: Maternal health litigation is uncommon and redress is rarely sought. Maternal health cases are not brought to court because the public lacks awareness of their health rights, fear victimization, have a fatalistic view, and perceive the process as costly.

STATE OF MATERNAL HEALTH LITIGATION TODAY

Finding 18: **Maternal health litigation is uncommon and alternative means are used to seek redress.**

Respondents in the FCT and seven states (all except for Jigawa state) said that litigation for maternal health is extremely uncommon. Most respondents indicated that they did not know of any maternal health cases that had been litigated. A lawyer in Enugu state reported that legal interventions are more common among women who are considered "higher status."

Some respondents alluded to the fact that people sometimes pursue alternative justice systems to seek redress. A health worker in the FCT spoke about patients petitioning clinics directly for cases of negligence. A state government official in Kano spoke about pursuing an edict to prevent early marriage, citing this as a central reason for maternal deaths in the state. A lawyer from Lagos state commented on the role mediation has played, although typically unsuccessful, and that litigation would probably reduce health practitioners' negligence and carelessness substantially. Finally, a respondent in Niger state drew attention to the fact that there may be in-roads to seek redress under Sharia law by taking a case to an Alkali court.

> *I can't say honestly that we are flooded with litigation cases concerning maternal health. Because, more often than not, the issue is a reluctance to make it a case, so we have more of mediation to resolve issue; you counsel and then it dies a natural death. Perhaps if we were litigating most of the cases, the issue of negligence and carelessness of health practitioners would reduce substantially.* – Legal respondent, Lagos state (Lagos City)

> *There are avenues to seek redress for violations of women's rights. Within Sharia, there are components that respect women's rights. In Sharia, a woman has the right to go to an Alkali to complain. Secularly, what are the components of reproductive health laws that are justiciable?* – CSO respondent, Niger state

ENABLERS OF AND CONSTRAINTS TO MATERNAL HEALTH LITIGATION

Finding 19: Maternal health court cases are constrained by unawareness of rights, fear of victimization, fatalism, and perceived cost.

A variety of respondents in Enugu, Kaduna, and Lagos states spoke of women's unawareness of their right to seek redress in court for grievances, and fear of victimization resulting from pursuing legal redress for maternal health-related cases. Respondents told of women being scared to speak up, families being the subject of gossip, and the prevailing perception that women should not air grievances in public. Respondents reported lack of confidence in authorities to pursue the matter and

medical staff's reluctance to appear in court because they do not want to give evidence against a colleague or be the cause of potential financial implications a successful case might have on the facility. Some respondents said that the cost of litigation precludes people from pursuing legal cases related to maternal health.

> *Fear always grips them. We don't even know our rights: what we are supposed to do and what we are not supposed to do. If you are talking, and even when what you are saying is right, the next person to you says "Shhhh, they will just kill you, O." You will just shut up.* – Woman respondent, Enugu state (Izi-Uzo)

> *Lots of women do not know if they can report and where to report, and as such people just normally give in to fate.* – Woman respondent, Lagos state (Mushin)

Male and female respondents in Bauchi, Enugu, Jigawa, Kaduna and Lagos states told stories of how "fatalism" prevents litigation of maternal health cases and that pregnancy-related death is seen as "God's will." Some spoke of the finality of death and the perception that pursuing legal redress after the fact is "considered a waste," due in part to the perception that the outcome will be unsuccessful.

> *I had an acquaintance who hadn't had a child in a very long time, and then she got pregnant… she was stressed and went into labor. They called the doctor, and he said he was coming, and the nurses said he was watching football [soccer]. By the time he came, she lost her baby so they just brought out a still birth. Did she want to sue? No! She said, "leave it to God," that she wants to cross that bridge and move on; God will bless her with another child.* – Legal respondent, Lagos state (Lagos City)

IMPROVED AND IMPLEMENTED MATERNAL HEALTH POLICIES

This section reports on existing maternal health policies and those being implemented at state and federal levels.

To achieve maternal health policy improvement and implementation by federal, state, and local level governments, especially the Free Maternal Health Policy, Advocacy Nigeria, CISLAC, and DevComs will work in the FCT, and Adamawa, Gombe, Jigawa, Kaduna, Kano, Katsina, Lagos, and Zamfara states. Grantees will advocate to legislative committees to oversee maternal health policies, and to policy makers to prioritize maternal health, and to improve and implement existing maternal health policies, especially implementation of free maternal health services.

Summary of Findings on Maternal Health Policy: Policy implementation is generally not prioritized. This is exacerbated by verbal policies that tend to fluctuate with frequent government turnover, due in part to election cycles and poor government coordination. The Free Maternal Health Policy is well-known and is in various stages of implementation across the country, but there is inconsistent understanding of what the policy covers.

Maternal health policy implementation is effective where there is government commitment/political will, skilled health workers, and technical and financial support from development organizations.

Maternal Health Policies Implemented at Federal and State Levels.

Finding 20:The Free Maternal and Child Health policy is well-known, but there is inconsistent understanding of what it covers and if it is being implemented.

Respondents in Bauchi, Enugu, Kaduna, Kano, and Lagos states spoke of the need to prioritize implementation of existing state and federal maternal health policies, and the need for better government coordination to move from paper to actual implementation. Respondents said that public pronouncements or verbal policies (i.e., statements made by government without legal backing) need to be signed into law. Respondents spoke about ensuring that the national health coverage policy is in place and that it covers all maternal health services.

Respondents in all eight sample states and the FCT spontaneously mentioned the Free Maternal and Child Health policy when asked what important maternal health policies exist and are being implemented in their states and nationally. State officials in Gombe, Kaduna, Kano, and Niger states said that the policy exists, but is not being implemented. Respondents in the FCT, and Enugu, Gombe and Lagos states said that most of the services under the policy were not totally free. Respondents in six sample states spoke of the need to improve communities' and rural women's awareness of maternal health, including the availability of state government-provided free antenatal care.

> *The most important maternal health policy I can remember in Bauchi state is Free Maternal and Child Health care services provided by the present government.* – Media respondent, Bauchi state

> *We have a pronouncement on provision of free maternal health services, not a written policy. We have a policy on free medical services for women and children. We also have a policy on free delivery at any health facility.* – State government respondent, Niger state

> *The free maternal health care is not really free, you buy card, etc… the doctors are also in short supply, and facilities are inadequate.* – CSO respondent, Gombe state

Finding 21: Maternal health policies are not being implemented due to lack of government commitment/political will, skilled health workers, and technical and financial support from development organizations.

Respondents in all eight states and the FCT said that the most important enabler of maternal health policy implementation is political will and government commitment, which in turn leads to the provision of funds to health services. Respondents noted that maternal health was key campaign point during the April 2011 state elections. Health personnel in Lagos state facilities and policy makers in Bauchi state spoke of the importance of health staff's capacity to implement policy, and the role state-level health workers' training has played in effective policy implementation. A range of respondents emphasized the importance of the technical and financial support development projects have provided for maternal health policy implementation through programs geared towards reducing maternal mortality, help in developing policies that promote maternal health rights, and funding for policy implementation.

> *What supports the implementation of these policies in the state is basically the government commitment toward health delivery in the state. The contribution of the donor agencies and CSOs also assisted, especially in ensuring the capacity building of the health workers, and provision and strengthening of the health facilities.* – Local government respondent, Bauchi state

Finding 22: Maternal health policy implementation is interrupted by frequent turnover of government officials and constrained by financial, logistical, and cultural issues.

Respondents in the FCT and Enugu, Gombe, Kano, and Lagos states reported that government response can hinder effective implementation of maternal health priorities. When there is a change of government, more often than not, policies are halted, especially if they are verbal policies. Respondents stated that, because of the political environment, there are constant changes in policy makers, and the Director and Permanent Secretaries in ministries are redeployed continuously making it difficult for policy implementation to continue seamlessly. Respondents reported that there is usually a lot of politicizing of issues in the country, including maternal health.

> *The major hindrance to the implementation of these policies is the policies introduced in the state* [that] *do not have legal backing, i.e., the house did not legislate on them.* – State government respondent, Gombe state

According to Respondents in Bauchi, Enugu, Gombe, Jigawa, and Lagos states, inadequate funding at the state level hinders implementation of health policies, especially in terms of not having an appropriate supply of drugs and other commodities, and shortage of staff.

> *Bauchi state like any other state in the country, and North East in particular, is faced with the challenge of funds, and it hinders the proper implementation of maternal health policies in the state. Other factors include shortage of trained manpower, which includes community health workers, traditional birth attendants, and health volunteers.* – State government respondent, Bauchi state

Conclusions

The baseline findings were validated at the Abuja Data Consultation meeting in October 2014. External and internal stakeholders confirmed the findings were accurate and grounded in the Nigeria's context.

The assumptions and information on which the grant portfolio was built remain relevant. The seven grants, four accountability pathways, and theory of change respond to the existing challenges and opportunities to advance maternal health and reduce maternal mortality in Nigeria.

The general public seems disenfranchised to take action needed to foster change in maternal mortality. Without a 'thirsty' public, there is little incentive to publish stories, participate in MDRs, bring maternal health cases to court, or implement policies. The grant portfolio is addressing this challenge through the community mobilization strategy by fostering collaboration among civil society to monitor health service delivery and advocate for policy implementation (including budget performance), improving media coverage, and improving the maternal death audit processes. In order to strengthen the maternal health evidence base, grantees are organizing and mobilizing CSOs to monitor maternal health service delivery, and marshaling media for increased and improved frequency and coverage of maternal health and mortality. Government commitment to social change also depends on a vibrant and empowered media sector to collect and disseminate information on service delivery performance, and to expose corrupt practices through awareness-building and investigative reporting.

There is a need, however, for more emphasis in the portfolio on budget performance; one grantee seems insufficient given the importance of this accountability strategy in Nigeria. Also there is strong resistance and suspicion from the Federal Ministry of Health down to facilities regarding the MDR process and reporting, which the Foundation and grantees need to address stridently.

Considerations

This section presents considerations for grantees and the MacArthur Foundation based on the conclusions, baseline findings, and the Data Consultation meeting. These considerations are organized by the baseline questions.

1. **How are civil society organizations collaborating and coordinating around maternal health accountability? What hinders and supports collaboration and coordination?**

Civil society collaboration is important to minimize duplication and increase joint advocacy for maternal health that will, in turn, strengthen demands for government accountability and quality maternal health services.

There is evidence of some collaboration among CSOs largely enabled by a shared passion for maternal and reproductive health, partnerships/networks, and development projects. Deeper collaboration, however, is currently constrained by competition among organizations, mainly fueled by funding and shifting funding streams. At baseline, civil society collaboration in Enugu, Kaduna, and Kano states is especially strong.

Portfolio grantees working on the community mobilization strategy are needed across states. Advocacy Nigeria, CHR, CISLAC, and DevComs are playing a coordinating role in Kaduna and Kano states. They are, therefore, well-placed to build on the existing relationships. Grantees working with CSOs may consider strengthening partnerships and networks. The data show that partnerships and networks play an important oversight function of their members by specifying roles and responsibilities, such as via memorandums of understanding or by identifying independent monitors to help solve problems and define roles.

2. What enables and hinders Maternal Death Review committee formation and functioning?

Maternal Death Reviews are useful tools for measuring and improving quality of care in a variety of contexts. The process includes case identification, data collection, and analysis of findings and action. In order for MDRs to be effective perceptions of accountability need to change by moving away from blame-placing towards making necessary changes that contribute to reductions in maternal mortality. This includes anonymity in conducting maternal death audits at the local level where it may be hard to maintain.

For MDRs to work, there needs to be an enabling environment. The National Council on Health approved MDR policy and guidelines in August 2013. The establishment of a federal-level MDR committee, which requires the Minister of Health signing the draft guidelines, would complete the process. Eventually, MDRs will require legislation that insulates reports from the legal system and ensures confidentiality throughout the process.

At baseline, MDR Committee recommendations are largely unused so more is needed to increase understanding among health providers that MDR reports are purely intended for fact-finding, internal improvements, and advocacy purposes, not for litigation.

SOGON, WHARC, and WARD C, with the Foundation, should consider a joint approach/strategy for helping the Federal Ministry of Health and other stakeholders understand the synergistic efforts of portfolio activities to support MDRs and advance jurisprudence for maternal deaths. It is very important that stakeholders are well-informed that these activities are not mutually exclusive or contradictory, that they clearly understand that MDR reports will not be used for litigation purposes, and that litigation is everyone’s right even if MDR reports cannot accommodate it.

3. What maternal health evidence are media houses, policy makers, and lawyers using to inform their maternal health-related work?

Journalists, lawyers and government officials, key partners in the Portfolio’s theory of change, must be able to draw on accurate and timely information for meaningful reporting, litigation, and policy development, improvement, and implementation. The process of gathering, accessing and using information is complex, and understanding the drivers of that process can help sharpen the portfolio going forward. Meaningful information on maternal health involves accurate data, awareness that the data exists, access to the data, and requisite skills to use the data. At baseline, a central, Nigeria-specific resource on maternal health is not available. Portfolio grantees’ are well placed to contribute to filling this gap by building a maternal health evidence-base in Nigeria and creating a central resource for access and use.

4. What is the extent and quality of media coverage of maternal health? What enables and constrains maternal health reporting?

The media has become part of the structure to ensure accountability as CSOs continue to improve media's knowledge and role, and engage them in holding government accountable to their commitments. The media have an important role to play in information dissemination regarding service delivery performance, and in exposing corrupt practices through both awareness-building and investigative reporting. Collaboration with other journalists, CSOs, and development projects is seen as important to improving the quality of media coverage in terms of sharing knowledge and having strength in numbers for media coverage of sensitive topics.

Baseline data show that media coverage of maternal health topics was generally infrequent and inaccurate, and existing programs and reports are primarily driven by international organization or project funding. Data indicate that more reporting on maternal health can be achieved by identifying and fueling passion for the topic amongst journalists, and by assisting with exercising rights under the Freedom of Information Act to combat media censorship and victimization.

More work is needed to build journalists' technical capacity in maternal health. Grantees may consider encouraging CSOs to form long term partnerships with journalists on project implementation, not just collaboration on discrete activities, in order to build deeper understanding of and commitment to maternal health, and to ensure they are working with the "right" journalists, and including media house executives as well as journalists.

5. What are 2014 maternal health budget allocations, disbursements, and use rates? What enables and hinders maternal health budget performance at the federal, state, and local level?

Monitoring government expenditures (budget tracking and analysis) involves monitoring government-approved budgets for maternal health, and checking them against actual federal, state, and local government expenditures. Budget tracking and analysis reports can be used for advocacy to improve budget performance for maternal health policy and program implementation. Challenges identified by the Foundation and grantees prior to baseline include the lack of earmarking for all maternal health costs, and government reluctance or inability to release budget data. The baseline findings show that these challenges still exist. The Foundation may want to consider increasing the number of grantees working on budget analysis and tracking so as to deepen stakeholder participation in budget processes, ensure that budgets are appropriately aligned with needs, and improve budget monitoring.

6. a) What is the state of maternal health litigation? What enables and hinders litigation of maternal health cases?

Legal strategies for holding governments accountable include a range of activities, from case documentation to strategic litigation in courts, writing shadow reports, and drafting policy briefs. Dissemination of cases by media is essential to raising awareness among the public and key stakeholders, such as health systems and judicial branches. Legal strategies seek redress and systemic changes to prevent future abuses. This grant portfolio seeks to contribute to improved maternal

health policy effectiveness (both policy change and effective implementation) by advocating for policy development and implementation, including litigation. At baseline there are strong cultural and legal barriers, and resistance to fully executing existing legal strategies. WARD C may want to consider broader stakeholder engagement in legal strategies as an approach to holding governments accountable, as well as awareness-raising among health providers, relatives of the deceased, and others on legal strategies and rights related to maternal death.

b) What federal and state maternal health policies exist? Which policies are being implemented?

Accountability involves holding the government answerable for commitments made. Nigeria is considered one of the countries whose achievement of Millennium Development Goal 5 by 2015 is unlikely. The government has made some political commitments and pronouncements – such as saving one million lives by 2015 – and started initiatives targeted at women and children. Other efforts include state-specific initiatives such as free maternal services for pregnant women in public facilities, introduction of free family planning services in all government hospitals, and commitment of funds to family planning commodity security.

The baseline data show that policy implementation remains a challenge, and that is coupled by the public's lack of knowledge or understanding of existing policies. Portfolio grantees are well placed to collaborate with others for strategic advocacy for full policy implementation, continuous monitoring of policy implementation, and increased understanding among communities and women of policy use, maternal health rights, and legal avenues.

Annex 1. Evaluation Team Members

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Annex 2. Observable Actions in the Spheres of Control, Influence and Interest

Sphere of Control	Sphere of Influence		Sphere of Interest
	Boundary Partners	Actions	
Sensitize and increase awareness (training, workshops, advocacy campaigns)	• Lawyers • Civil society organizations • Community members • Maternal Death Review (MDR) Committees (state, community, and facilities) • Media • Legislative committees	• Lawyers litigate on maternal health cases • Civil society and community members advocate for and monitor government commitments to and actions on maternal health (legal, policy, budget, maternal deaths) • MDR committees are active and generate accurate maternal death reports • Media (electronic, print, social) accurately cover maternal health • Legislative committees oversee maternal health policies	• MDRs are used to improve planning and practice • Increased media coverage of maternal health • Increased jurisprudence around maternal rights and formulations of new laws and policies on maternal health • Increased community reporting on maternal deaths • Existing maternal health policies improved and implemented • Increased budget allocations, disbursements and use
Form civil society organization coalitions	• Civil society organizations (including grantees)	• CSOs collaborate to minimize duplication and increase joint advocacy for maternal health (legal, policy, budget, maternal deaths) • Civil society and community members advocate for and monitor government commitments to maternal health	
Increase the evidence base (web portal, resources)	• Media • Policy Makers • Lawyers	• Media use evidence to write stories on maternal health • Policy makers use evidence to inform maternal health policy decisions • Lawyers use resources for maternal health litigation	• Improved data for planning • Free maternal health policy implemented
Track and analyze budgets (expenditure analysis, allocation analysis, project costing)	Policy Makers (state, national, local)	• Maternal health budget allocations are released and used	• Improved budget performance of government resources for maternal health

Annex 3. Data Collection Matrix

The table below presents the key evaluation questions and sub-questions, illustrative indicators and data sources, and the questions used for this baseline. This data collection matrix was developed during baseline activities. Indicators and data sources will be refined as grantees finalize their monitoring strategies and begin collecting data. The indicators listed will be used for analysis at midline and will be further refined and prioritized during the midline evaluation design meeting. The baseline and grantee monitoring activities will provide comparative data to track progress along the way.

Evaluation Questions	Relevant Sub-questions	Illustrative Indicators of Progress/Results	Illustrative Data Sources	Baseline Questions
1. In what ways does civil society collaboration and coordination lead to increased government accountability to maternal health?	a. What enables and hinders civil society collaboration and coordination for maternal health accountability? b. How has civil society collaboration influenced changes in government commitment to maternal health?	Number of interventions/actions taken by Advocacy Nigeria, CISLAC, DevComs, and CHR that have directly or indirectly mobilized civil society to influence or change government commitment to maternal health Government stakeholders perceive that civil society collaboration and coordination has led to increased government accountability to maternal health	Interventions and actions tracked by grantees Data collection during midline and endline evaluations to capture changes in perceptions	a. What enables and hinders civil society collaboration and coordination for maternal health accountability? b. How are organizations collaborating now, and what opportunities for collaboration in the future do organizations see?
2. What enables and constrains activation and accurate reporting by Maternal Death Review committees?	a. How has the grant portfolio influenced the formation of Maternal Death Review Committees? b. How has the grant portfolio influenced the effectiveness of Maternal Death Review Committees? c. How has the grant portfolio influenced	Number of MDR committees reached by SOGON and community verbal autopsies facilitated by WHARC Percent of MDR committees in the FCT that meet at least once every two months Topics discussed at committee	Attendance lists collected by SOGON and WHARC for all training, meetings, and consultations Evidence of meetings (minutes, attendance lists, etc.) collected by SOGON MDR Committee meeting	a. What enables and hinders formation and functioning of Maternal Death Review Committees?

Evaluation Questions	Relevant Sub-questions	Illustrative Indicators of Progress/Results	Illustrative Data Sources	Baseline Questions
	the accuracy of Maternal Death Review reports? d. How has the grant portfolio influenced the use of Maternal Death Review reports? e. What enables and hinders successful Maternal Death Review Committees?	meetings align with best practices Facilities use MDR reports to improve maternal health processes. Key stakeholders perceive improvement in accuracy of maternal death reporting	minutes collected by SOGON Data collection during midline and endline evaluations/media reports collected by SOGON and WHARC research report Data collection during midline and endline evaluations/Media reports collected by SOGON and WHARC	
3. In what ways has the grant portfolio contributed to the evidence on maternal health and accountability?	a. How have grantee contributions to the evidence base (portals, publications, resources, etc.) been used by media, lawyers, and policy makers to inform their work?	Number of maternal health evidence documents produced by Advocacy Nigeria, CISLAC, and DevComs Maternal health evidence documents developed by grantees are cited by stakeholders sampled in the evaluation (disaggregated by distribution channels) Monthly increase in the number of web hits on information websites developed by DevComs	Evidence produced by grantees Data collection during midline and endline evaluations to focus on the influence of a sample of documents and distribution channels Website analytics from DevComs	a. What evidence do media houses use to inform print stories, electronic programs, and social media on maternal health? b. What evidence do policy makers use to inform policy improvements and implementation? c. What evidence do lawyers use for maternal health litigation?
4. To what extent has the grant portfolio led to improved media reporting on maternal health?	a. How has the grant portfolio influenced reporters to write more and more accurate stories on maternal health? b. What has changed in the quantity of media reporting on maternal	Number of journalists trained by DevComs and CISLAC in maternal health reporting Percent of media staff trained by DevComs and CISLAC who produce at least two reports on maternal health/maternal mortality within 1 year of the training (disaggregated	Training attendance lists collected by DevComs and CISLAC Media Tracking Reports produced by DevComs Interviews by DevComs and CISLAC with trained media staff.	a. What is the extent of media coverage on maternal health today? b. How is the quality of media reporting on maternal health perceived today? c. What are the current enablers and

Evaluation Questions	Relevant Sub-questions	Illustrative Indicators of Progress/Results	Illustrative Data Sources	Baseline Questions
	health over the grant portfolio lifecycle? c. What has changed in the quality of media reporting on maternal health over the grant portfolio lifecycle? d. What enables and hinders media reporting on maternal health?	by type of media – print/radio/TV/electronic) Key stakeholders perceive increase quantity and improved quality of maternal health reporting	Data collection during midline and endline evaluations to focus perceptions of improvement of a sample of reporting and distribution channels	constraints that influence media reporting?
5. How has the grant portfolio contributed to improved maternal health budget performance at federal, state, and local levels?	a. How has the grant portfolio contributed to maternal health budget allocations (disaggregated by level)? b. How has the grant portfolio contributed to disbursement of maternal health budget allocations (disaggregated by level)? c. How has the grant portfolio contributed to usage rates of maternal health funds (disaggregated by level)? d. What enables and hinders maternal health budget	Number of CSOs trained by CHR advocating for improved budget performance for maternal health to local and state governments Policy makers perceive CSO advocacy and budget analysis as positively influencing maternal health budget performance	Attendance lists collected by CHR Advocacy material produced by CSOs Data collection during midline and endline evaluations to focus on the influence of a sample of advocacy/budget analysis activities and associated targets for those activities	a. What are 2014 maternal health budget allocations at federal, state, and local levels? b. What are the maternal health budget disbursements at federal, state, and local levels at data collection? c. What are the maternal health budget utilization rates at federal, state, and local levels at data collection? d. What enables and hinders maternal health budget performance (disaggregated by level)?

Evaluation Questions	Relevant Sub-questions	Illustrative Indicators of Progress/Results	Illustrative Data Sources	Baseline Questions
	performance (disaggregated by level)?			
6. How has the grant portfolio influenced maternal health policy effectiveness (policy change, effective implementation)?	a. How has the grant portfolio influenced litigation of maternal health cases? b. How has the grant portfolio contributed to maternal health policy change? c. How has the grant portfolio contributed to effective implementation of maternal health policies?	Number of maternal mortality litigation cases brought to court by lawyers reached by WARD C Civil society advocates or policy makers perceive that Advocacy Nigeria, CISLAC, and DevComs have contributed to improved effectiveness of maternal health policy implementation	New cases taken up by trained lawyers tracked by WARD C WARD C summaries (2 per year) of maternal mortality cases that capture successes, challenges, and lessons learned Data collection during midline and endline evaluations to focus on the influence of a sample of activities and associated targets of those activities Data collection during midline and endline evaluations to focus on the influence of a sample recommendations and policy makers	a. What is the state of maternal health litigation today? b. What enables and hinders litigation of maternal health cases? c. What maternal health policies exist at federal and state levels? d. What maternal health policies are being implemented at federal and state levels?

Annex 4. Grantee Activities Across Accountability Areas and States

Grantee (accountability area)	Activities	States / FCT
Advocacy Nigeria **Community mobilization (policy advocacy)**	• Advocate to policy makers for prioritization of maternal health, especially implementation of free maternal health services (with CHR, CISLAC and DevComs) • Organize civil society groups to monitor the delivery of services in their communities and demand quality services	Adamawa, Gombe, Zamfara
CHR **Community mobilization (policy advocacy), budget analysis**	• Support quarterly state-level activities of Integrated Supportive Supervision • Strengthen Ward Development Committees forum at the state level for effective advocacy and engagement of LGAs on improved maternal health • Enhance advocacy and budget analysis/tracking skills of CSOs for advocacy to LGAs and states (with Advocacy Nigeria and DevComs) • Strengthen existing accountability mechanisms and establish them where they do not exist • Support media engagement in maternal, newborn and child health through the Accountability in Maternal Health in Nigeria structure	Bauchi, FCT, Jigawa, Kano, Niger, Sokoto
CISLAC **Community mobilization (policy advocacy)**	• Build capacity of legislative committees in their oversight functions and substantive maternal health issues • Advocate to legislature leadership to establish legislative committees where they do not exist • Advocate to and engage lawmakers and policy makers around existing maternal health policies • Mobilize CSOs and media to pressure governments to deliver maternal health services • Mobilize media for increased and better coverage of maternal health issues (with DevComs) • Develop policy briefs • Produce a bi-monthly newsletter with pages dedicated to maternal child health	Jigawa, Kaduna, Kano, Katsina
DevComs **Community mobilization (media, policy advocacy)**	• Increase public awareness and demand for maternal health through use of social and other media • Increase media frequency and coverage of maternal mortality • Increase knowledge and action of policy makers around maternal health • Collaborate and coordinate with other CSOs on media related to maternal health	FCT, Jigawa, Kaduna, Lagos
SOGON **Maternal death audits**	• Pilot a common maternal death review tool at selected facilities and communities	FCT

Grantee (accountability area)	Activities	States / FCT
WARD C **Legal approaches, community mobilization (policy advocacy)**	• Develop jurisprudence around maternal and health rights • Develop public campaigns on maternal health (with DevComs and Advocacy Nigeria) • Research and documentation on maternal health and rights in Nigeria • Mobilize community members on maternal health	Enugu, Kaduna, Lagos
WHARC **Maternal death audits**	• Implement MDRs at facilities and conduct verbal autopsies at community level (with SOGON, and DevComs)	Lagos

Annex 5. Sampling Strategy

Given available resources, baseline data collection was limited to eight states and the FCT, selected using the following criteria:

- Accessibility
- Security
- Geographical spread
- Population density
- Breadth of accountability strategies
- Density of grantee activity
- Magnitude of maternal health challenges

The list of selected eight states and FCT and 16 LGAs in the sample are as follows:

State	LGA	Geopolitical Zone
N/A	Abuja Metropolitan	FCT
Niger	Chanchaga	North Central
Jigawa	Dutse	North West
Kaduna	Kaduna North, Kaduna South, Kaura	North West
Kano	Kano Central (includes Fagge LGA), Khumbotso	North West
Bauchi	Bauchi	North East
Gombe	Gombe	North East
Enugu	Enugu South, Isi-Uzo, Nkanu East	South East
Lagos	Ajeromi, Lagos City (inclusive of Ikeja, Kosofe, Lagos Island, Surulere, and Yaba LGAs), Mushin	South West

Annex 6. Stakeholder Groups by State

Stakeholder	State(s)
Civil Society Organization	
Jama'atu Nasril Islam	Bauchi, Gombe, Jigawa
International Federation of Female Lawyers (FIDA)	Enugu, Lagos
Federation of Muslim Women Association of Nigeria (FOMWAN)	Bauchi, Jigawa, Niger
Civil Resource Development and Documentation Centre (CIRDDOC)	Enugu
Community Health and Research Initiative (CHR)	Kano
Civil Society Legislative Advocacy Centre (CISLAC)	Kano
Adolescent Health Information Project (AHIP)	Kano
Development Communications Network (DevComs)	Lagos
Women Advocates Research and Documentation Centre (WARD C)	Lagos
Centre for Women Health and Information (CEWHIN)	Lagos
International Centre for Reproductive Health and Sexual Rights (INCRESE)	Niger
Christian Association of Nigeria (CAN)	Bauchi
Planned Parenthood Federation of Nigeria (PPFN)	Niger
Maternal Child Health Partnership	Kaduna
Mothercare NGO	Kaduna
Support Health and Education for Development (SHED)	Kaduna
Society for the Future	Gombe
Waziri Yariman	Gombe
Advocacy Nigeria Network	Bauchi
AAON	Gombe
Village Development Initiative	Jigawa
Life Rehabilitation Foundation for Womanhood	Niger
Nigerian Youth Parliament	Kano
Professional Associations	
National Association of Community Health Practitioners of Nigeria	Bauchi
Nigerian Bar Association	Enugu, Kaduna
National Union of Journalists (NUJ)	Gombe, Kano
Society of Gynecology and Obstetrics of Nigeria (SOGON)	FCT

Stakeholder	State(s)
Government	
State Primary Health Care Development Agency	Bauchi, Gombe, Kaduna, Niger
Ministry of Finance	Bauchi
Ministry of Justice	Enugu
Ministry of Gender Affairs and Social Development	Enugu
Department of Foreign Affairs, Trade and Development	FCT
Subsidy Reinvestment and Empowerment Programme (SURE-P)	FCT
Ministry of Women's Affairs	FCT, Jigawa
Ministry of Health	Gombe, Lagos, Kaduna, Kano
State House of Assembly (Committee on House, Committee on Women's Affairs, House Committee on Finance)	Gombe, Jigawa, Kaduna, Kano
Primary Health Care Agency	Gombe, Kaduna, Kano, Lagos
Ministry of Economic Planning	Kaduna
Malaria Control Booster Project	Bauchi, Gombe, Jigawa
Niger State Planning Commission	Niger
State Secretariat	Niger
Planning, Budget and Economic Planning Directorate	Jigawa
Civil Society and International Partners Matters National Assembly	Kano
Health Management Board	Kano
Local Government	Bauchi
Primary Health Care Board	Lagos
Gunduma Health System	Jigawa
Gombe Emirate Council	Gombe
International Organizations, Projects, Universities, and Donors	
Expanded Social Marketing Project in Nigeria (ESMPIN) Project	Enugu
African Law Foundation	Enugu
Accountability Mechanism for Maternal Health in Nigeria (AMHIN)	FCT
Partnership for Transforming Health Systems (PATHS2)	Enugu, Jigawa, Kano
State Accountability and Voice Initiative (SAVI)	Kaduna
AID Foundation	Kaduna
Evidence for Action (E4A)	FCT
Centre for Development and Population Activities (CEDPA)	FCT
Nigerian Urban Reproductive Health Initiative (NURHI)	FCT

Stakeholder	State(s)
Society for Family Health	Enugu, Kano
Women for Health (W4H)	Kano
United Nations Development Programme (UNDP)	Niger
University of Aberdeen	United Kingdom
Canada Department of Foreign Affairs, Trade and Development (formerly Canadian International Development Agency)	FCT
Media	
Nigerian Television Authority	FCT, Jigawa, Kano
Gombe Media Corporation	Gombe
Abubakar Rimi TV Kano	Kano
Radio Kano	Kano
Bauchi Radio Corporation	Bauchi
Daily Trust Newspaper	Gombe
Freedom Radio Dutse	Jigawa
Radio – GMC	Gombe
Facility	
General Hospital Ajeromi	Lagos
Gbagada General Hospital	Lagos
MDR Committee	FCT, Lagos
Asokoro District Hospital	FCT
Island Maternity Hospital	Lagos
Other	
Women utilizing facilities and participating in WARD C activities	Bauchi, Enugu, Jigawa, Kaduna, Lagos

Annex 7. Data Collection Tools

The interview and focus group discussion guides used for data collection are provided here. All respondents were administered a confidentiality and informed consent statement.

FOCUS GROUP DISCUSSION GUIDES

CSOs

ENABLERS AND CONSTRAINTS TO CSO COLLABORATION AND COORDINATION AROUND MATERNAL HEALTH

1. **Please tell us your first name and years working on maternal health.**

2. **Please take a moment and reflect on a time when you felt that civil society collaboration and coordination made an exceptional difference in holding governments accountable to maternal health in your state/Federal level. Please describe that time, what made it successful, what role you and your organization played, and what others did to make it successful.**

Affinity mapping questions

- *What themes do you see?*
- *What surprises you?*
- *What concerns you?*
- *What hinders civil society collaboration and coordination? (**capture these on a flipchart**).*
- *How are organizations collaborating and coordinating now around maternal health accountability? (**capture these on a flipchart**).*
- *What opportunities do you see in the future for civil society collaboration and coordination around maternal health accountability?*
- *Is there anything else they would like to share related to CSO collaboration and coordination?*

JOURNALISTS

ENABLERS AND CONSTRAINTS TO EFFECTIVE MEDIA REPORTING ON MATERNAL HEALTH

1. **Please tell us your name and years working as a journalist**
2. ***Please* take a moment and reflect on your involvement with media reporting experience. What enables and constrains *accurate* and quality stories in State/Nigeria today?**

Affinity Mapping Questions

- *What themes do you see?*
- *What surprises you?*
- *What concerns you?*

Ask:

- *To what extent do you report on maternal health?*
- *In what ways is reporting on maternal health different from reporting on other stories?*
- *Where do you look for information to write stories on maternal health?*
- *Ask them if there is anything else they would like to share related to media reporting on maternal health?*

WOMEN

ENABLERS AND CONSTRAINTS TO WOMEN HOLDING GOVERNMENT ACCOUNTABLE FOR QUALITY MATERNAL HEALTH SERVICES

1. **Please tell us your first name and engagement with WARD C.**

2. ***Please*** take a moment and reflect on **women's experiences with** maternal health **services in your State/LGA. What supports exist for women to bring cases of** mistreatment or maltreatment related to maternal health services?

Affinity Mapping Questions

- *What themes do you see?*
- *What surprises you?*
- *What concerns you?*

3. ***Please*** take a moment and reflect on **women's experiences with** maternal health **services in your State/LGA. What hinders women from bringing cases of** mistreatment or maltreatment related to maternal health services?

Affinity Mapping Questions

- *What themes do you see?*
- *What surprises you?*
- *What concerns you?*

Ask:

- *What more needs to be done for women and their families to demand better maternal health services? (**capture these on a flipchart**).*
- *What more needs to be done for women and their families to bring maternal health cases of mistreatment or maltreatment to court? (**capture these on a flipchart**).*
- *Is there anything else they would like to share related to government accountability to maternal health?*

SEMI-STRUCTURED INTERVIEW GUIDE

The evaluation team developed a master interview guide that was then tailored for each stakeholder group. In most cases the evaluation team was unable to ask all questions. Below is the representative master protocol.

BACKGROUND

1. **We are aiming to get a better understanding of maternal health activities in Nigeria. From your perspective, what are the maternal health priorities in your State/Federal level?** *(select the most relevant context)*

2. **What is your involvement in maternal health?**

3. **Reflecting on your work or engagement in maternal health, I'd like you to share one time you felt you made an exceptional difference in advancing maternal health in your State/Federal level. Please describe that time, what made it successful, what role you and your organization played, and what others did to make it successful.** *(select the most relevant context)*

Looking for *a specific story that details what supports maternal health in terms of media report, legislation, budget performance, and social mobilization.*

Use of Maternal Health Evidence

4. **Given your role in maternal health in your State/Federal level,** *(select the most relevant context)* **where do you go to get updated information on maternal health?**

- **For journalists** – ask about information to inform print stories, electronic programs and social media on maternal health
- **For policy makers** – ask about information to inform policy decisions
- **For respondents in the legal field** – ask about information to inform maternal health litigation
- **For civil society organizations** – ask about information for advocacy and monitoring government commitments

Probe for portals, websites, social media, newspapers, radio, TV….

5. **How do you tend to USE this information in your work?**

- **For journalists** – ask about use of information to inform reporting
- **For policy makers** – ask about use of information to inform policy decisions
- **For respondents in the legal field** – ask about use of information to inform maternal health litigation
- **For civil society organizations** – ask about use of information for advocacy and monitoring government commitments

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Maternal Death Reviews

6. **In what ways are you involved with maternal death reviews?**

Probe for knowledge and involvement with MDR committees and for how long. If no engagement, skip section.

7. **Who else is working on improving maternal death reviews in Nigeria?**

8. **In what ways has the maternal death review process been successful? What is going well?**
   a. What needs to change to have even more success?

9. **We understand that in some cases, MDR committees have been formed, and in other cases, they have not. What do you think supports MDR committee formation? What do you think hinders MDR committee formation?**

10. **We understand that some MDR committees are active, and others are less so. Why do you think this is the case? What factors support MDR committees to be active? What factors hinder MDR committees from being active?**

Budget Tracking and Analysis

11. (if not directly involved in health budgets) – **What is your involvement with health budget development, allocations and use at Federal, State, or LGA levels?**

If no engagement skip section.

12. **Who else is working on Maternal Health budgets?**

13. **In what ways are Nigeria's maternal health budget development, allocations, and use at federal, state, and LGA levels working well?**
    a. What needs to change for budget development, allocation, and use to work even better?

Probe for differences at federal, state, and LGA levels

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Improved Media Reporting

14. **Please reflect on a recent story in the media on maternal health that you read or wrote that was accurate and effective. Where did you read that story? What made it accurate and effective?**

15. **In what ways are the media accurately reporting on maternal health?**
    a. What needs to change to have even more accurate reporting on maternal health by the media?

16. **What supports media to write accurate, quality stories on maternal in Nigeria? What hinders them?**

Civil Society Collaboration

17. **What is your involvement with civil society working on maternal health?**

18. **Reflecting on your work or observations, I'd like you to share one time you felt that civil society collaboration and coordination made an exceptional difference in holding governments accountable to maternal health in your state/Federal level/Nigeria,** *(select the most relevant context).* **Please describe that time, what made it successful, what role you and your organization played, and what others did to make it successful.**

19. **In what other ways are civil society organizations collaborating and coordinating successfully to hold governments accountable to maternal health commitments?**

20. **What supports civil society organizations to collaborate and coordinate successfully to hold governments accountable to maternal health today?**

21. **What hinders civil society organizations from deeper collaboration and coordination around maternal health?**

Maternal Health Policy Effectiveness

22. **What important maternal health policies exist in Nigeria today?**

Probe for Federal, state and LGA levels

23. Which of these policies are being implemented?

24. What supports maternal health policy implementation?

Probe for level of support and different forms of support.

25. What hinders maternal health policy implementation?

26. If you were granted three wishes to improve maternal health policies in Nigeria what would they be?

For legislative committee members:

27. Please describe your role on the legislative committee.

28. Reflecting on the committee's role in overseeing maternal health policies, what is the committee doing especially well?

29. What could be improved about the way the committee oversees maternal health policy?

For lawyers, and other stakeholders involved in maternal health litigation:

30. In what ways are you involved in maternal health cases?

31. How would you assess the state of maternal health cases in your State/Federal level/Nigeria today? *(select the most relevant context)*

Probe for quantity and types litigation cases

32. What supports and hinders maternal health cases being brought to court in your State (or at Federal level)?

33. What is needed for more maternal health cases to be brought to court?

34. What else influences maternal health litigation in your State (or Federal level)?

Concluding Questions

35. What else would you like to tell me/us but didn't because I/we didn't ask the right question? Any other comments/insights/questions you would like to share?

Annex 8. Evaluation Limitations

The following limitations were identified for this evaluation:

Collecting Comprehensive Data at Baseline

Assessing actual baseline values to be judged against at midline and endline was constrained for some of the areas by concurrent evaluative activities. The evaluation team simultaneously collected baseline data in the Sphere of Influence while building capacity of grantees to develop monitoring systems and skills for collecting and analyzing data in the Sphere of Control. Given this, some of the baseline data in the Sphere of Control will be collected after the baseline and be used as comparative data for midline.

Context

All data collection protocols focused on maternal health, but in some cases it was unclear if respondents were speaking about maternal health or health in general.

Sample

Due to budget constraints, data collection teams had only 3 days in each state to conduct interviews and focus group discussions, and collect relevant documents. This limited timeframe precluded more comprehensive data collection in terms of sample size, and traveling outside of state capitals.

The evaluation team aimed to collect data in two LGAs per state to get LGA stakeholders as well as Federal and state stakeholder perspectives, but that was not possible in Bauchi, Gombe, Jigawa and Niger States, and the FCT due to several factors. Generally MacArthur Foundation grantee activities in this portfolio take place in the state capital, and almost all the planned respondents were located in the state capital. In Gombe state the team was constrained by time, and the facilities identified by the Gombe State Primary Health Care Development Agency were in areas perceived to be relatively urban. Grantees are only working in urban areas of Bauchi state, and arranging visits to rural facilities could take days, and some LGAs such as Tafawa Balewa were inaccessible due to high levels of violence.The one grantee with activities planned in Niger state had not begun any form of engagement in the state so could not provide any contacts for the evaluation team. The evaluation team secured the help of an interlocutor through the MacArthur Foundation and used our own connections to identify key respondents, which were all in the state capital. In the FCT, the grantee had not yet selected facilities to work with at the time of data collection, there were bureaucratic bottlenecks around inaugurating the MDR committee, and the grantee was unable to provide any contacts outside Abuja. Other interviewees in the FCT were Federal level-focused.

Among the states where data were collected, MDR committees were formed only in Lagos state, so the data on enabling and constraining factors for MDR committee functioning were limited.

In Jigawa state, the evaluation team spent a significant amount of time obtaining clearance to conduct the baseline. Once clearance was granted, the state experienced serious security challenges that nearly resulted in suspending data collection there, and restricted the team to the state capital.

Budget Analysis

Allocation and disbursement data are based on a review of 2012, 2013, and 2014 Federal government health budget summaries. To facilitate the review, the following keywords were used: maternal, obstetrics, reproductive, MNCH (maternal, newborn, child health), and midwife. The findings pertain to line items with these keywords. The data presented in the findings pertain to line items that had more than 1 year of allocation and expenditure data, which allowed for an examination of trends across years. Budget formats and line item wording change from year to year, therefore, the keyword search could have inadvertently omitted recurring line items.

Annex 9. Data Consultation Meeting

A 2-day data consultation meeting in Abuja was held October 14-15, 2014 with 20 participants from all portfolio grantee organizations, and five representatives from the MacArthur Foundation Nigeria office. The first day included 16 representatives from a sample of key stakeholders including Federal Ministries, development partners, professional associations (lawyers and journalists), international organizations/projects, and civil society. The meeting allowed grantees and key stakeholders to validate and interpret baseline findings, provide input into the conclusions and considerations, and discuss the implications of the baseline findings and conclusions, and identify considerations for the maternal health community going forward. The following are summaries of the key discussions that occurred on the first day of the data consultation meeting.

MDRS AND MATERNAL DEATH LITIGATION

There was much debate during the meeting when some participants raised concern that the Foundation's grant portfolio had two, seemingly conflicting approaches: (1) advancing the formation and functioning of MDR committees, and (2) creating an environment to enable maternal death litigation. A Federal Ministry of Health representative expressed unease about having these two activities in the same grant portfolio when Nigeria is still in the early stages of the MDR system and explicitly established the "no name, no blame, no shame" policy to assure health providers that MDRs are not punitive or used for litigation, but serve as an audit for fact finding to inform health facilities. Participants acknowledged that this tension is reflective of the ongoing debate in Nigeria and, it may be difficult for those working on the MDR process to collaborate with those working on jurisprudence. Participants remarked that this "double-edged sword" has the potential to exacerbate the lack of demand for and difficulty in obtaining maternal death reports by an apathetic public. Additionally, as one participant pointed out, states have not legalized the Federal-level approved MDR process so until states send guidelines to their respective assemblies for enactment this will continue to be a constraint.

There is a draft MDR policy currently with the Federal Ministry of Health for approval, but several states have started using it. According to stakeholders, what is left is to print the final document. There is also the need to adopt the draft document and to formalize it. The guideline document was submitted to the Ministry in 2011 and the National Council on Health (the highest governing body on health for which the Ministry of Health is the Secretariat) adopted the document in August 2013. What remains is for the Federal Ministry of Health to append it with the signature of the Minister. The implication is that since the National Council on Health adopted the guidelines some states have been using it to implement MDRs at various stages and it is the guidelines adopted in the FCT. Participants are unsure why there is a delay in ministries approval when the greatest barrier of getting the National Health Council to adopt the guidelines has been done.

CHALLENGES IN MEDIA REPORTING ON MATERNAL HEALTH

In the discussion on media, some participants remarked that journalists are often treated poorly and have to fend for themselves due to low salaries. One participant noted that their organization conducted a media study and 60 percent of respondents revealed that financial motivation is one of the largest challenges journalists confront. They often faced how to travel to perform their duties when no financial assistance is provided by their office. In response, one participant suggested that CSOs should not always wait until they have programs in place before seeking media coverage. Rather, journalists should be made a part of the process so that when CSOs are launching programs, the cost of media coverage, such as transportation and incidentals, is included.

Participants remarked that a challenge both CSOs and journalists face is that the majority of large, privately-owned media houses are supported by the government. In order to retain subscribers, media executives are reluctant to pursue or publish articles that may criticize the government. In order to address this issue, CSOs should make it known to the government that journalists are actually working with them, not against them.

In response to the discussion of these challenges, media participants disagreed with some of the points made. This included that reporters covering a particular beat are given orientation on how to work through that beat and in doing so acquire expertise in that particular area. He emphasized the need to work with media experts to get the “right people” to cover stories. A second media representative said she regretted that most CSOs come to the media for information only when they are seeking grants. When this process is complete, they seem to disappear, only to reappear when they are in pursuit of something new.