JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION

Maternal Health Accountability-related Grants in Nigeria

MIDLINE EVALUATION REPORT

February 26, 2016

EnCompass LLC

Main Point of Contact:

Lyn Messner, Associate Director
Technical Assistance and Evaluation
EnCompass LLC
Tel: +1-301-287-8719
Email: lmessner@encompassworld.com

Alternate Point of Contact:

Lynne Franco, Vice President
Technical Assistance and Evaluation
Tel: +1-301-287-8717
Email: lfranco@encompassworld.com

CONTENTS

LIST OF EXHIBITS

Acronyms

CHR	Community Health and Research Initiative
CISLAC	Civil Society Legislative Advocacy Centre
CSO	civil society organization
DevComs	Development Communications Network
FCT	Federal Capital Territory
LGA	local government authority
MCH	maternal and child health
MDR	maternal death review
MDSR	maternal death surveillance and response
MNCH	maternal, newborn, and child health
SOGON	Society of Gynaecology and Obstetrics of Nigeria
WARDC	Women Advocates Research and Development Centre
WHARC	Women's Health Action Research Centre

Executive Summary

PURPOSE: Since 2013, the John D. and Catherine T. MacArthur Foundation (hereinafter, MacArthur Foundation) funds a portfolio of seven 3-year grants in Nigeria focused on government accountability to maternal and reproductive health, focusing on four accountability strategies – budget analysis, community mobilization, legal approaches, and maternal death audits. The portfolio spans federal, state, and local levels; 12 states and the Federal Capital Territory (FCT), and five geopolitical zones. The Foundation prioritized a learning-focused evaluation process for this portfolio, and commissioned EnCompass LLC to refine the portfolio's theory of change, conduct baseline and midline assessments, and build grantee organizations' capacity to monitor their grants. This midline evaluation report assesses progress along the portfolio theory of change to identify what grantees should do more of, less of, or differently in the remaining year of their grants to ensure grant and portfolio effectiveness.

METHODOLOGY: Building from the six evaluation questions developed collaboratively in 2014, EnCompass facilitated a July 2015 midline design meeting with grantee organization representatives to focus midline topics and questions on identification of which accountability areas are affecting change. The evaluation team used a mixed-methods approach using qualitative stakeholder data, document review, and analysis of grantee monitoring data. The team collected data in August/September 2015 in the same eight states and the FCT reached in the baseline, and conducted 117 interviews and 21 focus group discussions.

MIDLINE FINDINGS

Civil society collaboration and coordination

- How has civil society organization (CSO) collaboration and coordination, with other CSOs and government, around maternal health accountability changed since baseline? How has it influenced government accountability to maternal health?

Civil society coordination and advocacy for maternal health accountability have increased since baseline, and there is more CSO-government collaboration and cooperation. Grantee organizations (Advocacy Nigeria, Community Health and Research Initiative [CHR], Civil Society Legislative Advocacy Centre [CISLAC] and Women Advocates Research and Documentation Centre [WARDC]) have developed CSO networks and built CSO capacity to collaborate on targeted advocacy activities, and CSOs have advocated for increased maternal health commitments, compliance, and improved services. CSO passion and commitment have enabled this collaboration and coordination, but funding and competition continue to be the biggest constraints.

Maternal Death Surveillance and Review (MDSR) committee formation and functioning

- How has targeted maternal death surveillance and response (MDSR) committee functioning changed since baseline?

MDSR committees have been formed and are functioning in the FCT and Lagos. Committees are meeting, reviewing maternal deaths, and also engage in awareness creation and sensitization. MDSR

committees are generating recommendations for improved maternal health services, and there is evidence that State governments and facility management are using MDSR committee recommendations. Strong enablers to MDSR functioning include good leadership, strong political will, response to recommendations, and commitment by MDSR members. Yet, functioning continues to be constrained by inadequate funding, staff shortages, poor feedback mechanisms, and inadequate maternal health record keeping. Society of Gynaecology & Obstetrics of Nigeria (SOGON) and WHARC support and capacity building have aided the formation and effective functioning of MDSR committees, but more needs to be done to ensure that MDSRs continue effectively: sustaining motivation, continuous advocacy, and awareness raising.

Maternal health evidence

- What grantee-generated maternal health/mortality evidence has been used by journalists, lawyers, and policy makers to inform their work?

Policymakers have used grantee organization-generated maternal health data and data from other sources to inform planning and decision making, including use of the score by Advocacy Nigeria, CHR and CISLAC, Advocacy Nigeria's advocacy materials, and CISLAC's project reports, distribution lists, and policy briefs. Journalists are making more use of primary and secondary maternal health data than at baseline, often sourcing Development Communication Network (DevComs). Although journalists, CSOs, and policymakers used grantee organization-generated maternal health data and documentation, they appear to be accessing more data from other sources than those generated by grantee organizations.

Maternal health media coverage

- How have targeted journalists changed their maternal health reporting since baseline?

Grantee organizations (CHR, CISLAC, and DevComs) have influenced the quality/accuracy and volume of maternal health news produced by journalists, as well as the frequency of reporting. Most respondents (across stakeholder groups in all locations) report improvements in visibility of maternal health and use of expert information in media coverage. Media capacity building, personal interest, availability of facts, partnerships with CSOs, and public outcry are the key enablers of increased reporting —a change from the baseline when enablers were mainly personal motivation. Constraints include information hoarding and inadequate resources to support logistics.

Federal allocations to health budgets

- How has CSO advocacy for improved budget performance influenced government accountability to maternal health at midline? How have grantees influenced this CSO advocacy?

CHR's work since the baseline has strengthened CSOs' advocacy on improved budget for maternal health. However, health and maternal health budget allocations have not changed much in the past year in FCT, Gombe, Kano, and Lagos states, and budgetary allocations have dwindled in Jigawa State. Effective budget allocation has been quite constrained by elections, politics, and inadequate finances on the part of the government.

Maternal health policy

- How has maternal health policy changed (creation, modification, and implementation) since baseline?

Between baseline and midline, some pending bills related to maternal health have passed into law, while others are receiving greater attention from legislators. However, there are differing opinions between policymakers and others about any improvement in *implementation* of the free maternal and child health policy since baseline, and there was limited agreement across stakeholders on whether legislative committee oversight has improved at midline. Where there has been success, key factors supporting change include effective and inclusive coordination mechanisms and political will. Advocacy Nigeria, CHR, and CISLAC have made palpable contributions to strengthen policy implementation in the project states, through election demands by CSOs, influencing political parties to make commitments, embarking on evidence-informed advocacy, and creating demand for maternal and child health services.

Maternal health litigation

- How has maternal health policy changed (creation, modification, and implementation) since baseline?

Maternal health litigation remains uncommon, and alternative means are used to seek redress. Maternal health court cases are constrained by apathy to litigation, lack of awareness of rights, fear of victimization, fatalism, culture/religion, and perceived cost. WARDC's activities have generated changes in awareness among lawyers on issues of litigation around maternal death, and there is increasing momentum as people seek alternative solutions for deaths and abuses related to maternal health issues of litigation around maternal health abuses.

CONCLUSIONS: Overall, midline evaluation results indicate that the Maternal Mortality Accountability portfolio of grants has increased CSO collaboration (among CSOs and with government), MDSR committee functioning (with increased use of committee recommendations), and the quantity and quality of media coverage. Less progress has been seen related to budget performance and litigation of maternal death cases. However, CSOs have increased awareness and tracking for budgets, and increased awareness and interest in alternative solutions to maternal deaths and abuses. Policymakers and others are using more evidence in their work, although from more sources than just the grantees.

RECOMMENDATIONS: The following recommendations have been collaboratively generated, following an in-depth discussion on the midline evaluation report findings with representatives from the MacArthur Foundation, seven grantee organizations, and other key stakeholders.

All Grantee organizations should: have a sustainability plan/strategy; be more strategic in their collaboration with each other; continue to strengthen monitoring of their grant activities; collaborate more on CSO coalition-building; and improve visibility of their information, education, and communication efforts.

The MacArthur Foundation should work with grantees to clarify and broaden maternal health budget performance efforts beyond CHR.

Recommendations for specific aspects of the portfolio include:

- Women's Health and Action Research Centre (WHARC) should integrate local government authority and state MDSR players and consider a Lagos-based presence
- SOGON and WHARC should work with government to ensure that MDSR recommendations are implemented at facility and state levels
- Grantee organizations working with media should go beyond training
- Advocacy Nigeria and CISLAC should refocus efforts on the new government and use their platforms for maternal health advocacy
- WARDC should expand its activities to include the judiciary and increase its public sensitization efforts.

Introduction

BACKGROUND AND PURPOSE

According to the 2013 Nigeria Demographic and Health Survey, the maternal mortality ratio in Nigeria is 576—almost the same as the 2008 Nigeria Demographic Health Survey (545)—and maternal deaths account for 32 percent of all deaths among women aged 15 to 49. The lifetime risk is that 1 in 30 Nigerian women will die due to pregnancy or childbearing, and an estimated 14 percent of global maternal deaths occur in Nigeria. In response to the great need to improve maternal health, the MacArthur Foundation funded a portfolio of seven 3-year grants to increase the Nigerian government's accountability to maternal health.[1]

Awarded in 2013, the grant portfolio focuses on four accountability strategies—budget analysis, community mobilization, legal approaches, and maternal death surveillance and response—and spans three levels of government (federal, state, and local), 12 states and the Federal Capital Territory (FCT), and five (of six) geopolitical zones. **Annex 1** provides a list of grantee organization activities across accountability strategies, states, and the FCT.

The Foundation prioritized a learning-focused evaluation process for this grant portfolio (**Exhibit 1**) to identify which aspects were working well and which could be improved to strengthen government accountability to maternal health. The Foundation commissioned EnCompass LLC (see **Annex 2**) to refine the theory of change for the portfolio, conduct a baseline study and midline evaluation, and build grantee organizations' capacity to monitor their grants under this portfolio.

Exhibit 1: Evaluative Activities for Grant Portfolio

The evaluative process draws on baseline and midline data collected by the EnCompass evaluation team and monitoring data collected by grantee organizations. Together, these data provide a longitudinal comparison of progress and results for formative learning to improve portfolio design and implementation. The purpose of the midline evaluation is to assess progress (since baseline) along the portfolio theory of change to identify what has worked and should be continued in the next round of 3-year grants, which areas should be discontinued, and in what areas more information is needed.

[1] The Foundation defines accountability as "the exercise of power constrained by external means or internal norms."

CONTEXT AND PROGRAM ACTIVITIES

CONTEXT

In the spring of 2015, Nigeria held general elections across federal, state, and local governments. Given this portfolio's focus on government accountability, the elections were a milestone event. However, the post-election environment represents a significant shift in the political landscape. Many of the elected officials who were engaging in the first year of implementation have now left office and new relationships must be built. This shift in the political landscape is both a constraint and an opportunity.

GRANTEE ORGANIZATION ACTIVITIES

Exhibit 2 presents the accountability strategies and geographical areas of action for each grantee organization.

Exhibit 2: Grantee Organizations by Accountability Strategy and State

Grantee Organization	Accountability Strategy	States/FCT
Advocacy Nigeria	Community mobilization (policy advocacy)	Adamawa, Gombe, Zamfara
Community Health and 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 Gynaecology & Obstetrics in Nigeria (SOGON)	Maternal death audits	FCT
Women Advocates Research and Documentation Centre (WARDC)	Community mobilization (policy advocacy), legal approaches	Enugu, Kaduna, Lagos
Women's Health Action Research Centre (WHARC)	Maternal death audits	Lagos

DESIGN, SAMPLE, AND METHODS

DESIGN

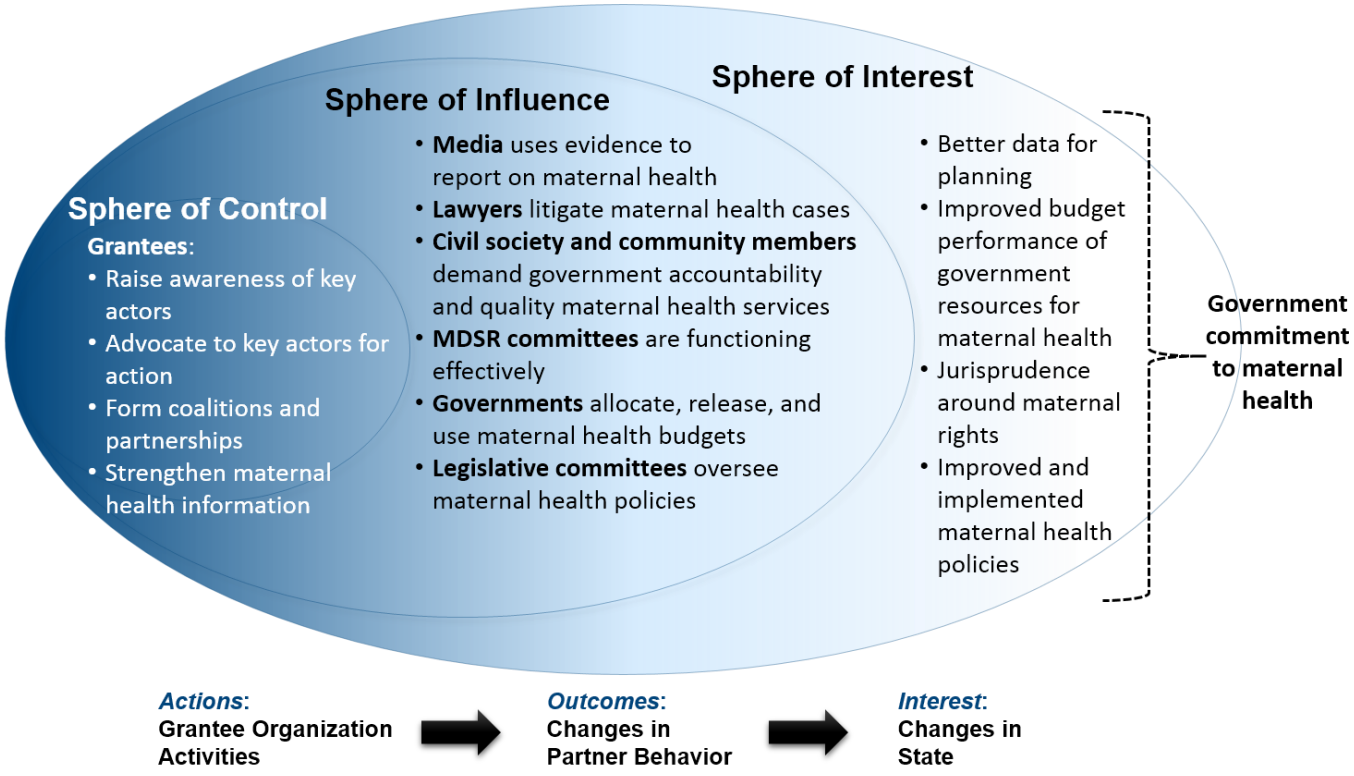
Accountability pathways are complex. The literature acknowledges that the accountability landscape is filled with a broad array of actors with multiple connections, creating layered webs of accountability with varying degrees of autonomy and sources of control/oversight. One challenge

inherent in evaluating this grant portfolio is establishing direct attributions to changes when multiple grantee organizations, 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 this 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 grantee organizations' direct actions ("sphere of control"), the resulting changes desired among the stakeholders or boundary partners with which the grantee organizations interact ("sphere of influence"), and the resulting changes intended by federal, state, and local governments ("sphere of interest").

Exhibit 3 presents an outcome map for the maternal health accountability grant portfolio in Nigeria, adjusted during the July 2015 midline design workshop to better reflect grant implementation.[2] **Annex 3** presents a detailed set of observable actions within each of the three spheres.

Exhibit 3: Theory of Change to Achieve Government Commitment to Maternal Health



In February 2014, EnCompass worked with grantee organizations and the Foundation to develop six endline evaluation questions to guide the evaluation process (baseline, midline, and endline) and indicators to measure progress. Grantee organizations incorporated some of the indicators into their monitoring systems and collected data to track progress against them. Other indicators guided data collection for the midline evaluation.

[2] Changes include several refinements and clearer language in the sphere of control and the sphere of influence.

During the July 2015 midline evaluation design meeting, representatives from grantee organizations generated a list of topics and questions they wanted the evaluation to answer. EnCompass used this list to develop the midline evaluation questions presented in **Exhibit 4**. The full set of midline evaluation questions and sub-questions is presented in **Annex 4**. The overall evaluation question guiding the midline was, "*Which accountability areas are affecting change?*"

Exhibit 4: Endline Evaluation and Midline Evaluation Questions

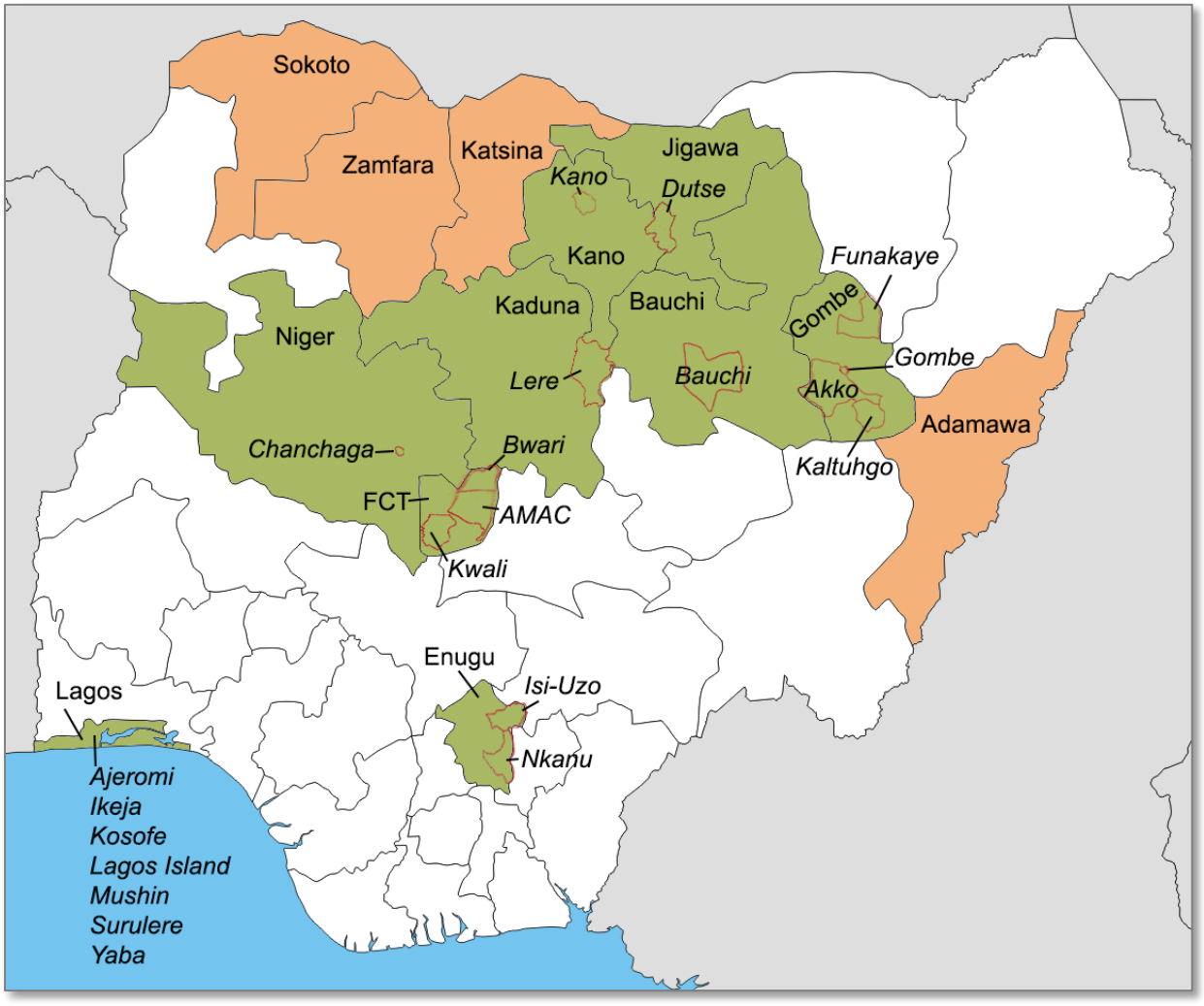
Endline Evaluation Questions	Midline Evaluation Questions
1. In what ways does civil society collaboration and coordination lead to increased government accountability to maternal health?	1. How has CSO collaboration and coordination, with other CSOs and government, around maternal health accountability changed since baseline?
2. What enables and constrains MDSR committee activation and accurate reporting?	2. How has CSO collaboration and coordination influenced government accountability to maternal health?
3. What enables and constrains Maternal Death Review Committee activation and accurate reporting?	3. How has targeted MDSR committee functioning changed since baseline?
4. In what ways has the grant portfolio contributed to maternal health evidence?	4. What grantee-generated maternal health/mortality evidence has been used by journalists, lawyers, and policy makers to inform their work?
5. To what extent has the grant portfolio led to improved media reporting on maternal health?	5. How have targeted journalists changed their maternal health reporting since baseline?
6. How has the grant portfolio contributed to improved maternal health budget perfomance at federal, state, and local levels?	6. How have grantees influenced CSO advocacy for improved budget performance on maternal health?
7. How has the grant portfolio influenced maternal health policy effectiveness (policy change, implementation)?	7. How has CSO advocacy for improved budget performance influenced government accountability to maternal health at midline?
	8. What enables and hinders maternal health budget performance?
	9. How has maternal health policy changed (creation, modification, implementation) since baseline?
	10. How have grantees influenced maternal mortality litigation?

SAMPLE

Given available resources, baseline and midline data collection was limited to eight states and the FCT, the same states sampled in the baseline. Criteria used to select the sample states were: accessibility, security, geographical spread, population density, breadth of accountability strategies, density of grantee organizations' activity, and magnitude of maternal health challenges. **Exhibit 5** depicts the states where the portfolio operates, with midline sample states in green and those not sampled in orange.

Grantee organizations had not begun implementation at baseline (conducted in April and May 2014) so data were not collected at the local government authority (LGA) level. At midline (conducted September and October 2015), selected LGAs were those where grantee organizations' work was being conducted. They are outlined in **Exhibit 5** and listed in italics.

Exhibit 5: Map of Nigeria with Sampled States and LGAs



The grantee organizations provided the evaluation team with a list of stakeholders they had engaged since baseline. The evaluation team used two sampling approaches to identify respondents from those lists: (1) maximum variation sampling to ensure that data collection captured a wide variety of perspectives, and (2) emergent/snowball sampling to allow for changing conditions on the ground and flexibility to collect data from emerging key informants not initially identified, but with the potential to yield rich evaluative data. Using these approaches, the evaluation team was able to reach a range of stakeholders:

- CSOs
- Health facilities

- Grantee organizations
- Government (federal, state, local)
- International projects
- Legal practitioners
- Media
- Professional associations
- Women using maternal health services or participating in WARDC activities, or both.

Annex 5 details the stakeholders sampled by group and state.

METHODS

The evaluation team (see **Annex 2**) used a mixed-methods data collection approach that included 117 semi-structured interviews (71 male, 44 female, and 2 undocumented), 21 focus group discussions with 166 participants (60 male, 104 female, and 2 undocumented), and triangulation with monitoring data provided by the grantee organizations. **Annex 6** presents the data collection tools. The evaluation team coded and analyzed all qualitative data in Dedoose, a cross-platform application for data analysis. Quantitative monitoring data were analyzed in Microsoft Excel in order to summarize data across grantee organizations and produce tables with descriptive statistics triangulated with qualitative data.

All data were disaggregated by sex, state, LGA, and stakeholder group, and triangulated across sources and stakeholders. Progress over the past year was assessed in two ways: comparison of midline and baseline findings,[3] and stakeholder perceptions of changes since the baseline.

Representatives from the grantee organizations, the MacArthur Foundation, and key stakeholders came together for a face-to-face feedback session in Abuja on January 25-26, 2016 to explore and validate findings and conclusions, and develop recommendations to inform modifications to grants for the third year of implementation. This final evaluation report takes into account written feedback on the draft report and input provided during the feedback session.

DATA LIMITATIONS

Several factors in the data collection process influenced the results presented here.

- The list of stakeholders provided by grantee organizations in some locations was not comprehensive. The evaluation team spent substantial time identifying stakeholders in those locations.

[3] The baseline was conducted before grant activities fully began and provided landscape metrics through the lens of the four accountability strategies.

- The evaluation period coincided with a major Islamic festival. In the northern states, many stakeholders could not be reached in the days before the festival. In Kaduna and Kano states, the team had to reschedule several appointments and make second visits for data collection.
- The evaluation scope required visits to health facilities in remote areas of Nigeria. Travel time associated with these visits limited the number of days the team could spend collecting data.
- The evaluation team also faced challenges in gaining government approval for their work and access to relevant government documents. Efforts were made to obtain an approval letter from the Jigawa Ethics and Review Committee, but the team did not receive a response. This was attributed to the change in government and delayed the team's work.
- Some respondents were reluctant to answer questions because they perceived the evaluation team to be investigating the government, especially when asked about implementation of the free maternal health policy. The evaluation team was not able to interview legislators or other key stakeholders who received policy briefs and/or were targeted by the Not Again campaign or other grantee evidence, nor were alternative media houses reached.
- The evaluation team was unable to access actual budgetary information to assess progress.
- Grantee organizations had not always communicated the full range of their activities to the evaluation team. Therefore, some activities were not adequately reflected in the data collection instruments. This was particularly true for WARDC media and CSO mobilization.
- Grantee organizations provided monitoring data in July 2015. As small CSOs, grantee organizations' capacity for monitoring advocacy programs was limited at the outset of the grants. To mitigate this challenge, the grantee organizations received substantial capacity-building support from EnCompass LLC to ensure the quality of their systems for collecting and maintaining records. These systems were not audited as part of this evaluation. Where gaps in data were found, the evaluation team sought clarification from grantee organizations. With three exceptions, data were reported against all monitoring indicators stipulated in the midline design.

Findings

CIVIL SOCIETY COLLABORATION AND COORDINATION

CHANGES SINCE BASELINE IN CSO COLLABORATION AND COORDINATION WITH OTHER CSOS AND GOVERNMENT AROUND MATERNAL HEALTH ACCOUNTABILITY

Finding 1: Civil society coordination and advocacy for maternal health accountability have increased since baseline.

Many respondents reported increased and improved coordination and collaboration around maternal health accountability in the past year. Respondents cited grantee organizations' influence, especially the role they play in developing networks, encouraging collaboration, building capacity, and advocating for maternal health accountability. At baseline, specific donor-funded projects (e.g., the State Accountability and Voice Initiative [SAVI]) were frequently credited with providing this type of support and capacity building. At midline, respondents cited grantee organizations more often for their efforts in these areas.

> *Collaboration has always been in existence, but it has been strengthened over the past year. —CSO respondent, Lagos State (Lagos City)*

As of August 2015, Advocacy Nigeria, CHR, CISLAC, WARDC, and DevComs had reached 1055 individuals through 54 civil society mobilization events. These events covered a wide variety of topics, ranging from media fora and policy dialogues to training on how to use scorecards to improve maternal health. Grantee organizations documented CSOs' actions following the events. Event participants represented a large number of organizations, with several participating in more than one

activity. **Exhibit 6**, based on monitoring data from Advocacy Nigeria, CHR, CISLAC, WARDC, and DevComs, displays grantee organization activities targeting CSOs and the individuals reached through their efforts.

Exhibit 6: CSO Events and Participation since the Start of Grant Activities

Organization	CSO Mobilization Interventions or Actions	Number of Participants at CSO Mobilization Interventions or Actions
Advocacy Nigeria*	15	170
CHR	6	105
CISLAC	16	367
DevComs	9	81
WARDC	8	332
TOTAL	**54**	**1055**

* Advocacy Nigeria includes events from September 2013 and CISLAC events from December 2013.
Source: Grantee organizations' monitoring data.

Respondents reported that grantee organizations' influence and capacity building contributed to more evidence-based CSO advocacy activities through the development and use of maternal health scorecards, specifically in the states where CHR operates (Bauchi, FCT, Jigawa, Kano, and Niger). CSOs reported that, by using this scorecard, they were able to gather information on the status of maternal health and use this information for better government advocacy, especially at state and local levels.

> *CHR are coordinating advocacy for improved services using evidence-based tools. —CSO respondent, Bauchi State*

Respondents also spoke of how Advocacy Nigeria and CISLAC have improved CSO collaboration through mobilization and coordination activities. Monitoring data show that these two grantee organizations have held approximately 30 CSO mobilization events and reached more than 500 participants since the start of the grants.

> *AN [Advocacy Nigeria] is the link, with MacArthur Foundation grant, we advised on having a network and we made it. We have monthly meetings with all the above listed organizations and individuals. —CSO respondent, Gombe State*

At baseline, CSO advocacy efforts were less coordinated and more focused on developing maternal health policies and budgets. These themes were still common at the midline, but CSO collaboration on advocacy to improve maternal health service provision was mentioned more than advocacy on policy and/or budgets.

> *There is a sort of improvement in 2015. The scorecard report will eventually be used for advocacy for increased budget. —State government respondent, Niger State*

Finding 2: There is more CSO-government collaboration and cooperation at midline.

CSO and government respondents alike highlighted improved CSO-government collaboration and cooperation at the midline. Respondents explained that CSO networks have played an intermediary

role between the government and communities by serving as a formal pathway through which citizen concerns can reach the government. These networks' advocacy has helped increase government awareness of the maternal health challenges communities have faced, ultimately allowing communities to hold the government more accountable for the implementation of maternal health policy, as well as allocation and distribution of budgets and resources, and service provision.

> *There is now more cooperation between government officials and the CSOs to ensure better service delivery. —CSO respondent, Jigawa State*

Enablers and Constraints to CSO Collaboration and Coordination Around the Maternal Health Accountability Areas

Finding 3: CSO passion and commitment are key enabling factors for CSO collaboration and coordination.

When asked about the factors that enable CSO collaboration and coordination, respondents regularly cited passion and commitment. CSO respondents from Bauchi, Gombe, Jigawa, and Kaduna states remarked on their own dedication to the cause of improving maternal health, government accountability, and their interest in serving their communities as the driving forces behind this passion and commitment. These themes are consistent with the baseline and have been important motivating factors for collaboration and coordination.

> *The individual commitment and the passion of the CSOs involved in the collaboration assisted in enabling the collaboration work better. —CSO respondent, Jigawa State*

Respondents also spoke of the important role donor organizations and grantee organizations play in enabling CSO collaboration and coordination. Donors were credited with providing programmatic support, consistent with the baseline, and grantee organizations were credited with providing coordination support for CSO collaboration agendas and activities.

Respondents also reported that government recognition of CSOs was an important enabling factor because it lends legitimacy to CSO collaboration. Respondents stated that this recognition has made CSOs more inclined to engage with such networks on maternal health issues.

> *Support from donor partners, an enabling environment for development activities, as well as high level of acceptance/cooperation by the government and its agencies. —CSO respondent, Niger State*

Although respondents often cited government as a constraint—due to low funding, bureaucratic struggles, and lack of programmatic support—government influence on CSOs was still viewed as strong. Obtaining government approval, along with grantee organization and donor support, helped formalize CSO networks and was an enabling factor for successful collaboration and coordination.

Finding 4: As at baseline, funding and competition were cited as the biggest constraints to CSO collaboration and coordination.

When asked about the factors that constrain CSO collaboration, respondents regularly cited funding and competition as the key constraints. CSOs respondents in Bauchi, Gombe, Kaduna, Lagos, and Niger states emphasized that inadequate funding has made it difficult for CSOs to carry out their work effectively. These themes were consistent with the baseline report and demonstrate that resources, especially funding, are still constrained and have an influence on CSO coordination and collaboration.

> *The major hindrance of the collaboration is the availability [of] funds to enable the coordination of the CSO and the government. —CSO respondent, Gombe State*

Respondents also cited competition (among CSOs, and between CSOs and the government) as a hindrance to collaboration and coordination. According to respondents, CSOs have competed with one another for funding and power within collaborations. Respondents also spoke of tensions that arose when the government felt CSOs were competing with them for clients and service delivery.

> *One of the things that hinders collaboration is the challenge we are having with Government staff (not the ones in our facility). There is this unhealthy rivalry between our staff and those of Government. They see us as a threat. —CSO respondent, Niger State*

Grantee Organizations' Influence on CSO Collaboration and Coordination

Finding 5: Grantee organizations have developed CSO networks and built CSO capacity to collaborate on targeted advocacy activities.

When asked about grantee organizations' influence, CSO respondents in Gombe and Niger states, policymakers in Gombe State, and grantee organizations and state government officials in Kano State reported that grantee organizations have acted as umbrella organizations to support CSO collaboration. Grantee organizations coordinated CSO networks and built their capacity to advocate with the government for developing and implementing maternal health services, budget, and policy. Respondents most frequently mentioned CHR, CISLAC, Advocacy Nigeria, and the scorecard as having helped CSOs promote government accountability and gather information for future advocacy efforts. Grantee organizations were viewed as providing capacity-building and programmatic support necessary for CSOs to increase their advocacy efforts.

> *CHR has collaborated with us by training CSOs in Abuja on advocacy to ensure that governments are fully involved in implementing policies aimed at reducing maternal mortality. —CSO respondent, Niger State*

CSOs and state governments mentioned grantee organizations' influence on CSO collaboration and activities. Even though CSOs were working to address maternal health issues through their own initiatives at the baseline, respondents indicated that grantee organizations helped increase formal coordination and collaboration, and highlighted that advocacy activities have become more focused in the last year.

Donor influence, highlighted at baseline, was seen as important, but the new influence of the grantee organizations has also had a positive impact. CSOs' use of evidence for more effective advocacy is a theme respondents mentioned; this is related to CHR's introduction of the scorecard that allows CSOs

to collect information about the status of maternal health and develop advocacy efforts based on their findings.

> *CHR are coordinating advocacy for improved services using evidence-based tools. —State government respondent, Bauchi State*

Advocacy Nigeria and CISLAC were regularly mentioned for their influence on improved coordination among CSOs. CSO coordination around maternal health was not new; however, targeted, evidence-based, and collaborative efforts using advocacy to increase government accountability were seen as a new development. Respondents attributed this change to grantee organizations' influence.

CSO Collaboration and Coordination's Influence on Government Accountability for Maternal Health

Finding 6: CSOs have advocated for increased maternal health commitments, compliance, and improved services.

CSO advocacy has focused on government commitment (budget allocation and policy development), compliance (policy implementation), and maternal health service provision. Government respondents supported the perception that CSOs have had a positive impact on maternal health service provision. The need to improve maternal health services was mentioned by respondents more than increasing commitment or compliance.

> *Yes they [CSOs] are doing their best, keeping the government on their toes. They have been working to ensure that services are adequately carried out and they raise alarm when they observe problems with regards to facility and manpower. —State government respondent, Kaduna State*

CSO respondents spoke of the role they play in keeping the government accountable, while government respondents recognized the advocacy efforts of CSOs to keep policy implementation on track and act as intermediaries between the government and the community.

> *Civil society always tracks allocations to the health sector and ensures judicious utilization of the funds to ensure compliance with the commitment already made towards maternal health in the state. —CSO respondent, Kaduna State*

CSOs' relationship with communities has positioned them as an important link between the government and the people around issues of maternal health, in terms of improving collaboration and increasing government awareness of and accountability for maternal health services.

> *We are collaborating with Jigawa state government especially by collecting the citizens' demand for MCH [maternal and child health] services and present it [to] the government for consideration. We also go together with the members of the State House Assembly for advocacy visit. We are also involved in budget development and tracking. We also work with the government agencies to mobilize the communities toward implementing government policies and programs. —CSO respondent, Jigawa State*

MDSR COMMITTEE REPORTING

MDRs have metamorphosed into MDSR since baseline. The MDSR is meant to account for each maternal death and put in place interventions to prevent future deaths. These systems allow governments to track, systematically review, and address factors that contributed to maternal deaths. The MDSR is a more comprehensive, ongoing surveillance system that builds on the MDR. It is a continuous action cycle that aims to identify, notify, and review all maternal deaths in communities and facilities, providing information to develop effective, data-driven interventions that will reduce maternal mortality and permit measurement of their impact.

CHANGES IN TARGETED MDSR COMMITTEE FUNCTIONING SINCE BASELINE

Finding 7: MDSR committees have been formed and are functioning in the FCT and Lagos. Committees are meeting, reviewing maternal deaths, and generating recommendations for improved maternal health services.

MDSR committees were formed and are functioning in the FCT and Lagos. This is an improvement from the baseline when the FCT had not yet formed these committees. Monitoring data indicate that MDSR committees are meeting. Respondents from facilities in Lagos noted that meetings were not as regular as they ought to be due to doctors' strikes and staff shortages. In the FCT, however, community MDSR committee meetings are held monthly and facility-level MDSR committees meet often as well.

Exhibit 7: MDSR Committee Activity

	SOGON*	WHARC**
Number of committees reached	7	3
Percentage of months with a facility-level MDSR committee meeting	58%	39%
Percentage of months per year with a maternal death in which a facility-level MDSR committee meeting was held, or in which a meeting was held in the following month	33%	50%
Number of community verbal autopsies	2	0
Percentage of maternal deaths reviewed by facility-level committees	79% (11/14)	42% (16/38)

Source: Grantee organizations' monitoring data
*SOGON: November 2014 – October 2015
**WHARC: November 2014 – May 2015

> *We try to meet when there is mortality. Meetings have not been regular in the past year because of some irregularities, like the strike in the health sector, all of which affected the meetings. This time, we have met like three times, we quickly schedule a meeting when there is a mortality, but don't sit when there is no mortality. —Facilities respondent, Lagos State*

> *There is change in the health workers' attitude to work because they know that if a death occurs, everyone involved will, at the monthly meetings, give account of the role he or she played so that has put a check and has made them to rise to their responsibilities. In maternity, they are aware that we meet monthly. All those involved in the management of a patient are invited when a patient dies. Everyone is on his or her toes. —Facilities respondent, FCT*

Generally, MDSR committee functioning has improved. The committees are reviewing their setup and adjusting to better fit their function. According to some respondents, there have been minor changes in how the MDSRs function. In some facilities in one LGA in Lagos State, membership has been streamlined or expanded to include the local government medical officer of health. There has also been improved government response to issues raised by committees.

> *No, not really, but it has changed subtly because we have modified the process a bit. The committee involved so many people (about nine) initially who were not contributing to the meeting so we have shrunk it to those with real contributions, but if we need the attention of others, we will call them. We set up a clinical services committee early this year to look at issues concerning clinical services in the hospital and members were coopted into the MDSR committee, especially as WHARC was now getting more involved. —Facilities respondent, Lagos State*

> *An example of the positive effect is that – there was a problem in Kwali, a maternal death resulted from delay in referring the client to the secondary facility. After the case was reviewed by the MDSR Committee, all PHC [primary health care] heads were assembled and given refresher training on the importance of timely referral. —State government respondent, FCT*

Finding 8: State governments and facility management are using MDSR committee recommendations.

Facility respondents in Lagos State reported that the state government's involvement in the MDSR process has supported MDSR committee functioning. Respondents in Lagos also noted that MDSR recommendations are now being used and have resulted in a number of decisions by the state government to improve maternal health. Facility respondents from the FCT also noted that recommendations are being responded to and yielding results. This is a shift from the baseline when lack of use of the MDSR committee recommendations was cited as a constraint. Recommendations are being taken into consideration and this has yielded positive results, in terms of response, at facility and state government levels.

> *A number of decisions have been taken based on the seriousness of the outcomes of the committee report within the hospital. Just like the way it has affected Government, so has it affected us here too. We noted some bottlenecks that could affect antenatal care. So we have increased the number of days dedicated towards antenatal care. —Facilities respondent, Lagos State*

> *Apart from Government approving Intensive Care Unit (ICU), they have also approved the improvement of the critical care unit at Lagos State University Teaching Hospital (LASUTH). All these improvements are as a result of our MDSR recommendations. —Facilities respondent, Lagos State*

Respondents in the FCT and Lagos State said that the MDSR has also resulted in a closer relationship between the state-owned facilities and local, government-owned primary health care centers and communities. In one LGA in Lagos, for example, the medical officer for health was invited to join the MDSR committee because of the numbers of deaths in the area, and respondents noted improved awareness creation on maternal health in the community.

> *The reviews have been going on. We have seen positive results. There is improvement in the level of awareness and consciousness. There was a death at Kwali General Hospital due to delay at the PHC. This stimulated the need to talk to the Heads of PHCs in Kwali. We gave them a refresher – a reorientation on identification of danger signs and this has strengthened the referral system. —Professional association respondent, FCT*

Respondents also noted that the MDSR has positively affected the way their hospitals respond to maternal health emergencies/cases, with shorter response time as a result of MRSR committee recommendations being adopted by facilities and the government.

> *We come up with recommendations, e.g., now we don't wait for consultants to do 'cut down'. Our residents do that. —Facilities respondent, Lagos State*

Finding 9: MDSR committees are involved in more than reviews; they also engage in awareness creation and sensitization.

MDSR committees were reported to be functioning at various levels in the FCT and Lagos State. The committees are set up to review maternal deaths, but their scope has expanded to include other

activities, such as community sensitization and awareness creation about maternal death. This additional function is reported to have resulted from feedback from reviews in several facilities that prompted community engagement in Ajeromi LGA (Lagos State) and the FCT. The committees have engaged communities at different levels.

> *Relationship between community and facility has improved since we started MDSR. There is also collaboration with the community and community-based members help in dispatching information to the grass roots. —Facilities respondent, FCT*

Whereas the FCT has started verbal autopsy (MDRs) at community levels, Lagos State has not, although communities have been engaged in awareness raising on danger signs in pregnancy and the local government medical officer of health is included in review meetings. For instance, a respondent described how a challenge emerging from a review led to town hall meetings with communities to ensure that women are brought to the hospital early. This involvement has resulted in communities contributing to health amenities in some health centers.

> *We identified an issue the 1st delay in maternal death, people were not aware and they did not even seek help. We did town hall meetings with the governor's wife. We knew where the deaths were. We found out that Ajeromi/Ifelodun was the worst in terms of patients being brought in. We had another town hall meeting to tell them why they should use health facilities. I do not know the feedback now, but it made a lot of sense. Politicians, market women, governor's wife, bales, etc. We demonstrated Mama Kit for free. —Facilities respondent, Lagos State*

According to respondents, MDSR committees have collaborated with a wide range of stakeholders, including grantee organizations, government, communities, and other CSOs and development partners. Monitoring data reveals that in the FCT, three maternal deaths have been reported from the community and two have been reviewed. According to respondents from the FCT, the relationship between the MDSR committee and the local community is productive and MDSR activities, including education and awareness raising, are supported by the community.

> *The relationship between MDSR and the communities is cordial. The Chief, women leader who is also a TBA [traditional birth attendant], and youth leader were part of the inauguration and are part of the MDSR committee. So they help to disseminate useful information and enlighten their groups. In his normal cabinet meetings, he talks about maternal mortality reduction and hospital use. The TBA brings women to the health facility and the Youth Leader enlightens young people on hospital use. —Facilities respondent, FCT*

Respondents reported that grantee organizations, other CSOs, and development partners have collaborated with MDSR committees to build their capacity and promote their activities, as well as supply some equipment to improve facility service provision.

> *We have worked with CSOs and NGOs [nongovernmental organizations] and they have helped us mobilize women to access maternal health services. —State government respondent, FCT*

ENABLERS AND CONSTRAINTS FOR MDSR COMMITTEE FUNCTIONING

Finding 10: Good leadership, strong political will, response to recommendations, and commitment by MDSR members are key enablers for MDSR committee functioning.

Facility respondents in Lagos State noted that the state government's commitment to reduce the number of maternal deaths has supported MDSR committee formation and functioning. The state government's directives for conducting MDSRs have been a strong motivating force for the committees to conduct reviews. According to respondents, committee reports are sent to the state MDSR officer, who sends it to the state-level MDSR committee, which is responding to the recommendations. This response has boosted committee members' efforts to continue the reviews.

> *Pressure that the ministry is involved. The political will—first and foremost the idea was sold to the then commissioner, it was not going to cost them anything extra. Fear of sanctions because it is coming from the boss, just because the government was committed and wants it done. So if you are not rendering data you will have to answer government. —Facilities respondent, Lagos State*

Respondents from the FCT and Lagos State also cited good leadership as a key to well-functioning committees, especially in terms of effectively delegating MDSR tasks, motivating staff to hold review meetings, and ensuring follow-through. Respondents noted that grantee organizations' support enabled the committees to function well. Grantee organizations supported meetings and provided refreshments for committee meetings in some instances. Facility respondents in the FCT said that SOGON's attendance and supervision at their meetings has been a good source of encouragement.

> *[The] process of building consensus and visits from SOGON, and the support for refreshment during meetings and home visits. —Facilities respondent, FCT*

The "no name, no blame" policy has continued to help promote MDSR processes and health workers' commitment to conducting MDSRs. This policy has remained a strong source of support for the way the committees work and has kept fear of how the reports will be used to a minimum.

> *Maternal death review is a good thing to happen to the obstetrics and gynecology unit. Initially, I had the fear that the society of SOGON might be exposing their rear, but with the philosophy of "no blame, no shame", it has made it wonderful. I remember a case we reviewed, it was identified that a banned drug was administered to a patient, but the doctor that handled the case was not aware; this made us call on the education committee to enlighten us more on drugs to use. In the end, we are all the better for it. It brought to the fore that we are lacking in the area and are in need of continuous education. —Facilities respondent, Lagos State*

Finding 11: MDSR committee functioning is constrained by inadequate funding, staff shortages, poor feedback mechanisms, and inadequate maternal health record keeping.

FCT and Lagos State respondents reported that MDSR committee functioning has been constrained by poor record keeping, lack of funds, heavy workloads in hospitals, and staff shortages, causing

delays in committee meetings, especially in Lagos State. Inadequate funding and staff shortages were also mentioned as constraints during the baseline.

At the baseline, MDR committee members in Lagos State said that some MDR directives were not clearly stated, leading to confusion. Now, the MDSR process seems to be clearer and committees are functioning well.

> *The load is heavy and there is pressure on the committee members. The MDSR officer is also the Chief Resident and the workload is overwhelming. Now we just batch all the reports (deaths) and review after a few months. —Facilities respondent, Lagos State*

> *Man power shortage–it is an extensive thing, plus everything you have to do you need to fill forms. Record keeping is a major issue. Once a patient dies, you must take custody of the case not to render your report. The smaller hospitals run after case notes. Fear of personnel instigation. —Facilities respondent, Lagos State*

One respondent in Lagos State shared that MDSR committees lacked the resources to function effectively (e.g., no photocopier, no paper, and no funds for smooth operation). According to another respondent, record keeping was also a challenge: once a woman dies, it is difficult to retrieve her folder. It was also noted that patients sometimes arrive in an emergency state of health and die before much can be done. In such cases, it is usually difficult to identify individuals who can provide a history of what transpired before the patient arrived at the hospital.

> *There is no funding for MDSR and we have been sitting for almost 2 years now, and for the first time Women Health and Action Research Centre (WHARC) gave us refreshment at a meeting. We have not been motivated in anyway. There is no photocopier, no paper, etc. We need funds to make copies of report and all that. I use my money to make copies and some other things. The protocol says the office of the medical director is supposed to be funding MDSR, we did not know this until when the old medical director left and the new director requested for MDSR file where we have all letters and reports pertaining to MDSR activities are kept. Funding MDSR administrative activities is key. —Facilities respondent, Lagos State*

Grantee Organizations' Influence on MDSR Formation and Effective Functioning

Finding 12: SOGON and WHARC have aided the formation and effective functioning of MDSR committees through support during meetings and capacity building of committee members.

Facility respondents in the FCT and Lagos State noted that SOGON and WHARC had supported the committees in a number of ways, and that this support has facilitated their work. Grantee organizations have built the committee members' capacity on how to use the MDSR forms and on other medical procedures that assist with safe delivery. SOGON has provided support with home visits during verbal autopsy (MDR) and has been involved in sensitizing government on MDSRs in the FCT and Lagos State. During supervisory visits in the FCT, SOGON trained committee members and followed up to confirm that forms were completed appropriately. SOGON also supervised the MDSR meetings, and SOGON and WHARC gave financial support and/or provided snacks for the meetings.

Women Health and Action Research Centre (WHARC) has collaborated with us by building our capacity, training, and re-training on how to review well. We also collaborate to build the capacity of some other facilities, institutional support. —Facilities respondent, Lagos State

Financial support by SOGON has helped ensure that meetings hold. What SOGON did was really an eye-opener for us in terms of easy detection of the cause of death. The forms provided by SOGON make data collection easy. SOGON's review and supervision—they go through the reporting formats to see if there is compliance and also inspection of the facility. —Facilities respondent, FCT

Finding 13: More needs to be done to ensure that MDSRs continue effectively: sustained motivation, as well as continuous advocacy and awareness raising.

Respondents from the FCT and Lagos State highlighted several things that would be required to improve the MDSRs and ensure the effectiveness of the committees to conduct reviews properly and regularly. Suggestions included general improvement of the maternal health service system: adequate staffing, staff motivation, continuous advocacy and enlightenment on maternal health and MDSR, improved referral systems, and increased government commitment to maternal health and sustained commitment to MDSRs.

Increase human resource because we are few and we hardly are able to reach the community to organize health talks as much as we want. The process can also be improved here when our security issue is addressed to enable us [to] work 24 hours as expected. —Facilities respondent, FCT

Commitment and ensuring that all deaths are reported. They can be awaited and then we can have management protocol. We need a specific officer on MDRs so that he/she can prompt for reviews. —Facilities respondent, Lagos State

GRANT PORTFOLIO CONTRIBUTION TO MATERNAL HEALTH EVIDENCE

USE OF GRANTEE ORGANIZATION-GENERATED MATERNAL HEALTH AND MORTALITY EVIDENCE BY JOURNALISTS, LAWYERS, AND POLICYMAKERS

Finding 14: Policymakers have used grantee organization-generated maternal health data and data from other sources to inform planning and decision making.

Policymakers in Gombe and Niger states and the FCT mentioned that their sources of data include MDSR data generated by SOGON in the FCT, and data generated through the use of scorecards and advocacy materials produced by Advocacy Nigeria. Project reports, distribution lists, and policy briefs indicate that CISLAC has also made data available to policymakers and legislators by publishing and distributing briefs.

A policymaker in Gombe State reported that information generated by Advocacy Nigeria has also informed awareness-creation programs geared toward increasing community-level demand for health services.

> *We get the data from our facility; especially the recent scorecard sponsored by CHR has given us some recent data on our health facilities in the state. —Policymaker, Niger State*

Finding 15: Journalists are making more use of primary and secondary maternal health data than at baseline.

While baseline respondents indicated poor access to accurate, relevant maternal health data, midline respondents across all evaluation locations reported better access to and use of accurate maternal health data.

> *Most times, I use Google to get figures. I get information from programs I attend. The NGOs are more into this, so I get my information from them too—DevComs and Ministry of Health. There are press releases; I make use of them when there is a need to. —Media respondent, Lagos State*

At midline, journalists who participated in focus group discussions across states reported using primary and secondary maternal health data for reporting. There appeared to be more use of primary data generated through investigative journalism at midline than at baseline. Midline data also indicate that journalists have become more proactive in seeking information that would add a human face to their reports ("human angle stories") and have used such data sources as the following:

- *Primary data sources:* Women, caregivers, husbands, relatives, medical experts
- *Secondary data sources:* Government reports, development partners, fellow journalists, CSOs, DevComs, and donors.

Respondents across stakeholder groups (CSOs, journalists, and policymakers in all sample states) indicated wider access to maternal health data from a variety of sources, especially government sources such as health facility records, reports by monitoring and evaluation units, and government-led surveys/studies (Nigeria Demographic Health Survey). Several respondents also mentioned scorecards administered by the maternal, newborn, and child health (MNCH) partnerships in the evaluation locations as a data source. Some grantee organizations, such as CHR in Kano and Niger states, are members of the MNCH partnerships. Advocacy Nigeria also generates facility-based data, which have fed into evidence-based advocacy for maternal health, especially in Adamawa, Gombe, and Zamfara states.

Although most of the available data used at midline were from other sources, grantee organizations contributed to making accurate facility-based data available in the focal states through the production of scorecards (Advocacy Nigeria and CHR) and other engagements (e.g., DevComs).

Other Sources of Maternal Health/Mortality Evidence and Information Key Stakeholders Are Using to Inform Their Work

Finding 16: Although journalists, CSOs, and policymakers used grantee organization-generated maternal health data and data from other sources, they seemed to have accessed more data from other sources than those generated by grantee organizations.

Grantee organizations have produced a number of pieces of maternal health evidence. The number of visits to DevComs' website is increasing, as can be seen in **Exhibit 8**.

Exhibit 8: Evidence Generated by Grantee Organizations

	Pieces of Maternal Health Evidence Produced	Monthly Increase in Web Hits
CHR	2	--
CISLAC	17	--
DevComs	20	6%

Source: Grantee organizations' monitoring data.

However, journalists, lawyers, and policymakers mentioned a variety of sources of evidence that they have used to inform their work in the past year. A major source of information/data mentioned was the government, including health facilities, national survey reports, and government departments and agencies, such as monitoring and evaluation units and the State Action Committee on HIV/AIDS.

> *I get most of my information from the facilities in my area. In the last few years, children died of the six killer disease[s], but today it has improved. I am getting to know some of them from the reports of the facilities in my area as the chairman ward development committee. —CSO respondent, Gombe State*

> *Our work here usually depends on what government wants from us so we use facility-based data, data from Health Management Information System, quarterly supervision data, Integrated Supportive Supervision (ISS) data, data from joint annual review of operational plan, MNCH routine data… we have MNCH scorecards that we use to generate data. —Development partner, FCT*

Lawyers in Lagos State mentioned some other sources of data: law reports from other jurisprudence, medical evidence, and medical doctors who are often required to give expert opinion in court. Lawyers in Enugu mentioned national laws (the Child Rights Act 2003) and research reports as useful sources of data for litigation.

> *Law reports from other jurisprudence; medical evidence, even though they don't usually give us. Doctors are also needed in courts to give experts' opinion. —CSO respondent, Lagos State*

MEDIA REPORTING

Changes in Targeted Journalists' Maternal Health Reporting Since Baseline

Finding 17: Most respondents across stakeholder groups in all locations report improvements in visibility of maternal health and use of expert information in media coverage.

At baseline, media coverage of maternal health was reported as "generally infrequent and inaccurate." At midline, some journalists mentioned that the frequency of reporting had increased to between one and three reports in a week. Others referred to several radio programs that exclusively focus on maternal health, including *Lafiyar Jiki*, a general wellness program that sometimes discusses women's issues, and *Lafiyar Iyali*, which focuses on maternal child health (both are in Kano State).

Overall, there was no significant difference in the types of media mentioned—radio, TV, print, and social media—although radio was mentioned more frequently in the northern states as a source of maternal health information and reports.

Journalists at midline across the sample states mentioned a wide range of topics related to maternal health, such as antenatal care, immunization, family planning, and maternal mortality.

> *Voice of America sponsors/pay us to rebroadcast their program on 'lafiya jiki,' it is not a maternal health program, but takes on different health issues at any time. Another one is,' Lafiya lyali,' this is focused on maternal and child health. We invite doctors to come and present. We sponsor this program as part of our social responsibility. There is another program, 'Ya-take ne arewa'—a family enlightenment program we present in collaboration with BBC media action. They produce it and we go over there to attend. We have our Freedom Radio BBC every week. We report maternal health issues, it is between 3 to 6 minutes every Wednesday. —Media interview respondent, Kano State*

Enablers and Constraints for Journalists to Report on Maternal Health

Finding 18: Enablers for reporting on maternal health include capacity building, personal interest, availability of facts, partnerships with CSOs, and public outcry—a change from the baseline when enablers were mainly personal motivation.

Journalists across sample states mentioned that maternal health coverage is enabled by several factors: capacity building of journalists by grantee organizations and other development partners; "personal interest/passion/human sympathy;" availability of facts; CSO (including grantee organization) partnerships with the media; and public outcry. Other enablers mentioned included support by editors and a favorable/enabling reporting environment.

> *The support has mainly been the training we have spoken about – capacity building for our staff on health issues and guidelines on health coverage. Some of them provided us with small equipment that can be used for maternal and child health coverage, e.g., giving of recorders and requesting it be used for maternal child health issues coverage. —Media respondent, Kano State*

CSOs involve media in their activities. It is a commitment we make with them. So, we make use of media report. There is an increased collaboration between CSOs and media. It has improved over the past year. —CSO focus group discussion respondent, Kano State

Finding 19: Constraints to reporting on maternal health include information hoarding and inadequate resources to support logistics.

Targeted journalists participating in focus group discussions and interviews listed several factors as constraints/challenges: women's reluctance to open up; information hoarding in government; cultural inhibitions around speaking with the opposite sex; inadequate resources to support logistics for investigative journalism in hard-to-reach communities; bottlenecks created by third parties such as personal assistants; and some journalists' quest for gratification.

Data gathering is a challenge… When there is much news to cover, we have the challenge of providing logistics for them to move around… The cooperation of the people is still a challenge. Our people don't voice out. Husbands still restrict women from speaking…. Getting professionals to talk with you, there are some who will rather be hostile, especially if you go to a government hospital… In Kano, it is easier to call/invite a doctor to our office than interviewing them in their office/hospital…. Civil servants are not allowed to talk to media for fear of victimization. —Media respondent, Kano State

Respondents across all sample states mentioned that cultural and religious inhibitions, especially the belief that death is an act of God, present difficulties for investigative journalism because family members are often reluctant to discuss the causes of death.

Women and Government still don't want to open up, especially if it is a crucial case. We are used to reporting in hardships. —Media focus group discussion respondent, Kano State

Information hoarding, mentioned at baseline, remains a phenomenon among government workers who believe they have a responsibility to protect their employer or to refrain from revealing information that could damage the government's reputation. When asked whether the Freedom of Information Act has made it easier to obtain information, focus group discussion participants in the FCT and Kaduna State said that not everyone was familiar with provisions of the act. Some participants reported that they had tried to use the Freedom of Information Act to request information, but that their requests had been ignored.

Sometimes even if you follow the procedure and make an official request, they just file your letter and leave it there. —Media focus group discussion respondent, Kaduna State

At baseline, journalists perceived the Freedom of Information Act as a law that could potentially make it easy to access information from government institutions. The midline data does not show any improvement in the deployment of the act.

Grantee Organizations' Support for Targeted Journalists to Report on Maternal Health

Finding 20: Grantee organizations have influenced the quality/accuracy and volume of maternal health news produced by journalists, as well as the frequency of reporting.

Journalists across the sample states mentioned that some grantees—CHR, CISLAC, and DevComs—have supported their work in many ways. Grantee organizations' reports and databases show that there has been improvement in engaging journalists. CISLAC and DevComs have been involved in training journalists on maternal health, use of data from a variety of sources, and conducting of investigative journalism. DevComs has provided journalists opportunities to embark on field trips, and platforms for networking and information sharing. **Exhibit 9** shows grantee organizations' activities and results.

Exhibit 9: Grantee Organization Activities to Strengthen Maternal Health Reporting

	Journalists Trained*	Media Staff Trained Who Produced at Least Two Articles Within 6 Months of Training	Maternal Mortality Litigation Cases Reported by Journalists	Media Advocacy Visits to State/Local Government
CHR	7	0%		
CISLAC	102	34%		4
DevComs	132	64%		
WARDC	-	-	1	

* The earliest journalist training took place in December 2013.
Source: Grantee organizations' monitoring data.

WARDC has used press conferences to increase coverage of maternal deaths, and has tracked 30 articles published on maternal deaths, the NotAgain campaign, and other efforts to achieve justice for maternal mortality.

MATERNAL HEALTH BUDGET PERFORMANCE

Sphere of Influence

- Governments allocate, release, and use maternal health budgets.

Grantee organization activities since baseline:

- **CHR: Capacity Building for CSOs and media on budget tracking and advocacy**

Grantee Organizations' Influence on CSO Advocacy for Improved Budget Performance on Maternal Health

Finding 21: CSOs' advocacy on improved budget for maternal health has been strengthened.

Respondents reported on several activities their organizations were doing in terms of advocacy for government accountability to maternal health. However, very little was mentioned in terms of the influence that these activities have on government accountability to maternal health budgets. Jigawa State respondents noted that their involvement in budget planning with government had yielded positive results in service provision. CSOs have supported the Kano State Ministry of Health through capacity building, training, and support with health budget development.

> *There is a committee called Accountability Mechanism in Kano State (AMKAS) that works with Maternal Newborn and Child Health (MNCH2). They support the ministry when it comes to maternal health issues. Last week, we were in a training supported by MNCH2 on budget tracking and analysis. —State government respondent, Kano State*

> *We are involved in budget planning at the Ministry of Health and Gunduma Health System; we are also involved in the budget process at the house of assembly, engaged government in the release and use of the funds approved by the house of assembly. Personally, I can say the collaboration is yielding a lot of positive results on the quality of service delivered. —CSO respondent, Jigawa State*

Influence of CSO Advocacy for Improved Budget Performance on Government Accountability to Maternal Health at Midline

Respondents reported no changes to federal health budget allocations when compared with baseline, and budgets still lacked earmarks for maternal health line items. The only exception is in Jigawa State, which recently earmarked maternal health line budgets in its 2015 budget (see **Exhibit 10**). According to CSO respondents, the advocacy activities of grantee organizations and other CSOs in the state had an impact on the government's decision to include a line item in the budget for maternal health.

Exhibit 10: Changes in Maternal Health Budget Performance since Baseline

State	Budget Performance
Bauchi	No increase in allocation
FCT	No change
Gombe	No change
Jigawa	No increase in allocation or release, but maternal health budget line created
Kano	No change
Lagos	No change
Niger	Increase in health budget, but not specifically targeted to maternal health
Enugu	*No information currently available*
Kaduna	*No information currently available*

Source: Interviews

Finding 22: Health and maternal health budget allocations have not changed much in the past year in FCT, Gombe, Kano, and Lagos states, and budgetary allocations have dwindled in Jigawa State.

Respondents had mixed views about whether government budget allocation, distribution, and use for maternal health had changed in the past year, and this varied from state to state. According to state government and CSO respondents from Bauchi and Jigawa states, there has been a reduction in the

allocation to maternal health in the state. According to these respondents, last year has been challenging in the state in terms of the release and use of funds because the government was focusing on the election activities to the detriment of the social services.

> *Budget performance is very poor. In 2011 it was good, about 15 percent. Since then it has been declining. The allocation to health has not improved; talk more on release, nothing works. In the past administration they talked about free maternal child health, but no money to back it. This is a new government we cannot rate it now. The 5-point agenda for health was released last week. —State government respondent, Bauchi State*

Some respondents in Jigawa State noted the creation of a budget line for free maternal child health and nutrition in the 2015 budget. However, it was clear from several respondents that inclusion of the budget line did not necessarily translate into an increase in budgetary allocations. Several respondents noted that allocations in Jigawa State had dropped from 14 to 12 percent.

> *The main change I noticed on the state budget is the creation of a budget line for free MNCH activities and nutrition, which was traditionally budgeted under drugs resolving funds. This is a great change. —Development partner respondent, Jigawa State*

CSO respondents in Niger State reported that there has been an increase in budgetary allocations.

> *Though [there is] no defined budget line for maternal health to my knowledge, but the budget line for health and hence public health (which has maternal health inclusive) has improved compared to what we had in previous years and the present government. —CSO respondent, Niger State*

CSO, professional association, and grantee organization respondents in the FCT and in Gombe, Kano, and Lagos states noted that there had been no changes to budgetary allocations for maternal health.

Enablers and Constraints for Maternal Health Budget Performance

Finding 23: Effective budget allocation is constrained by elections, politics, and inadequate finances on the part of the government.

State government respondents in Gombe and Niger states spoke of challenges to disbursements. Not only were the health budgets inadequate, but the actual release was less than the allocation. Respondents from Jigawa and Niger states noted that the dwindling cost of crude oil has negatively affected the availability of resources to the state, with an impact on the health budget, because the amount of available resources partly determines whether it increases or decreases.

> *Depending on the cost of crude oil per barrel, health budget may either increase or reduce. Price fluctuations usually affect the amount of resources available. We budgeted using $65 per barrel, federal government is pegging it at $40 per barrel. —State government respondent, Niger State*

Midline respondents did not explicitly state enablers for maternal health budget performance.

POLICY EFFECTIVENESS

CHANGES IN MATERNAL HEALTH POLICY (CREATION, MODIFICATIONS, AND IMPLEMENTATION) SINCE BASELINE

Finding 24: There are differing opinions between policymakers and others about whether there has been an improvement in policy implementation since baseline.

At baseline, policy implementation was not prioritized. This was attributed to frequent turnover in government and inadequate coordination. Although there seemed to be adequate awareness about the existence and implementation of the free maternal and child health policy, there was inconsistent understanding of what it covered. Baseline respondents also expressed a desire for the government to sign the free maternal and child health policy into law.

As during the baseline, the free maternal and child health policy was the policy mentioned most frequently by respondents across all sample states. In many states, policymakers noted an improvement in budgetary allocation to fund maternal health policy implementation and cited examples of better implementation, to include:

- "better supply of drugs, free drugs including antiretrovials to pregnant, HIV-positive women and misoprostol" (Bauchi, Enugu, Lagos, Kaduna, Kano, and Niger states)
- "better coordination and oversight" (Niger State)
- "new infrastructure/facilities upgraded, new Primary Health Care Centres" (Gombe, Kano, Lagos, and Jigawa states)
- "funds released regularly on a quarterly basis/increase in allocation" (Gombe and Kano states)

- "distribution of delivery kits" (Bauchi State)
- "tackling of personnel issues" (Kano State).

> *The maternal and child [health], we made it a policy for free services and we released funds to the Ministry of Health on quarterly basis. —Policymaker, Gombe State*

> *There was improvement in infrastructural development of health facilities in the state, many primary health care facilities were upgraded to secondary health facilities, and some were turned to general hospitals. —Professional association respondent, Jigawa State*

However, many CSOs participating in interviews and focus group discussions said that, overall, the level of implementation of the free maternal and child health policy was low and/or inadequate.

> *All we hear from the Executive Secretary, SPHCDA [State Primary Health Care Development Agency] is that services are free. We told him we were on ground. He told us that not everything that is free. Sometimes government will supply some items to cater for the delivery of women. —CSO respondent, Gombe State*

Other policies mentioned in addition to the free maternal and child health policy included the following:

- The National Health Policy
- National Policy on the Health and Development of Adolescent and Young People in Nigeria
- National Strategic Health Policy
- Midwives Service Scheme Policy
- The Reproductive Health Policy
- The 5-year Strategic Health plan (FCT)
- Free Under 5 Healthcare Program
- Resolutions of the National Council on Health
- Free treatment of HIV-positive pregnant women.

Finding 25: Between baseline and midline, some pending bills related to maternal health have passed into law, while others are receiving greater attention from legislators.

At the federal level, the National Health bill was passed into law on December 9, 2014, after several years of advocacy. The Violence Against Persons Prohibition Act passed in 2015.

In Enugu State, a CSO respondent mentioned that the free maternal and child health policy has been passed into law. In Niger State, respondents from the Ministry of Health said that they had been advocating for the passage of the Primary Health Care Under-One-Roof law. Currently, primary health care is organized and funded by different tiers of government. The Ministry of Health funds some components and the LGA funds others. Coordination has been a problem.

> *The National Council on Health at its 56th session approved the PHC Under-One-Roof concept. Its pillars are – Funding, Minimum Service Package, Human Resource Governance, Operational*

> *Guidelines. It will have one management, one plan, and one M&E [monitoring and evaluation] framework. —Policymaker, Niger State*

In Kaduna State, the Primary Health Care Under-One-Roof bill was signed into law in 2015 and advocacy by the CSO MNCH partnership is in progress for passage of the free maternal and child health policy. The bill is said to be receiving attention in the judiciary.

> *The bill on free MNCH is with the house and passed the first and second readings. Now we don't know the status of the bill. —CSO respondent, Jigawa State*

Respondents in Lagos State also mentioned that the state passed a law on health insurance while Kaduna State is set to pass the "Service Charter," which, when passed, will ensure that a doctor, midwife, or nurse who does not attend to a pregnant woman within 30 minutes of her arrival at the health facility will be sanctioned. Also in Kaduna State, reference was made to a bill for a health insurance program for women and children; this bill is still in the works.

The Primary Health Care Under-One-Roof Act will improve availability of commodities and skilled personnel through distribution of personnel between primary health centers across the state and improvement of quality of maternal health services, especially because primary health centers are closer to women than secondary and tertiary hospitals.

Factors Supporting Changes in Maternal Health Policy

Finding 26: Effective and inclusive coordination mechanisms and political will are the main factors supporting changes in maternal health policy and implementation.

In several sample states, respondents mentioned the existence of effective and functional coordination mechanisms, including key government personnel, development partners, and civil society. In Kaduna State, for example, development partners led by the MNCH2 Project (funded by the U.K. Department for International Development) set up an accountability mechanism co-chaired by CSOs and government. This group holds monthly meetings at which key implementers, including government representatives, highlight the work being done to implement commitments under the free maternal and child health policy. Respondents perceived that this mechanism will promote effective policy implementation.

In other states, the existence of effective MNCH partnerships, some of which are co-chaired by CSO and government representatives, was seen as an enabler (Kaduna, Kano, and Jigawa states). These partnerships used scorecards and cooperated with government to conduct facility assessments/audits. Kaduna State has a MCH-CSO partnership that conducted periodic facility assessments. These partnerships used findings from different assessments to inform advocacy with the government. At midline, CHR introduced the use of scorecards in Niger State; respondents mentioned that a draft report had been developed. The MCH-CSO partnership was considered very influential in Kaduna State and gave rise to other communities of practice, including Journalists for Better Health and Journalists for Immunisation.

Policymakers in Niger State indicated that the Ministry of Health has established several layers of supervision in order to improve maternal health services at facility level.

> *What we have generally is that we have multiple tiers of supervision, which works better. The three–tier level of supervision engenders proper oversight. The aspect of traditional supervision—visiting facilities unannounced—should not be jettisoned. This brings in checks and balance to the work of health in the state. We have developed a Sniffer tool with different levels of relevance – general screening, diagnostic visitation, interventional visitation, assessment visits, reevaluation visit. It's a 'one cap fits all' tool. —Policymaker, Niger State*

In Kaduna and Niger states, stakeholder groups highlighted that development partners, CSOs, and media representatives who participate in interviews and focus group discussions opined that the new governors have shown deep interest in maternal and child health, and that CSOs have shown reciprocal interest by embarking on evidence-based advocacy. One interview respondent mentioned that legislators in Kano State have shown support and willingness to deepen ongoing engagements on maternal and child health.

> *Implementation is stronger now with the change in government because, by the grace of God, the lack of funding, which was an issue before, is now history. Our Governor is passionate about maternal health and has made a lot of moves in that regard, and the first lady too is a gynecologist and seems very interested in maternal well-being. —Policymaker, Niger State*

In Enugu State, a CSO interview participant mentioned "a reawakened interest and direction for CSOs and media outfits in the state towards activities to improve MNCH services in the state."

Grantee Organizations' Influence on Policy Improvement and Implementation

Finding 27: Grantee organizations have made palpable contributions to strengthen policy implementation in the project states.

According to midline data, grantee contributions include facilitating inclusion of maternal and child health in election demands by CSOs (Advocacy Nigeria); influencing political parties to make commitments toward effective implementation of the free maternal and child health commitments (Advocacy Nigeria); conducting health facility assessments and embarking on evidence-informed advocacy (Advocacy Nigeria and CHR); media and legislative advocacy (Advocacy Nigeria, CISLAC, and DevComs); presenting MDSR data and recommendations to government (SOGON and WHARC); and creating demand for maternal and child health services (WARDC, working with community women).

> *In partnership with CHR, we carried out a research on viability of Primary Health Care facilities using scorecards. CHR sponsored the scorecard project. A draft report of this assessment has been submitted and is awaiting validation before dissemination. We have some examples of preliminary change. —Policymaker, Niger State*

CHANGES IN LEGISLATIVE COMMITTEE OVERSIGHT OF MATERNAL HEALTH POLICIES SINCE BASELINE

Finding 28: Stakeholders held opposing opinions on improvement in legislative committee oversight at midline.

Opinion was divided on legislative oversight. Some stakeholders said oversight had improved, while others said that there was no improvement.

> *They are doing it. The former house committee (health) members are visiting health facilities in the state. We see on TVs what they do. The present house committee chairman is a medical doctor. There was even a time he visited a health facility and volunteered as a doctor during the bomb blast that recently hit Gombe. They are taking a tour of facilities, e.g., the state specialist hospital and nearby facilities. —CSO respondent, Gombe State*

> *I do not know of any change in the activities of the state house of Assembly in the last 1 year. What I know is that, the state house did not pass the maternal and child health care bill that was with them for long, and I am very sure that they will not pass it into a law because they want to avoid being held responsible for adding a burden on the government tilt revenue, which cannot even pay staff salaries. —CSO respondent, Bauchi State*

LITIGATION

GRANTEE ORGANIZATIONS' INFLUENCE ON MATERNAL MORTALITY LITIGATION (STATE OF MATERNAL HEALTH LITIGATION)

Finding 29: Maternal health litigation is uncommon and alternative means are used to seek redress.

Despite an increase in awareness-raising activities with regards to litigation of maternal health-related deaths, respondents from Enugu, Kaduna, and Lagos states noted that maternal health litigation remains uncommon and that people usually accept such deaths as an act of fate or the will

of God. People are generally reluctant to take maternal deaths to court due to these beliefs. Respondents cited culture and religion as the major reasons for not wanting to go to court.

WARDC monitoring data show that a total of three judicial and non-judicial cases have been identified, but to date none have gone to court. Some respondents alluded to the fact that people sometimes pursue alternative justice systems to seek redress. They also noted that because they are not supported by family, most cases cannot be conducted.

> *Maternal death litigation is at zero level in the state. People don't know where to report their cases to, they are afraid of victimization and many take the death of a woman as the will of God. I only saw one woman that has an organization called Healing Hearts Foundation, they work and advocate for widows. She is the only one I know that is trying to initiate the process of litigating for maternal death. She has two cases to treat when she concludes her advanced study in litigation processes. —State government respondent, Enugu State*

MATERNAL HEALTH LITIGATION ENABLERS AND CONSTRAINTS

Finding 30: Maternal health court cases are constrained by apathy to litigation, lack of awareness of rights, fear of victimization, fatalism, culture/religion, and perceived cost.

Respondents said that maternal health court cases are constrained by apathy to litigation, lack of awareness of rights, fear of stigma, fear of victimization, fatalism, and perceived cost, a list that is similar to the baseline. Respondents in Enugu, Kaduna, and Lagos states spoke of women's fear of victimization as a result of pursuing legal redress for maternal death-related cases. Respondents spoke of the perceived stigma generated by wanting to pursue a case. Respondents reported the impact of culture and religion on the belief that death is spiritual ("God's will"), hence their reluctance to take up cases related to maternal death. Respondents also mentioned the long time it takes for a court case to be concluded and the courts' delay in giving judgments as constraints to maternal health litigation.

> *Women don't seek for help because of fear of stigmatization. —Female focus group respondents, Enugu State*

Respondents in Enugu, Kaduna, Kano, and Lagos states told stories of how "culture and religion/fatalism" prevent litigation of maternal health cases and that pregnancy-related death is seen as "God's will."

> *For the past 20 years, there has been only one litigation in respect of maternal death that I'm aware of. Litigation is zero because of religious beliefs, culture, and norms. We bury the dead without knowledge of the cause. —Development partner, Kano State*

Respondents in Enugu, Kaduna, and Lagos states reported how lack of finances hindered families and women from taking up cases. They also considered the cases a waste, given their strong beliefs that the cases will never be concluded or that litigation would take too long. Legal professionals also reported that it was difficult to get evidence on maternal death cases. According to one respondent,

hospitals do not usually want to release their reports, and the hospital report sometimes differs from the client's, making it difficult to establish a case.

> *People are poor, they do not have money to take up cases. If there are offices around where people can report, it will be good. I am sure they will have reports if such a place exists. We need to identify places where we can work with. There is need to give information to people as to where they can go and report cases of maltreatment or if there is a challenge, please call this number. —Female focus group respondent, Lagos State*

> *To get a witness is always a challenge, but if you can locate them you can subpoena them and treat them as hostile witnesses. Hospitals usually do not release their reports. Access to medical reports is challenging. You can imagine getting a hospital report and the case file is saying something else and the person involved is saying something else. Nowadays, there are small hospitals and the professional ethics is neglected. We need to develop in the area of forensics. As forensic evidence is an area where there is a huge challenge. —Legal professional, Lagos State*

Grantee Organizations' Influence on Maternal Mortality Litigation

Finding 31: Grantee organizations' activities have generated changes in awareness among lawyers on issues of litigation around maternal death.

Legal professionals and CSO respondents in Enugu and Lagos states who attended the Nigerian Bar Association side conferences organized by WARDC reported being impressed by the training they received. According to lawyers, the training gave them good insight into maternal health issues and the possibility of litigating on maternal deaths.

> *I use the information I get from those trainings to inform my legal activities. I work with facts. The most impactful part of the training is the enlightenment on women's rights. —Legal professional, Enugu State*

> *The training has been impactful because we were enlightened on how to address maternal issues in Nigeria. Now, I work with facts. The major support we get from WARDC is the training I just talked about and the facts/information we get from them. The training has sharpened our skills on how to intervene in maternal health issues. I go to the court to file my cases. —CSO respondent, Lagos State*

WARDC conducted awareness-creation activities targeting the community in Enugu, Kaduna, and Lagos states. Female respondents who participated in WARDC activities from these three states reported that they were pleased with the awareness created during the activities. Focus group discussion respondents in Lagos State reported that they had gained a lot of information from WARDC's training and awareness-raising campaigns.

> *It was a wonderful day and I learnt a lot, we were taught how to lodge complaint to the government if there is anything we don't like at the health facility. Government is trying their possible best to stop death at childbirth. —Female focus group respondent, Enugu State*

According to focus group discussion and legal professional respondents from Enugu State, other than awareness-creation activities about project objectives, they had no further links with the organization and could not report on any influence on maternal health litigations. Legal professional respondents in Enugu would like to have more collaboration and coordination with the grantee organization so they can begin to effectively take on cases on maternal deaths.

Finding 32: WARDC has generated a lot of awareness on issues of litigation around maternal health; alternative redress options are being sought by citizens in Enugu, Kaduna, and Lagos states for maternal health abuses.

Respondents said that not much progress in terms of litigation of maternal health-related cases had been made in the past year, but that momentum has grown as people seek alternative solutions for deaths and abuses related to maternal health. Although a large number of individuals still "leave the case to God," respondents in Enugu and Kaduna states noted that they had reported cases to community or village elders, the ward head, or the village health committee for further action. Others noted that they had reported the case to other CSOs to assist with seeking redress. Women who had been a part of WARDC activities and participated in focus group discussions in Kaduna and Lagos states said that they had reported to the hospital leadership.

> *Women are being sensitized on their rights and they can report to the person in charge of the facilities when their rights are violated. We had to sensitize them, reassure them, and alleviate their fears. As a result of this case, the authorities now go around to check out what is happening at the health facilities. —Female focus group respondent, Kaduna State*

Respondents from Lagos State said that CSOs and other groups also held press conferences and organized rallies (protests/demonstrations) to protest ill treatment and negligence that may have caused maternal deaths. Reports have also been made to the public complaints commission or the medical and dental association.

> *Her case was taken to the Medical and Dental Practitioners Investigating Panel. We have finished the processes and are awaiting judgment. We also reported to the Public Complaints Commission. We got judgment here and then proceeded to the Medical and Dental Association Panel. The Public Complaints Commission found the hospital negligent. —CSO Respondent, Lagos State*

Respondents from Kaduna and Lagos states remarked that some community members had involved law enforcement agents in seeking redress. These different modes of seeking redress have yielded results. From a standpoint of "leaving things to God," people are sensitized enough to at least seek some form of redress; this is an improvement from the baseline.

> *We had a case of a doctor that was making money off women. He was injecting substances to make their stomach swell, claiming that he had helped their infertility. We reported to the Nigerian Medical Associations (NMA), brought in the police and all parties involved. At the end of the day, the women did not want the matter known. The police needs to ensure that the right thing is always done. —Legal professional, Lagos State*

Conclusions

These findings highlight progress made in government maternal health accountability. However, in determining changes since the baseline, it is important to remember that there is no "counterfactual." Therefore, it is not possible to know what would have occurred if none of the grantee organization activities had been implemented. Additionally, the change in government that followed the election both challenged progress and presented opportunities to engage. In some areas, progress slowed due to stakeholder involvement in the electioneering process and some advocacy gains were reduced because key stakeholders changed. Even in this context, several accountability areas have shown progress as illustrated in **Exhibit 11**.

Exhibit 11: Summary of Progress in Accountability Areas

CSO Collaboration	MDSR Committee	Evidence Generation/Use	Media	Budgetary Performance	Policy and Legislation	Litigation
• Improved collaboration among CSOs and with government	• Improved functioning • Recommen-dations being used	• More primary investigations • More data being used	• Apparent increase in coverage • Increased collaboration • Constraints remain	• Increased awareness and tracking • Little progress on increase • CSO influence unclear	• Mixed perceptions on progress to date	• No increase in litigation, despite greater awareness • Constraints remain firmly in place

CSO Collaboration: Collaboration is key for successful CSO mobilization on MNCH issues, both for increased effectiveness and to reduce duplication. Overall, CSO coordination and collaboration has increased since baseline. Advocacy Nigeria, CHR, CISLAC, and WARDC have influenced the development of CSO networks and supported CSO advocacy activities. The enablers mentioned by respondents at midline included grantee organization influence, as well as government recognition of CSO collaboration. Although CSO coordination and collaboration improved overall at the midline, competition still exists within collaborations and/or between CSOs and the government. The focus of CSO collaboration appears to have shifted toward holding the government accountable for the actual delivery of promised maternal health services. CSOs may be working together in grantee-organized networks, but they are still competing with one another for limited funding and support from grantee organizations, donors, and the government.

CSO collaboration and coordination resulted in increased advocacy to government for maternal health accountability. Grantee organizations' capacity building for these networks will help CSOs hold government accountable to maternal health in Nigeria. Although government and CSO respondents alike mention increased advocacy activities, the effect of these activities on government behavior is

not explicitly stated in most cases. It may be too early to see CSO advocacy translate into tangible results for government action. The overall focus is on CSOs' efforts to enact change and less on the resulting changes in government response or actions.

MDSR Committees: MDSR committee formation and functioning has improved in the last year, with committees meeting (albeit not regularly) and, more importantly, with committee recommendations being used and committees generating reports that influenced facility management and state government response. The "no name, no blame" policy has continued to help promote the MDSR processes and health workers' commitment to conducting MDSRs. Support from SOGON and WHARC has helped ensure that committees meet and strengthen their meeting process. Interviewees in the FCT and Lagos State spoke of increased awareness among health workers, government, and communities on maternal health issues, as well as improved accuracy of reporting, adjusted hospital procedures, appropriate response from government, improved health worker attitudes, capacity building for health workers, and increased referrals to the hospital.

Improvements were reported in terms of committee members' commitment to the MDSRs and some actions taken related to strengthening infrastructure. Although the committees have not met regularly, about 40 percent of maternal deaths were reviewed and committees have modified their processes to become more efficient. There are early signs that the potential for MDSRs to bring about health facility-level reforms is being realized and attitudes toward the MDSRs have changed since baseline. However, MDSR committees appear to be effective with the presence of grantee support, but results may not be sustainable after grantee exit because there have been challenges in getting LGA involvement.

Evidence Generation and Use: At midline, journalists, CSOs, and policymakers appear to be accessing more evidence, information, and data from grantee organizations' sources (available at baseline) and from government sources. Among targeted journalists, there was an increase in the use of primary information derived from investigative journalism. Even though grantee organizations' contribution, particularly the MDSR committees and the work of CISLAC and DevComs, to the evidence base was notable, policymakers, journalists, and CSOs were not always recognizing where grantee organizations' contributions were. Many stakeholders mentioned using data from scorecards and grantee organizations are supporting this in some states as part of the MNCH partnership. Some respondents (development partners) felt that stakeholders have a better understanding of the importance of data and evidence than at baseline.

Media: Coverage of maternal health appears to have increased since baseline and the capacity building that grantee organizations provided was frequently cited as an enabler. There is also evidence of increased journalist collaboration with CSOs; CSOs are now involving journalists in their activities, not just to cover the activities, but as stakeholders in the process, which was a recommendation from the baseline report. However, many of the same constraints from baseline remain, including logistics to generate stories and government "information-hoarding," although the need for gratification appears to be mentioned less frequently at midline. There have been some

missed opportunities for grantee collaboration around the use of media that could increase portfolio effectiveness.

Budgetary Performance: There is increased government awareness about the need to budget for maternal health, and CSOs are increasing their budget tracking (allocations and release) and advocacy. However, this is one area that has not made much concrete progress because falling oil prices have led to an economic crunch and budget releases are not happening as planned. Although budget tracking is taking place, CSO influence on overall budgetary performance remains unclear.

Policy and Legislation: Opinions differ on policy, legislation, and implementation. Policymakers are saying that implementation is ongoing, with hospitals being refurbished, funds being allocated, and drugs being made available. However, CSOs and other stakeholders are not seeing this progress – implementation is low or unchanged from the baseline. One bright area is the Primary Health Care Under-the-Same-Roof policy, which should bring about better coordination. The bill has been passed in Kaduna State; advocates in Niger State are still pushing for it.

Litigation: Although there is greater awareness of the availability of litigation as a form of redress in maternal death cases, especially as a result of negligence, the fact remains that such litigation is uncommon. People use alternative methods and have started to seek redress from professional medical associations and facility management. The issues that were noted as constraints to maternal health litigation at baseline remain strongly at midline. Finances, culture, and religion have played a major role in restraining people from taking up cases of maternal deaths.

Recommendations

The EnCompass evaluation team facilitated a 2-day (January 25-26, 2016) data consultation meeting in Abuja, Nigeria with 25 participants representing the MacArthur Foundation, seven grantee organizations, and other key stakeholders. The purpose of the meeting was to elicit MacArthur Foundation, grantee, and stakeholder input, reflections, and questions on draft midline evaluation report findings and conclusions, and generate recommendations to ensure relevance, accuracy, and use across the portfolio. The recommendations presented here were generated at that meeting and refined by the EnCompass evaluation team.

GENERAL

All grantees should have a sustainability plan/strategy. Given that this is the last year of the grant portfolio, all grantee organizations should develop or refine their sustainability plan or strategy for their maternal health accountability work. The plans or strategies should include a timeline and how they will work with other grantee organizations and coalitions, such as AMHiN (the Accountability for Maternal, Newborn and Child Health in Nigeria – a national coalition of civil societies, media, and professional bodies committed to promoting accountability and transparency in the health sector). Grantee organization sustainability plans should also include sourcing for other funding opportunities to ensure sustainability in the accountability area(s) they are currently working in.

Grantee organizations should be more strategic in their collaboration with each other. As the grant portfolio moves into its third year, it becomes more critical for grantees to collaborate and coordinate with each other, especially those working in the same accountability areas. The data consultation meeting showed increased awareness among grantee organizations of how their efforts have and can link, harmonize, and support the work of other grantee organizations. This has been an area of growth for the portfolio starting with establishing a shared Dropbox in July 2015. It was suggested that DevComs should create and manage a ListServ group for grantee organizations to bridge the gap in sharing and learning across the portfolio.[4] The MacArthur Foundation should allow grantee organizations to have a 1-day or half-day meeting to come together periodically to share programmatic success and identify synergies; perhaps in advance of the last round of grants for this portfolio. Grantee organizations should use DevComs' communication platform to disseminate their articles and information.

Grantee organizations should continue to strengthen the monitoring of their grant activities. The monitoring data collected and used for the midline evaluation were important for a more complete and well-rounded story of progress in the accountability areas. This was the first time grantee organizations had collected such data and the evaluation team found them useful, and also identified areas for improvement. All grantee organizations should continue to provide quantitative data on their activities, both what they have done and what has transpired as a result that can be used for the

[4] DevComs established this during the data consultation meeting.

endline evaluation. CHR, in particular, should source state health budgets in 2016 that can be used by the evaluation team for the endine evaluation.

Civil Society Organization Collaboration

Grantee organizations should collaborate more on CSO coalition building. Many of the grantee organizations in the portfolio are CSOs themselves and they should work more deliberately with other CSOs in partnerships and coalitions in the relevant states. This can include expanding the network among grantee organizations themselves for increased collaboration, and establishing more learning opportunities to share experiences. Advocacy Nigeria, in particular, should do more than one-off trainings and provide continuous capacity-building activities to strengthen skills of trained advocates, such as training of trainers for those already trained. CISLAC, for example, could collaborate with the Health Reform Foundation of Nigeria (HERFON) and Evidence for Action (E4A), and the MCH-CSO partnership in Kaduna State.

MDSR Committees

WHARC should integrate LGA and state MDSR players and consider a Lagos-based presence. There seems to be a disconnect between the LGA and state MDSR actors in Lagos State. Consequently, WHARC should play a liaising role to ensure that there is joint decision making and ownership across the two government levels for greater engagement and outcomes. WHARC should consider placing a person in the city of Lagos to engage with the MDSR committees regularly to take advantage of impromptu opportunities and meetings that may arise.

SOGON and WHARC should work with government to ensure that MDSR recommendations are implemented at facility and state levels. SOGON's and WHARC's work with MDSR committees has shown progress in terms of formation and functioning. SOGON and WHARC should work to support, encourage, and monitor the MDSR committees with which they work to ensure the committees follow up on the response part of their work, track recommendations, and ensure that proposed changes are implemented.

Evidence Generation and Use

Grantee organizations should improve visibility of their information, education, and communication efforts. Some grantee activities did not come through in the findings, although the evaluation team probed specifically for them, namely the Not Again Campaign and CISLAC advocacy materials. Given this, grantee organizations should broaden their audience and collaborate more around these shared activities—especially the Not Again campaign—to ensure that the desired information and messages are reaching the target audiences and the broader public. Specific recommendations for increased evidence generation and use are:

- All grantee organizations should increase advocacy around the Not Again campaign to increase awareness of the campaign more broadly.

- Advocacy Nigeria should increase awareness-creation activities and presence in project areas, especially around the Not Again campaign.
- CISLAC should distribute their information, education, and communication materials more broadly and make use of other user-friendly formats, such as abridged versions, fact sheets, and electronic versions.
- DevComs should do more to ensure that the impact of Not Again campaign is felt on a larger scale using more social media platforms.

MEDIA

Grantee organizations that work with media should go beyond training. Grantee organizations have trained a lot of journalists, and the next step is to build on those trainings and mobilize journalists to take action. CHR, CISLAC, and DevComs, should promote specialization on health- and maternal health-related work in journalism and in journalist training schools. Advocacy Nigeria, CHR, and CISLAC should work closely with media-related colleagues to push information out in the public domain to help fast-track results.

BUDGET PERFORMANCE

The MacArthur Foundation should work with grantees to clarify and broaden maternal health budget performance efforts, beyond CHR. At baseline and midline the area of budget performance related to maternal health has been the most challenging. Yet, only one grantee organization, CHR, is working specifically in this area. Going forward, the MacArthur Foundation should work with all grantee organizations in the portfolio to clarify the specific maternal heath components of health budgets the portfolio should focus on, and make this the responsibility of all grantee organizations. This could include developing or identifying budget subheadings that should be included in health budgets so that grantee organizations can specifically look and advocate for them in federal, state, and LGA budgets. For example, CISLAC could build the capacity of legislators in the health committee on how to develop health budgets. CHR should build capacity of other grantee organizations on how to use the scorecard as an evidence-based tool for their work so other organizations can also work on budget performance in their states of focus.

Grantee organizations should add activities that track, build capacity, and disseminate gains related to maternal health budget performance. Grantee organizations (to be determined by the MacArthur Foundation) should conduct a retrospective tracking of health resources, i.e., how much was ultimately committed to health. Tracking the exact amount spent is more relevant monitoring of budgetary allocation than what executives announce they will give to health. CHR should find out what influenced Bauchi state to meet the Abuja Declaration, and work with other grantee organizations, such as DevComs, to give this achievement media exposure and hype so as to make Bauchi state a model that can be used to encourage other states to do the same. Advocacy Nigeria and CISLAC should use the new government's anticorruption campaign as a means to track maternal health expenditures and/or leverage attention on maternal budget allocation and release.

POLICY AND LEGISLATION

Advocacy Nigeria and CISLAC should refocus efforts on the new government and use their platforms for maternal health advocacy. The new government brings opportunities for Advocacy Nigeria and CISLAC to increase advocacy and create awareness on the reduction of maternal mortality among the new national and state administration and parliaments (e.g., state governors, the president, and legislators). CISLAC already tracks implementation of policies that have been passed into law and they should continue to do so.

LITIGATION

WARDC should expand its activities to include the judiciary and increase its public sensitization efforts. Pervasive, longstanding, deep-rooted cultural and social beliefs around maternal mortality and distrust of the legal system in Nigeria are strong barriers to maternal health accountability. This makes the work of WARDC critical, but challenging, especially given that they are the sole grantee organization working in this area. WARDC should increase its focus on demand creation, i.e., encouraging the general public to engage the services of WARDC. This should be encouraged even before the need arises. WARDC should build more sensitization of the public on the positive impact of litigation because this may help/encourage them to take up maternal death and health cases. WARDC should do more work to build sympathy in the judiciary for maternal health issues. This could include training judges, judiciary staff, registrars, clerks etc., and presenting at judges conference. WARDC should also co-opt more litigators in other states and sensitize doctors, medical and dental council, and the judiciary on the need to cooperate with lawyers on litigation processes.

Annex 1. Grantee Organization Activities Across Accountability Areas Since Baseline

Grantee (accountability area)	Activities	States / FCT
Advocacy Nigeria **Community mobilization (policy advocacy)**	• Advocacy to identified stakeholders (governments, religious, traditional leaders, and political parties) • Capacity building for CSOs and health care workers on use of scorecards • Administration of scorecards at primary health centers • Mapping of the existing political parties • Meeting with political parties, legislators, executives/policy makers • Documenting improved budgetary allocation for MNCH at all levels	Adamawa, Gombe, Zamfara
Community Health Research Initiative (CHR) **Community mobilization (policy advocacy), budget tracking and analysis**	• Support the AMHiN coalition meeting and advocacy group • Support the activities of the MNCH accountability mechanisms at state level • Develop scorecard on key maternal health indicators • Develop annual shadow report in line with the Commission of Information Accountability (CoAI) • Capacity building for CSOs and media on budget tracking and advocacy • Support the implementation of quarterly Integrated Supportive Supervision (ISS)	Bauchi, FCT, Jigawa, Kano, Niger, Sokoto
Civil Society Legislative Advocacy Centre (CISLAC) **Community mobilization (policy advocacy)**	• CSO participation in maternal health public hearing (including capacity building for CSOs) • Audit of the state of maternal health in the four states • Develop and disseminate policy brief to policymakers and legislators • Media engagement (media parley) and advocacy to CEOs of media houses in the four states • Public hearing on the maternal health (including capacity building for legislative reporters) • Production of bimonthly newsletters and policy briefs to enhance public and legislature awareness of key health issues • Town hall meeting on strengthening MDG committees in State Assemblies • Town hall meeting on understanding legislative oversight on maternal health in four states	Jigawa, Kaduna, Kano, Katsina
Development Communications Network (DevComs)	• Quarterly publications of bulletin (MP4) on emerging MH issues • Regular update of Not Again portal and social media to share maternal health information among media, CSOs, and the public • Field visits by journalists to underserved communities and primary health centers	FCT, Jigawa, Kaduna, Lagos

Grantee (accountability area)	Activities	States / FCT
Community mobilization (media, policy advocacy)	• Publication of media handbook on maternal health reporting • Media support for CSO activities on maternal health accountability • Media appearance on relevant international days to discuss maternal health accountability • Quarterly civil society-media forum for interaction between media and CSOs on maternal health accountability	
Society of Gynaecology & Obstetrics in Nigeria (SOGON) **Maternal death audits**	• Sensitize on importance of functional MDSR committees across Nigeria • Train organizations in MDSR committee role and function • Maternal death reviews and response tracking data from communities, primary health care centers, general hospitals, and states • Monthly supervisory visits to communities, primary health care centers, and general hospital MDSR committees	FCT
Women Advocates Research and Documentation Centre (WARDC) **Legal approaches, community mobilization (policy advocacy)**	• State and national launch of the Not Again Campaign/community mobilization • Submission of 3 million signatures • Engaging treaty bodies • Video documentary • Advocacy to health institutions • Litigation • Annual side event at the Nigerian Bar Association • Press conference • Roundtable meeting with CSOs to mobilize CSOs to engage maternal health discussions	Enugu, Kaduna, Lagos
Women's Health Action Research Centre (WHARC) **Maternal death audits**	• Monitoring MDSR committee meetings in the three project sites • Training of MDSR committees and other health providers in three health facilities conducting MDSRs • Publication and dissemination of Lagos state MDSR protocol • Knowledge, attitudes and practices (KAP) survey on MDSR in three facilities	Lagos

Annex 2. Evaluation Team Members

Lyn Messner, Team Leader

Lynne Franco, Vice President of Technical Assistance and Evaluation

Atinuke Olufolake Odukoya, Regional Coordinator

Ejiro Joyce Otive-Igbuzor, Regional Coordinator

Jennifer Casto, Gender Integration Associate

Zachariah Falconer-Stout, Evaluation Associate

Abigail Ladd, Senior Technical Assistance and Evaluation Specialist

Sabine Topolansky, Project Assistant

Aliyu Aminu Ahmed, Regional Coordinator

Abubakar Baba Mustapha, Data Collector

Amina Kwajafa, Data Collector

Aminu Muhammad Mustapha, Data Collector

Blessing Olutoyin Williams, Data Collector

Loveth Metiboba, Data Collector

Mabinu Olasumbo Oladipo, Data Collector

Annex 3. Theory of Change: Initial Observable Actions in the Spheres of Control, Influence, and Interest

Sphere of Control	Sphere of Influence		Sphere of Interest
	Boundary Partners	**Actions**	
Raise awareness of key actors	Lawyers Community members Maternal Death Surveillance and Response (MDSR) Committees (state, community, and facilities) Media	Lawyers litigate on maternal health cases MDSR committees are funded, active, and generate accurate maternal death reports Media executives support and enable accurate and timely maternal health coverage Media (electronic, print, social) accurately cover maternal health	MDSRs are used to improve planning and practice Increased media coverage of maternal health Increased jurisprudence around maternal rights Increased community reporting on maternal deaths
Advocate to key actors to take action to advance maternal health	Legislative committees National/State Primary Health Care Development Agency Civil society organizations	Civil society and community members advocate for and monitor government commitments to and actions on maternal health (legal, policy, budget, maternal deaths) Legislative committees oversee maternal health policies Governments allocate, release, and use budgets related to maternal health	Existing maternal health policies improved and implemented Increased budget allocations, disbursements, and use for maternal health Formulations of new laws and policies on maternal health
Form civil society coalitions and partnerships	Civil society organizations (including grantees)	Civil society organizations collaborate to minimize duplication and increase joint advocacy for maternal health (legal, policy, budget, maternal deaths) Civil society organizations form partnerships with government stakeholders around the accountability areas	
Strengthen maternal health information	Media Policymakers Lawyers	Media use evidence to write stories on maternal health Policymakers use evidence to inform maternal health policy decisions Lawyers use resources for maternal health litigation	Improved data for planning Free maternal health policy implemented

Annex 4. Midline Data Collection Matrix

Midline Evaluation Questions	Indicators of Progress	Data Sources
Endline Evaluation Question: In what ways does civil society collaboration and coordination lead to increased government accountability to maternal health?		
1. How has CSO collaboration and coordination, with other CSOs and government, around maternal health accountability changed since baseline? a. What enables and hinders CSO collaboration and coordination around the maternal health accountability areas at midline? b. How have grantees influenced CSO collaboration and coordination?	Changes in perceptions by key stakeholders of civil society engagement and advocacy around the accountability areas Number of interventions/actions taken by Advocacy Nigeria, CISLAC, CHR, and DevComs that have directly or indirectly mobilized civil society to influence or change government commitment to maternal health Key stakeholder perceptions of grantees' influence on CSO collaboration and coordination	Data collection at midline to capture changes in perceptions Grantees' monitoring data to capture actions they have taken Data collection at midline to capture perceptions of grantee influence around CSO collaboration and coordination
2. How has CSO collaboration and coordination influenced government accountability to maternal health at midline?	Government stakeholders' perceptions of influence of civil society collaboration and coordination on government accountability to maternal health	Data collection with government stakeholders at midline to capture perceptions of how CSO collaboration and coordination has contributed to government accountability to maternal health
Endline Evaluation Question: What enables and constrains MDSR committee activation and accurate reporting?		
3. How has targeted MDSR committee functioning changed since baseline? a. What enables and hinders MDSR committee functioning? b. How have grantees influenced MDSR formation and effective functioning?	Number of MDSR committees reached by SOGON and WHARC, and community verbal autopsies facilitated by WHARC Percent of state MDSR committees in the FCT and Lagos that SOGON and WHARC are supporting that, in turn, meet at least once a quarter Percent of facility MDSR committees in the FCT and Lagos that SOGON and WARC are supporting that, in turn, meet at least once a month MDSR committee recommendations and implemented actions aligned with best practices	Evidence of recommendations made and implemented, as collected by SOGON and WHARC SOGON supervisory visit reports Attendance lists collected by SOGON and WHARC for all training, meetings, and consultations Evidence of meetings (minutes, attendance lists, MDR session reports, inauguration reports, etc.) collected by SOGON and WHARC Data collection among targeted MDSR committees to capture perceptions of grantee contributions to committee formation and effective functioning Maternal deaths (and causes) tracked by WHARC Data collection to capture perceptions of improvement in accuracy of maternal death reporting

Midline Evaluation Questions	Indicators of Progress	Data Sources
	Key stakeholders perceive improvement in accuracy of maternal death reporting Key stakeholders perceive improvement in maternal health services and response as a result of MDSR recommendations and actions	Data collection to capture perceptions of improvement in maternal health services and response as a result of MDSR recommendations and actions
Endline Evaluation Question: In what ways has the grant portfolio contributed to maternal health evidence?		
4. What grantee-generated maternal health/mortality evidence has been used by journalists, lawyers, and policymakers to inform their work? a. What other maternal health/mortality evidence and information are key stakeholders using to inform their work?	Number of produced maternal health evidence produced by Advocacy Nigeria, CISLAC, and DevComs Maternal health evidence developed by grantees is 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 among key stakeholders to capture recall and perceived influence of a sample of grantee-generated maternal health/death evidence developed and disseminated by various distribution channels by grantees Website analytics from DevComs (Not Again and social media trackers)
Endline Evaluation Question: To what extent has the grant portfolio led to improved media reporting on maternal health?		
5. How have targeted journalists changed their maternal health reporting since baseline? a. What enables and hinders targeted journalists to report on maternal health? b. How have grantees supported targeted journalists to report on maternal health? c. How have stakeholder perceptions of maternal health reporting changed since baseline?	Number of journalists trained by CHR, CISLAC, and DevComs in maternal health reporting Percent of media staff trained by CHR, CISLAC, and DevComs who produce at least two reports on maternal health/maternal mortality within 6 months of the training (disaggregated by type of media – print/radio/TV/electronic) Number of maternal mortality litigation cases reported by journalists Key stakeholders' perception of maternal health reporting	Training attendance lists collected by CHR, CISLAC, and DevComs Media Tracking by CHR, CISLAC, and DevComs Interviews by CISLAC and DevComs with trained media staff to capture changes in media reporting after training WARDC media tracker Data collection with trained journalists to capture perceptions of grantee influence on maternal health reporting Data collection with key stakeholders to capture perceptions of change of maternal health reporting and distribution channels

Midline Evaluation Questions	Indicators of Progress	Data Sources
Endline Evaluation Question: How has the grant portfolio contributed to improved maternal health budget performance at federal, state, and local levels?		
6. How have grantees influenced CSO advocacy for improved budget performance on maternal health?	Number of CSOs trained by CHR advocating for improved budget performance for maternal health to local and state governments	Follow up by CHR on trained CSOs
7. How has CSO advocacy for improved budget performance influenced government accountability to maternal health at midline?	Policymaker perceptions of influence of CSO advocacy and budget analysis on maternal health accountability	Facility-level Service Statistics scorecard (Advocacy Nigeria) Data collection to capture the influence of a sample CSO advocacy to government for increased maternal health budget allocation, distribution, and use
8. What enables and hinders maternal health budget performance?	N/A	Data collection
Endline Evaluation Question: How has the grant portfolio influenced maternal health policy effectiveness (creation, change, implementation)?		
9. How has maternal health policy changed (creation, modifications, implementation) since baseline? a. What has supported changes in maternal health policy? b. In what ways have grantees influenced policy improvement and implementation? c. How has legislative committee oversight of maternal health policies changed since baseline?	Perceived changes by stakeholders of maternal health policy: creation, change, implementation in the past year Government perceptions of civil society influence on maternal health policy implementation Key stakeholders perceptions on improvement in legislative committee oversight of maternal health policies	Data collection to capture what bills have been passed into law and changes in policy implementation Data collection to capture the influence of a sample of CSO advocacy efforts on maternal health policy Data collection to capture stakeholder perceptions of changes in committee oversight of maternal health policies
10. How have grantees influenced maternal mortality litigation?	Judicial and non-judicial cases that have come to WARDC as a result of WARDC activities Number of maternal mortality litigation cases brought to court by lawyers trained by WARDC Perception of targeted lawyers of WARDC's influence	New cases taken by WARDC and trained lawyers tracked by WARDC (WARDC case tracker that tracks judicial and non-judicial cases instituted by WARDC or partners) WARDC summaries (two per year) of maternal mortality cases that capture successes, challenges, and lessons learned Data collection to capture lawyers' perceptions of training received by WARDC

Annex 5. List of Stakeholders

Stakeholder	State(s)
Civil Society Organizations	
Bauchi State Network of CSOs	Bauchi
Christian Association of Nigeria (CAN)	Bauchi, Gombe
Community Health and Research Initiative (CHR)	Bauchi, Kano
Federation of Muslim Women Association of Nigeria (FOMWAN)	Bauchi, Jigawa, Niger, Kaduna
Jama'atu Nasril Islam	Bauchi, Gombe, Jigawa, Kaduna
African Law Foundation	Enugu
Akko New Age Foundation	Gombe
Association for Orphaned and Vulnerable Children in Nigeria (AONN)	Gombe
Community Concerned Initiative	Gombe
Lawanti Foundation	Gombe
Life Boat Organization	Gombe
Society for the Future	Gombe
Ward Development Committee	Gombe
Jigawa Maternal Accountability Forum	Jigawa
Kamala Community Health Development Initiative	Jigawa
Village Development Initiative	Jigawa
Gender Awareness Trust (GAT)	Kaduna
Gender and Human Values Proactive	Kaduna
Kabala Health Forum	Kaduna
Maternal Child Health Partnership	Kaduna
MCH/Hope for the Village Child Foundation	Kaduna
PACA, St. John Parish	Kaduna
Support Health and Education for Development (SHED)	Kaduna
Kano Civil Society Forum	Kano
Kano Youth Forum	Kano
Network for Empowerment and Development Initiative (NEDIN)/Voice of the Hopeful Enlightenment and Development Initiative	Kano
Transparency and Development Information Initiatives	Kano
Socio Economic Right and Accountability Project (SERAP)	Lagos
Steering Committee, Lacsop	Lagos
Grantees	

Stakeholder	State(s)
Society of Gynaecology & Obstetrics of Nigeria (SOGON)	FCT
Advocacy Nigeria	Gombe
Civil Society Legislative Advocacy Centre (CISLAC)	Kano, FCT
Community Health and Research Initiative (CHRI)	Kano
Development Communications Network (DevComs)	Lagos
Women Advocates and Research Documentation Centre (WARDC)	Lagos
Professional Associations	
Nigerian Bar Association	Enugu, Lagos
National Association of Nigerian Nursing and Midwives	Jigawa
Ahmadu Bello University Teaching Hospital	Kaduna
International Federation of Women Lawyers (FIDA) Nigeria	Kaduna, Lagos, Enugu
National Association of Women Journalists (NAWOJ)	Kano
National Union of Journalists (NUJ)	Kano
Government – Local level	
Town Maternity	Bauchi, Gombe
Kwali Central Ward	FCT
Akko	Gombe
Kaltungo	Gombe
Kumo Health Center	Gombe
Primary Healthcare Centre	Gombe
Government – State level	
Ministry of Health	Bauchi, Enugu, Kano
Ministry of Information	Bauchi
Ministry of Gender Affairs	Enugu
Bwari General Hospital	FCT
FCT Primary Healthcare Board	FCT
Kwali Area Council	FCT
House Committee on Appropriations/ House Committee on Health	Gombe
National Primary Healthcare Development Agency (NPHCDA)	Gombe
Lagos State Primary Health Board	Lagos
House Committee on Health	Kano
International Projects	
Evidence for Action (E4A)	Bauchi, FCT

Stakeholder	State(s)
State Accountability Voice Initiative (SAVI)	Jigawa
Maternal, Newborn and Child Health Programme (MNCH2)	Kano
Media	
Bauchi Radio Corporation	Bauchi
News Agency of Nigeria (NAN)	Bauchi, Jigawa
Nigerian Television Authority	Bauchi, Jigawa, FCT
People's Daily	Bauchi
Radio Iran International/ Alheri Newspaper	Bauchi
Radio Nigeria (Globe FM)	Bauchi
Business Day	FCT
Leadership Newspapers	FCT, Jigawa
The Guardian	FCT
Vanguard	FCT
Federal Radio Corporation of Nigeria	Jigawa
Freedom Radio	Jigawa, Kano
Nigeria Tribune	Jigawa
Radio Jigawa/Jigawa State Independent Electoral Commission	Jigawa
The Nation Newspaper	Jigawa
The Telegraph Newspaper	Jigawa
Federal Radio Corporation of Nigeria (FRCN)	Kaduna
KSMC/DCA	Kaduna
National Mirror	Kaduna
Nigerian Rlot Newspaper	Kaduna
The Cross News	Kaduna
People's Qoul	Kaduna
Abubakar Rimi TV Kano	Kano, Lagos
Radio Lagos	Lagos
Radio One, 103.5 FM	Lagos
Facility	
Antenatal Clinic, Poly Clinic	Enugu
Asokoro General Hospital	FCT
Kwali General Hospital	FCT
Nyanya General Hospital	FCT
Ture Balam Maternity Clinic	Gombe

Stakeholder	State(s)
Ture Balam Town	Gombe
Ajeromi General Hospital	Lagos
Gbagada General Hospital	Lagos
Island Maternity Hospital	Lagos
Lagos State University Teaching Hospital (LASUTH)	Lagos
Community Members	
Bauchi Emirate Council	Bauchi
Civil Resource Development and Documentation Centre (CIRRDOC)	Enugu
WARDC Women – Lagos Island, Poly Clinic, Naara, Nkanu East	Enugu, Lagos
Legal	
Community Paralegal	Enugu
Prince SKC Ndigwa Associates	Enugu
Legal Practitioner	Lagos

Annex 6. Data Collection Tools

All tools included an informed consent statement that incorporated a confidentiality clause. Every effort was made to ensure that interviews and focus group discussions were conducted in locations that assured privacy or were comfortable for respondents if they were not fully private. At the start of each interview or focus group discussion, respondents were assured of confidentiality and asked if they consent to participate in this evaluation. The evaluators explained to all respondents that participation was completely voluntary and that they could end the interview or focus group discussion at any time with no negative consequences to them. It was also made clear that respondents' identity and the information they provided would be kept confidential.

FOCUS GROUP DISCUSSION GUIDES

CSOs

BACKGROUND

1. **Before we begin please state your first name, organization, and work in maternal health.**

2. **What has the CSO community done to increase government accountability to maternal health in the past year?** (*We mean accountability in three ways:*

    a. *increasing government commitments*
    b. *ensuring government compliance with commitments already made*
    c. *ensuring higher quality maternal health services*).

3. **How have the ways in which CSOs have worked together to increase government accountability to maternal health changed in the past year? What has stayed the same?**

COLLABORATION AND COORDINATION

4. **How do you collaborate with other CSOs on work related to maternal health?**

5. **How do you collaborate with government?**

6. **Has this collaboration and coordination changed at all in the past year?**

MATERNAL HEALTH POLICY EFFECTIVENESS

7. **What has changed in maternal health policy in the past year?**

8. **What has stayed the same?**

9. **In the past year, how have CSOs as a group facilitated maternal health policy passage, modification, or implementation?**

MATERNAL HEALTH LEGISLATION

10. **How have maternal health legislation and legislative oversight of maternal health policies changed in the past year?**

11. **How have CSOs as a group influenced maternal health legislation in the past year?**

IMPROVED MEDIA REPORTING AND EVIDENCE USE

12. **In the last year, where did you get maternal health and maternal mortality evidence/information to inform your work? (*Suggest listing out sources on flipchart; probe if from media)***

13. **In what ways has media reporting on maternal health changed or stayed the same in the past year? (*Probe to understand what the changes are)***

BUDGET TRACKING AND ANALYSIS

Only if group includes CHR-trained organizations:

14. **How have government budget allocation, distribution, and use for maternal health changed in the past year?**

15. **How has your organization worked in the past year to influence government budget performance and allocation for maternal health? *(Also, look for influence on the release and use of maternal health budgets)***

16. **What support have you received to improve your advocacy efforts for maternal health budgeting? What are you doing differently as a result of that support?**

CONCLUSING QUESTIONS

17. **To successfully improve government accountability[5] to maternal health in the current context, what needs to be done more of, less of, differently?**

18. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

19. **Do you all have any questions for me/us?**

[5] Further explanation of accountability – three main goals: 1) increasing government commitments; 2) ensuring government compliance with commitments already made; and 3) ensuring higher quality maternal health services.

JOURNALISTS

BACKGROUND

1. **Before we begin, please state your first name, media house, and your role (e.g., health desk, etc.) so we can know you a bit better.**

2. **What maternal health-related stories have you written in the last year? Which one are you most proud of?**

3. **How often have you covered these topics in the past year? (*Make sure to get answer on maternal mortality litigation cases)***

RESEARCH/USE OF EVIDENCE

4. **When you cover maternal health topics, what kind of evidence/information do you use? (*Write out general categories on flipchart)***

5. **Where do you get this information from? Whom do you interact/work with when covering maternal health?**

RELATIONSHIP WITH CSOs

6. **By which organizations have you been trained on maternal health in the past year? (*Inquire on grantees—CHR, CISLAC, DevComs—if they are not mentioned)***

7. **What topics were covered? What was the most important learning point for you from the training(s)?**

8. **How else do CSOs support your work?**

REPORTING ENVIRONMENT

9. **Has the overall reporting environment in terms of maternal health changed in the past year? If yes, how?**

10. **What enables you to research and report on maternal health? *(Suggest taking notes on flipchart for #9 and #10)***

11. **What particular challenges did you face in the past year when researching and reporting on maternal health?**

LOOKING FORWARD

12. **What aspects of maternal health will be the most important to report on in the coming year? (*Probe for litigation, MDR, government accountability, financing, etc.*) Where will you get your information?**

CONCLUDING QUESTIONS

13. **To successfully improve government accountability[6] for maternal health in the current context, what needs to be done more of, less of, differently?**

14. **What else would you like to share about your experiences in covering maternal health issues?**

15. **Do you have any questions for me?**

THANK YOU VERY MUCH FOR YOUR TIME AND INSIGHTS.

WARDC WOMEN

BROADER ENVIRONMENT

1. **What does maternal health mean to you? (*Probe for broader system, services, accountability)***

2. **What happens when there is a maternal death in the community? (*Encourage discussion around this. Is the answer typical? What about MDSRs?)***

3. **Tell me about a recent time when a maternal case (mortality/mistreatment/ maltreatment/morbidity):**
   a. **went to court**
   b. **was resolved in a different way**
   c. **did not get resolved**

   (*Probe: What happened? What was new? What could have been done differently? Facilitate the transition from #2 to #3 as necessary)*

[6] Further explanation of accountability – three main goals: 1) increasing government commitments; 2) ensuring government compliance with commitments already made; and 3) ensuring higher quality maternal health services.

ACCESSING SERVICES

4. **When there are complications, what supports a woman and her family to seek assistance? What prevents them?**

5. **Think of women/families you know who sought assistance on a case in the past year. How were they supported? *(Probe for awareness of any channels through which women can report mistreatment, etc.)***

6. **Think of women/families you know who did not get/seek assistance on a case. Why didn't they seek assistance?**

BACKGROUND

7. **Do you know about WARDC? How are you engaged with WARDC's work?**

8. **What has changed in terms of maternal health services and litigation in the past year?**

POLICIES

9. **What maternal health policies are you aware of?**

DATA/EVIDENCE

10. **Where do you get information on your maternal health and rights?**

11. **What other information/data would you want to have?**

CONCLUDING QUESTIONS

12. **To successfully improve services in the current context, what needs to be done more of, less of, differently?**

13. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

14. **Do you all have any questions for me/us?**

THANK YOU VERY MUCH FOR YOUR TIME AND INSIGHTS.

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.

CSOs

BACKGROUND

20. **What has been your engagement with increasing government accountability to maternal health in the past year?** (*We mean accountability in three ways:*

    a. *increasing government commitments*
    b. *ensuring government compliance with commitments already made*
    c. *ensuring higher quality maternal health services)*

21. **In the past year, what maternal health accountability activities are the same as before? What has been different?**

Note: for remaining questions, adjust questions based on answer to #1.

COLLABORATION AND COORDINATION

22. **With whom did you work on maternal health accountability in the past year?**

Note: If respondent does not work directly on maternal health, ask if they are aware of any existing CSO collaborative efforts.

23. **How did you collaborate with other organizations in the past year?** (*Probe for specific joint actions)*

24. **How did you collaborate with government in the past year?** (*Probe for specific joint actions)*

25. **What has enabled your collaboration and coordination efforts in the past year? Hindered them?**

MATERNAL HEALTH POLICY EFFECTIVENESS

26. **What has stayed the same and what has changed in maternal health policy in the past year?**

27. **How has your organization (or how have CSOs) facilitated maternal health policy passage, modification, or implementation?**

MATERNAL HEALTH LEGISLATION

28. **How have maternal health legislation and legislative oversight of maternal health policies changed in the past year?**

29. **How have CSOs influenced maternal health legislation in the past year?**

IMPROVED MEDIA REPORTING AND EVIDENCE USE

30. **In the last year, where did you get maternal health and maternal mortality evidence/information to inform your work**? *(Probe if they ever use information from media)*

31. **In what ways has media reporting on maternal health changed or stayed the same in the past year?** (*Probe to understand what the changes are)*

BUDGET TRACKING AND ANALYSIS

For CSOs trained by CHR only:

32. **How have government budget allocation, distribution, and use for maternal health changed in the past year?**

33. **How has your organization worked in the past year to influence government budget performance and allocation for maternal health?** (*Also, look for influence on the release and use of maternal health budgets*)

34. **What support have you received to improve your advocacy efforts for maternal health budgeting? What are you doing differently as a result of that support?**

CONCLUDING QUESTIONS

35. **To successfully affect government accountability for maternal health in the current context, what needs to be done more of, less of, differently?**

36. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

37. **Do you have any questions for me/us?**

THANK YOU VERY MUCH FOR YOUR TIME AND INSIGHTS.

DEVELOPMENT PARTNERS

BACKGROUND

1. **How are you involved in maternal health or government accountability to maternal health in Nigeria?** *(To explain further, we mean accountability in three ways: 1) increasing government commitments; 2) ensuring government compliance with commitments already made; and 3) ensuring higher quality maternal health services)*

2. **What groups/stakeholders did you work with on maternal health accountability, or other areas related to maternal health or maternal mortality in the past year?**

3. **How have these partnerships or individual organizations facilitated change in maternal health accountability?**

4. **What changes have you seen in maternal health accountability in the past year?** *(Possible areas of change: policy, reporting, accountability, budgeting, legislation, media, major players)*

EVIDENCE USE

5. **Where did you get evidence/information on maternal health in the past year? What evidence/information was the most useful?**

6. **How well do you feel key government and civil society stakeholders are using maternal health data?**

7. **What are the barriers to evidence use and how would you improve them?**

MATERNAL DEATH LITIGATION

8. **How has litigation around maternal death changed in the past year in terms of prevalence and in terms of the process?**

BUDGET PERFORMANCE

9. **How has CSO advocacy for improved budget performance on maternal health changed in the past year?**

THE MEDIA

10. **In terms of the media, how has reporting on maternal health changed in the past year?**

MATERNAL HEALTH POLICY EFFECTIVENESS

11. **How has maternal health policy changed** *(new, modification, implementation)* **in the past year? Who is driving that change?**

12. **How has legislative committee oversight of maternal health policies changed in the past year? (*If not, answered by question above)***

LOOKING FORWARD

13. **What are the biggest opportunities for increasing maternal health accountability looking forward? The biggest challenges?**

14. **How can you and others capitalize on these opportunities and address these challenges?**

CONCLUDING QUESTIONS

15. **To successfully increase government accountability for maternal health in the current context, what needs to be done more of, less off, differently?**

16. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

17. **Do you have any questions for me/us?**

GRANTEE ORGANIZATIONS

BACKGROUND

1. **What has been your engagement with increasing government accountability to maternal health in the past year?** (*We mean accountability in three ways:*

    a. *increasing government commitments*
    b. *ensuring government compliance with commitments already made*
    c. *ensuring higher quality maternal health services)*

2. **What changes have you seen in government accountability to maternal health over the past year? What is the same? What is different?**

3. **What changes have been made to your grant and grant activities in the past year? Why were those changes made?**

Note: for remaining questions, adjust questions based on answer to #1.

COLLABORATION AND COORDINATION

4. **With whom did you work on maternal health accountability in the past year?**

5. **How did you collaborate with other organizations in the past year?** (*Probe for specific joint actions*)

6. **How did you collaborate with government in the past year?** (*Probe for specific joint actions*)

7. **What has enabled your collaboration and coordination efforts in the past year? Hindered them?**

Maternal Health Policy Effectiveness

8. **What has stayed the same and what has changed in maternal health policy in the past year?**

9. **How has your organization facilitated maternal health policy passage, modification, or implementation?**

Maternal Health Legislation

10. **How have maternal health legislation and legislative oversight of maternal health policies changed in the past year?**

11. **How has your organization influenced maternal health legislation in the past year?**

Improved Media Reporting and Evidence Use

12. **In what ways has media reporting on maternal health changed or stayed the same in the past year?** *(Probe to understand what the changes are)*

13. **What has your organization done in the last year to increase or improve media reporting on maternal health and maternal mortality?**

Budget Tracking and Analysis

14. **How have government budget allocation, distribution, and use for maternal health changed in the past year?**

15. **How has your organization worked in the past year to influence government budget performance and allocation for maternal health?** *(Also, look for influence on the release and use of maternal health budgets)*

16. **Who have you worked with on advocacy efforts for maternal health budgeting?**

Concluding Questions

17. **To successfully affect government accountability for maternal health in the current context, what needs to be done more of, less of, differently?**

18. **What else would you like to tell me/us but didn't because I/we didn't ask the right question?**

19. **Do you have any questions for me?**

STAKEHOLDERS INVOLVED IN LITIGATION

BACKGROUND

15. **How have you been involved in litigation related to maternal health or maternal death this past year?**

16. **What training have you received on maternal health litigation in the past year?** (*Probe for training by WARDC*)

17. **How have you used this training? What has had a particular impact on you?**

COLLABORATION

18. **With whom do you collaborate when working on maternal death litigation?**

19. **What kinds of support do you receive when working on these types of cases? How has that support changed over the last year?** *(probe if more support would be useful and if so, what kind, and particularly for support from WARDC)*

PROCESS/SYSTEM

20. **Did you take or support any maternal death judicial cases to court this year?**
    If yes, please describe the case: who was involved, your role and involvement, the outcome, the case itself….. *(Note: Really try to capture the story of the case)*

21. **How did these cases come to you?** *(to see if WARDC was involved)*

22. **What would make people feel more comfortable bringing maternal death cases to court?**

23. **How has maternal death or neglect leading to morbidity litigation changed in the past year? What do you envision for the following year?**

24. **Did you take or support non-judicial cases? If so, please describe.**

RESOURCES AND EVIDENCE

25. **What evidence/data are most useful for your work? Where do you get this information?**

26. **If you need other assistance/resources, where do you go?**

CONCLUDING QUESTIONS

27. **To successfully affect government accountability for maternal health in the current context, what needs to be done more of, less of, differently?**

28. **What else would you like to tell me/us but didn't because I/we didn't ask the right question?**

Do you have any questions for me?

STAKEHOLDERS INVOLVED IN MDSRs

BACKGROUND

1. **Tell me about your involvement with maternal death surveillance and response (MDSR) reviews and committees in the past year.** (*Confirm if they are a part of a committee, have worked with one, etc.)*

Tailor remaining questions to aspects of the MDSR or MDSR committee that the respondent is most familiar with.

FUNCTIONS OF THE MDSR COMMITTEE

2. **How often has the MDSR committee met in the past year?**

3. **Has the MDSR process changed in the past year? If so, how?**

4. **In the MDSR process, what has worked well in the past year? What needs improvement?**

5. **In the past year, what has enabled the MDSR committee to do its job? What has hindered it?**

6. **In your opinion, how accurate is the maternal death reporting in your facility and/or community?**

COLLABORATION AND COORDINATION

7. **Who has assisted or collaborated with the MDSR committee in the past year? How?** (*probe for CSO/grantee involvement*)

8. **What is the relationship between the MDSR committees and communities? What has changed in that relationship over the last year? How did those changes come about?** (*probe for CSO/grantee involvement*)

9. **What is the relationship between the MDSR committee and the government? What has changed in that relationship in the last year? How did those changes come about?** (*probe for CSO/grantee involvement*)

INFLUENCE OF MDSR COMMITTEES

10. **How have MDSRs affected government accountability to maternal health in the past year?**

11. **How have MDSR committees affected maternal health services and response in the past year?**

12. **How effective/influential do you feel maternal death reporting in the past year has been?**

13. **How has the information that has comes from MDSRs been used in the last year? How has the use of this information changed since last year?**

    a. If the information is not being used, why not?

LOOKING FORWARD

14. **How can the MDSR process be improved to reduce more maternal deaths?**

15. **How can maternal death reporting be improved to reduce more maternal deaths?**

CONCLUDING QUESTIONS

16. **To successfully affect government accountability to maternal health in the current context, what needs to be done more of, less of, or differently?**

17. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

18. **Do you have any questions for me?**

MEDIA

BACKGROUND

1. **In the past year, how often have you reported on maternal health or maternal mortality issues?**

2. **Do you report on maternal mortality litigation?** *(if so, please describe)* **How often have you reported on maternal mortality ligation cases in the past year?**

3. **What other maternal health topics have you reported on in the past year?**

RESEARCH/USE OF EVIDENCE

4. **When you write about maternal health, what kind of data/evidence/information do you use?**

5. **Where do you get this information from? Whom do you interact/work with when writing a story?**

RELATIONSHIP WITH CSOs

6. **By which organizations have you been trained on maternal health in the past year** (*probe for CHR, CISLAC or DevComs*)**? What topics were covered? What was the most important learning point for you from the training(s)?**

7. **How have CSOs** (*tailor to answer to #3)* **supported you in your reporting efforts in the past year?**

REPORTING ENVIRONMENT

8. **Has the overall reporting environment in terms of maternal health changed in the past year? If yes, how?**

9. **In the past year, what has enabled you to research and report on maternal health?**

10. **What particular challenges did you face in the past year when researching and reporting on maternal health?**

LOOKING FORWARD

11. **What aspects of maternal health will be most important to report on in the coming year?** (*Probe for litigation, MDR, government accountability, financing, etc.*) **Where will you get your information?**

CONCLUDING QUESTIONS

12. **To successfully affect government accountability[7] for maternal health in the current context, what needs to be done more of, less of, or differently?**

13. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

14. **Do you have any questions for me?**

[7] Further explanation of accountability – three main goals: 1) increasing government commitments; 2) ensuring government compliance with commitments already made; and 3) ensuring higher quality maternal health services.

POLICYMAKERS

BACKGROUND

1. **How are you involved in maternal health in _____** *(federal/state/LGA)***?**

USE OF EVIDENCE

2. **In the past year, were did you get evidence and data on maternal health? How do you use this information?**

CIVIL SOCIETY ORGANIZATION

3. **How have CSOs influenced you in terms of maternal health in the past year?** (*probe for names of CSOs or networks)*

4. **In your opinion, what is the role of CSOs in maternal health accountability[8]?**
5. **Are you aware of CSO desk officers in the state? What is the role of CSO desk officers?** *(particularly for Jigawa and Kaduna states)*

MATERNAL HEALTH POLICY

6. **How has the implementation of existing maternal health policy/policies changed in the past year?**

7. **What gaps are there in current maternal health policy?**

8. **How would you recommend that government address these gaps?**

MEDIA

9. **How does the media report on maternal health? Has this changed in the past year?**

BUDGET PERFORMANCE

Only for Bauchi, Jigawa, Kano, and Niger states

10. **How have CSOs worked to influence maternal health budgeting? What is the impact of this?**

[8] We see accountability in three ways: 1) increasing government commitments; 2) ensuring government compliance with commitments already made; and 3) ensuring higher quality maternal health services.

CONCLUDING QUESTIONS

11. **To successfully affect government accountability for maternal health in the current context, what needs to be done more of, less of, differently?**

12. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

13. **Do you have any questions for me/us?**

PROFESSIONAL ASSOCIATIONS

BACKGROUND

1. **What has been your engagement with increasing government accountability to maternal health in the past year?** (*We mean accountability in three ways:*
    a. *increasing government commitments*
    b. *ensuring government compliance with commitments already made*
    c. *ensuring higher quality maternal health services)*

2. **In the past year, what maternal health accountability activities do you know have been carried out? Which activities are the same? What has been different?**

Note: for remaining questions, adjust questions based on answer to #1.

Collaboration and Coordination

3. **What partners have you worked with on maternal health accountability in the past year?**

Note: If respondent does not work directly on maternal health, ask if they are aware of any existing CSO collaborative efforts.

4. **How have you collaborated with other organizations in the past year?** *(Probe for specific joint actions)*

5. **What has enabled your collaboration and coordination efforts in the past year? What has hindered them?**

Maternal Health Policy Effectiveness

6. **What has stayed the same and what has changed in maternal health policy in the past year?** *(Probe for new policies, modifications, and implementation)*

7. **How has your organization facilitated maternal health policy effectiveness in the past year?** *(New policies, modifications, and implementation)*

Maternal Health Policy Legislation

8. **How has legislative oversight of maternal health policies changed in the past year?**

9. **How has your organization influenced maternal health policy legislation in the past year?**

Improved Media Reporting and Evidence Use

10. **Where did you get maternal health and maternal mortality evidence/information in the past year to inform your work?** *(Probe if they ever use information from media*)
11. **In what ways has media reporting on maternal health changed or stayed the same in the past year?** *(Probe to understand what the changes are)*

MDSR

For those associated with SOGON and WHARC only

12. **How has the maternal death surveillance and response process changed over the past year, if in any way?**

13. **How have MDSR committees collaborated with professional associations in the last year?**

14. **If you have been involved in a MDSR review in the past year, in what capacity? Please describe that review process.** *(Note: aim to get a story about MDSR review processes strengths and weaknesses)*

15. **How can the MDSR review process be improved moving forward?**

Budget Tracking and Analysis

For CSOs trained by CHR only:

16. **How have government budget allocation, distribution, and use for maternal health changed in the past year?**

17. **How has your organization worked in the past year to influence government budget performance and allocation for maternal health?** *(Also, look for influence on the release and use of budgets related to maternal health)*

18. **What support have you received in the past year to improve your advocacy efforts for maternal health budgeting? What are you doing differently as a result of that support?**

Concluding Questions

19. **To successfully increase government accountability to maternal health in the current context, what needs to be done more of, less of, or differently?**

20. **What else would you like to tell me/us, but didn't because I/we didn't ask the right question?**

21. **What questions do you have for me/us?**