THE WORLD BANK

FINAL FIELD REPORT

BASELINE DATA COLLECTION FOR THE IMPACT EVALUATION STUDY ON MATERNAL AND CHILD HEALTH INITIATIVE IN NIGERIA

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
CCTs	Conditional Cash Transfers
CHEW	Community Health Extension Workers
DEOs	Data Entry Officers
DEP	Data Entry Programme
EAs	Enumeration Areas
IE	Impact Evaluation
LGAs	Local Government Areas
MCH	Mother and Child Health
MDG	Millennium Development Goal
MNCH	Maternal, Neonatal and Child Health
MS	Microsoft
NCZ	North Central Zone
NEZ	North East Zone
NPHCDA	National Primary Healthcare Development Agency
NWZ	North West Zone
ODK	Open Data Kit
PIU	Project Implementation Unit
PHC	Primary Health Care
PM	Project Manager
PMTCT	Prevention of Mother to Child Transmission
SBA	Skilled Birth Attendant
SEZ	South East Zone
SURE-P	Subsidy Reinvestment and Empowerment Programme
SWZ	South West Zone
TBA	Traditional Birth Attendant
TOR	Terms of Reference
VHW	Village Health Worker
WDC	Ward Development Committee

CHAPTER 1

1.0 INTRODUCTION

1.1 Nigeria: Country Profile

One out of every five Africans is a Nigerian. With an estimated population of 180 million presently, Nigeria is the seventh most populous country in the world. This population is diverse with the existence of more than 300 ethnic groups and more than 500 languages/dialects spoken. With a birth rate that is significantly higher than the death rate, at 40.4 and 16.9 per 1,000 people respectively; a population growth of 3.2% per annum and a population density of 168 people per sq.km[1], it is increasingly challenging to meet the health demands of the populace and perhaps even more challenging to improve the quality of services.

Nigeria is a federal republic with the executive, legislative and judicial arms of government sharing power. Nigeria is divided into thirty-six states and one Federal Capital Territory (Map below), which are further sub-divided into 774 Local Government Areas (LGAs). The LGAs are further divided into about 9,955 wards. The states are aggregated into six geopolitical zones: North West, North East, North Central, South East, South South, and South West.

Health care provision in Nigeria is a concurrent responsibility of the three tiers of government. However, because Nigeria operates a mixed economy, private providers of health care play visible role in health care delivery especially in urban areas. The federal government's role is mostly limited to formulating policies, setting standards and regulation of the system. In addition to these, it manages service delivery in the university teaching hospitals and federal medical centers (tertiary health institutions); while the state government manages services in the various general hospitals (secondary health care); and the local government focus on primary health centers (primary health care) which are regulated by the federal government through the National Primary Healthcare Development Agency (NPHCDA).

Most services provided by private and public providers are clinic-based, with minimal outreach, home and community-based services. The services are fragmented, with many vertical disease control programs. Referral systems are weak and even tertiary facilities are used for provision of primary care thus diminishing the continuum of care and making the system inefficient. Also, despite the private sector delivering 60% of health care in the country, private-public partnership is very weak. The NPHCDA has defined a ward health care minimum package for PHC, but dissemination and implementation remain very limited. At higher levels, except for a few disease control programs, like Prevention-of-Mother-to-Child Transmission (PMTCT), TB, Malaria, Family planning and Essential Obstetric care, there are no standard operating procedures and treatment protocols. These lead to provider-initiated rather than client-centered delivery of care.

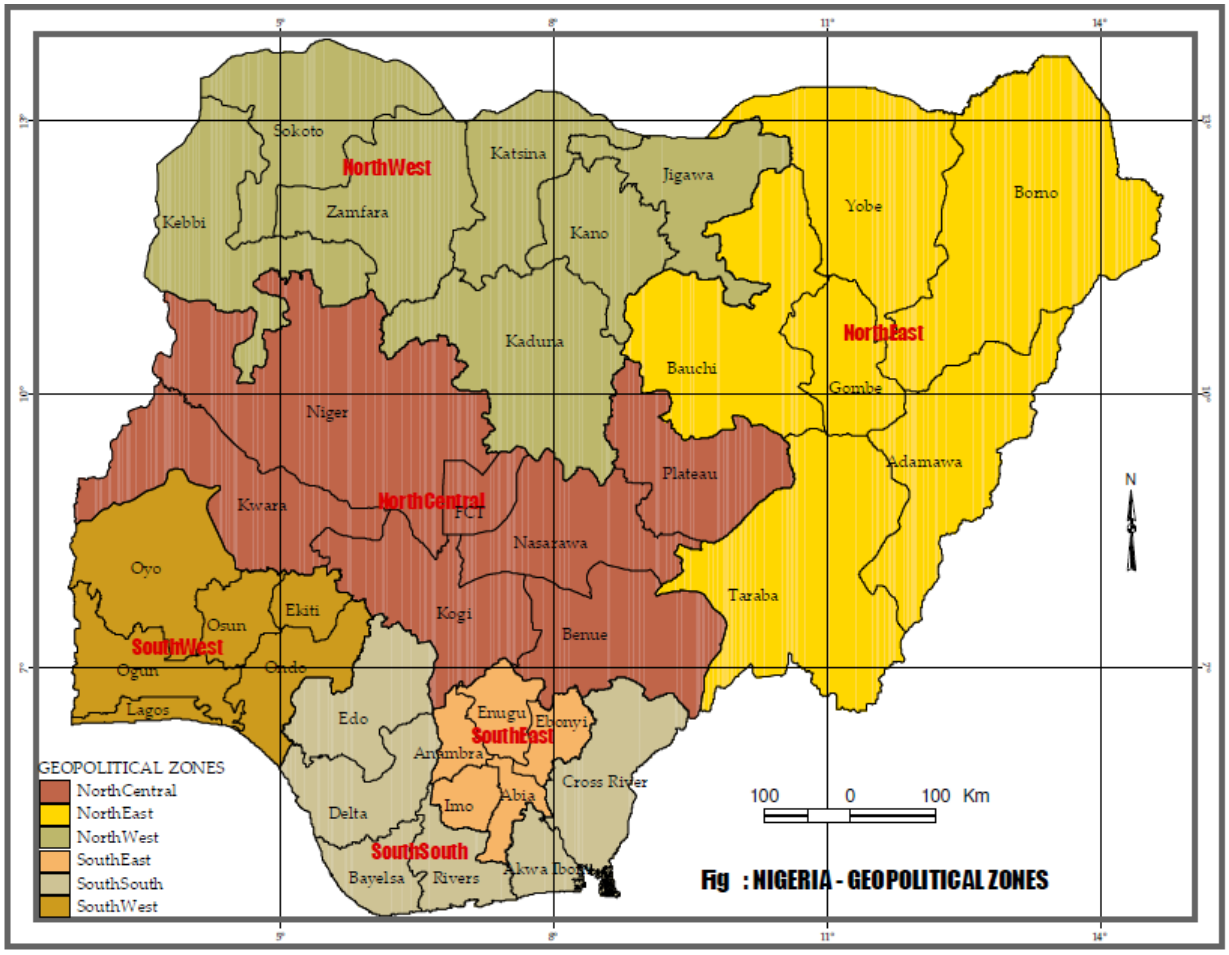
Other confounding factors that further limit quality of care include dearth in the skills and, quantity of available human resources for health with poor attitude of health care providers. In addition the country is confronted with lack of emergency preparedness to respond to

[1]Wikipedia (2014)

epidemics[2]. In conclusion, the health outcomes measured through key health indicators such as life expectancy, mortality rates and prevalence of key disease conditions are poor and shall require significant investments in order for Nigeria to attain the health millennium development goals in 2015. There are also large income inequalities in both health outcomes and utilization of healthcare with the rich having greater access and better quality of services.

In order to improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered. An important step towards attaining this is the establishment of baseline datasets as a diagnostic tool to design both short- and long-term solutions.

Map 1: Political Map of Nigeria showing the Six Geopolitical Zones, 36 States and FCT



1.2 Programme Background

The Maternal and Child Health (MCH) project of the Subsidy Reinvestment and Empowerment Programme (SURE-P), was set up by the Federal Government of Nigeria to ensure the efficient

[2]FMOH (2009): The National Strategic Health Development Plan Framework (2009-2015)

management of financial resources accruable from the removal of the fuel subsidy from January 2012.

The goal of the SURE-P MCH initiative is to reduce maternal and newborn morbidity and mortality and firmly place Nigeria on track to achieving Millennium Development Goal (MDG) 5, through the utilization of cost effective demand and supply interventions and creating a social safety net mechanism. The SURE-P MCH project aspires to ensure the good health of mothers and children in the target communities by addressing supply and demand constraints and reducing maternal and child mortality. This means increasing the available supply of skilled workers able to provide MCH services and increasing the demand for MCH services in vulnerable communities. The supply side intervention will dramatically scale up the number of health workers and with the help of the already existing Ward Development Committees (WDCs) allow a deeper reach into target communities thereby mitigating the challenges of Primary Health Care (PHC)-based service delivery. The SURE-P also plans demand side interventions that will stimulate demand for health services among women.

Specifically, the SURE-P MCH will implement the following activities:

1. Recruitment, training and deployment of additional skilled personnel including 2,000 midwives and 1,000 Community Health Extension Workers (CHEWs) throughout the states of the Federation with priority given to the areas with most need. In addition to the deployment of the skilled personnel to supported facilities, SURE-P would support capacity building of 12,000 Community Health Workers already employed in Primary Health Centers nationwide.

2. Support infrastructure upgrade of 500 selected PHC facilities, maternity units in the 125 selected referral General hospitals and mobile clinics (vans and boats) schemes.

3. Provide conditional cash transfers to pregnant women in rural areas based on the following criteria:

    a. Enrolment and completion of three Antenatal Care (ANC) visits
    b. Delivery by a Skilled Birth Attendant (SBA) at a health facility
    c. Receipt of zero-dose immunizations by their children

    Conditional cash transfers would also be made to Community Health Resource Persons (CORPs) i.e. Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs) who accompany the pregnant women to the PHC facility

4. SURE-P would support the identification, recruitment and training of 9,000 VHWs. This cadre of health workers would focus on prevention, healthy living and basic curative care in the community

5. Activation/orientation of Ward Development Committees (WDCs) in communities where the participating health facilities are located

1.3 Objectives of SURE-P MCH Initiative

The specific objectives of SURE-P MCH initiatives are:

1. To mitigate the impact of the fuel subsidy reduction on vulnerable populations in Nigeria by initiating a robust social safety net programme to improve lives

2. To contribute to reduction of maternal and newborn mortality and morbidity and increase maternal access to health services through two forms of intervention:

    a. Supply side: providing primary health care (PHC) facilities with health workers, infrastructure upgrades, drugs and commodities to enable sufficient quality service delivery

    b. Demand side: introducing village health workers for community outreach and providing Conditional Cash Transfers (CCTs) to pregnant women in communities across the nation to encourage them to go through the full continuum of Maternal, Neonatal and Child Health (MNCH) services

1.4 Impact Evaluation of the SURE-P MCH Initiative

In line with international best practice, a rigorous Impact Evaluation (IE) of the SURE-P MCH Programme was planned with the baseline survey data collection already completed. The IE is being implemented to determine the *causal impact* of the programme, that is the change in target outcomes which can be directly attributed to the programme as a whole and to several specific interventions that will be carried out under the program. The effectiveness of the SURE-P interventions shall be examined through statistically rigorous econometric analysis, which will also analyze *cost-effectiveness*. The IE will comprise a quasi-experimental impact evaluation whose aim is to evaluate the SURE-P package, and four experimental evaluations which will evaluate the impact that distinct components have within the SURE-P package. This will provide very valuable information to inform the SURE-P Program.

The IE will investigate the following: the effect of alternative incentives regimes to midwives on their retention rates; the effect of conditional cash transfers on utilization of MCH services; the effect of community monitoring of essential commodities on incidence of stock-out of supplies at the PHC; and the overall impact of the SURE-P.

1.5 Baseline Survey Components

The baseline survey was designed with data collection to occur in three levels; household, community and facility levels. The survey coverage targets were:

- All 500 SURE-P facilities across the country
- All SURE-P recruited midwives
- Five sampled eligible household respondents in each SURE-P facility catchment area
- WDC chairman or representative in all 500 SURE-P facilities

1.5.1 Facility Manager Survey

The facility manager survey was targeted to the in-charge of all 500 SURE-P facilities across the country. This survey includes modules on general information and facility characteristics, administration and management, human resources, service statistics, scope of services and user fees. The number of SURE-P facilities per state is between 12 and 16.

1.5.2 Household Survey

The household survey includes modules on demographic information, education, labour, housing, assets, health status and utilization and health related knowledge attitude and practice. Women who gave birth in the last three months preceding the survey were the targeted respondents. The sample size for this survey was 2,500 eligible respondents, which implies to 5 women from each facility catchment area. The sample size per state is between 60 and 80.

1.5.3 Midwife Survey

The midwife survey was targeted to all recruited SURE-P midwives at the facilities. In some states this includes CHEW midwives. The survey targeted 2,000 midwives with an average of 4 midwives working at selected primary health facilities. The midwife survey includes modules on demographic information, education and training, competencies, work history, workload, beliefs perceptions and pro social preferences and behaviors.

1.5.4 Ward Development Committee Survey

The WDC survey aims to elicit information about the WDC and their engagement with the facility and community. The WDC survey was targeted at WDC chairpersons or representatives of all 500 SURE-P facilities. The sample size was between 12 and 16 per state.

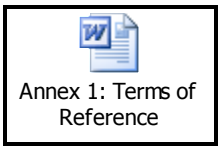
CHAPTER 2

2.0 METHODOLOGY

2.1 Approach

The approach to this assignment was appropriately designed to respond to the Terms of Reference (ToR). The baseline data collection for the impact evaluation study on the maternal and child health initiative in Nigeria was designed to be implemented simultaneously in all 36 states and the FCT. However, due to limited number of tablets for electronic data capture, states were divided into 3 clusters namely: cluster one (states in the South West and North Central zones), cluster two (states in the South East and South South zones) and cluster three (states in the North East and North West zones).

The impact evaluation baseline was conducted in three broad but interlinking phases; pre-field work, field work and post-field work. The pre-field work phase involved consultative meetings with the World Bank IE and SURE-P Project Implementation Unit (PIU) teams to agree on the details of implementation and also provide oversight to the conduct of the impact evaluation study. The baseline data collection for the IE study was carried out by capturing adequate data from the four different components of the survey. The sources were facilities, midwives, households and WDC.



The administration of the questionnaire and data collection was done electronically by the use of the Google Nexus 7 tablet as part of the field work. Questions were directly asked and responses were recorded electronically on the devices. Post-field work phase involved pay-out to midwives and cleaning of data.

2.2 Pre-field Work

2.2.1 Consultative Meetings

Consultative meetings were held throughout the pre-field, field and post-field phases between Consultants, World Bank IE and SURE-P PIU teams. Meetings were held to plan the field testing of the questionnaires, discuss the games, logistics for the trainings and to fine-tune the details of the survey.

2.2.2 Piloting of Questionnaires

Several steps were taken towards the finalization of the field survey instruments. One major step taken was the rigorous piloting of the field survey instruments.

The objectives of the piloting were to:

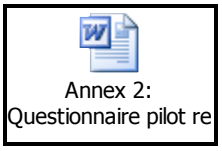
i. Administer questionnaires to respondents
ii. Determine time required to administer each questionnaire

iii. Determine respondents' understanding of questionnaires and relevance of questionnaires
iv. Identify and document changes to be made on questionnaires
v. Watch for and record respondents point of fatigue
vi. Collect GPS coordinates

Six states in the six geopolitical zones of the country were visited at one state per geo-political zone. The states visited were Anambra (South East Zone), Bauchi (North East Zone), Cross River (South South Zone), Ekiti(South West Zone), Kebbi (North West Zone) and Niger (North Central Zone). Twelve (12) interviewers were selected, trained centrally in Abuja and deployed to the 6 states for the purpose of piloting the questionnaires. The personnel further re-assembled to share experience and document desired changes to the questionnaires.

Six health facilities of similar characteristics and standard as SURE-P facilities were visited. At the facilities, 6 facility managers and 8 midwives were interviewed. In addition, 5 WDC chairmen and 12 women who gave birth in the last 3 months were interviewed.

Report of the pilot testing is presented as **Annex 2**.



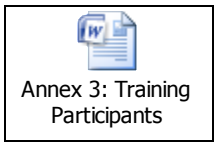
2.2.3 Selection of Personnel

The survey implementation team consists of core management, zonal coordinators, state supervisors and interviewers. The core management team consists of the Project Manager (PM) supported by a field coordinator and logistics manager. Six zonal coordinators, 37 state supervisors, 148 interviewers and 37 "listers" were recruited in all 37 states. The selection of the personnel was guided by the skills requirements demanded by the ToR.

Personnel selectivity factors include sound academic background; familiarity with the people, culture, terrain; and language affinity with the communities in each state. In addition, all personnel selected have practical knowledge in the use of computers and tablets.

2.2.4 Training of Personnel

As a result of the large number of interviewers and the need to ensure that skills are imparted in a consistent manner by a single training team, the implementation of the survey was phased. The training of interviewers for this assignment was conducted in three clusters. The first cluster training involved participants from 13 states from the SWZ and NCZ trained in Ekiti State. The second cluster training comprised of participants from 11 states in the SEZ and SSZ who were trained in Enugu State. Cluster three training was held in Kaduna with 50 interviewers and 13 supervisors from 13 states of the NEZ and NWZ in attendance. The list of participants trained in clusters one, two and three are presented in **Annex 3**.



Training objectives

The objectives of personnel training were to: (a) introduce and ensure that the participants understand the questionnaires, field manuals, and their application; (b) identify possible bottlenecks in the use and administration of the questionnaires; (c) emphasize the need for team building and working synergistically to achieve results on the field; and (d) adapt and finalize the questionnaire and the complementary field manual.

In Ekiti, six days was dedicated for training of enumerators while in Enugu and Kaduna, five days was dedicated for training in each cluster respectively. We have attached the training agenda of the first, second and third cluster trainings as **Annex 4, 5 and 6** respectively.

Technical Sessions

The technical sessions were preceded by a pre-test exercise to determine participants knowledge at the start of training and a team building 'nail exercise' to ensure the engagement of participants effectively. The technical sessions comprised the examination of each question in the Google nexus 7 tablet, this is comprised of: (a) facility questionnaire, (b) household questionnaire, (c) midwife questionnaire, and (d) WDC questionnaire interactively, one questionnaire after the other.

The participants were divided into two separate training halls; the facility-based and community-based groups for effective and specific trainings based on the aspect of the questionnaire the participants have been chosen to handle. The facility-based training focused on the facility and midwife questionnaires while the community-based training focused on household and WDC questionnaires.

Several scenarios were created during the question-and-answer session that helped to deepen participants' understanding of the questionnaire. Participants were given adequate opportunity to ask questions which were addressed satisfactorily. Role plays were carried out by participants for each questionnaire. They were divided into groups of two or three so that they could act out the actual administration of the questionnaire in health facilities. There was also practical hands-on-session in which hypothetical exercises simulating real life situations in the health facility were rehearsed as group team work to assess participants' understanding of each questionnaire.

<u>Day 1</u>

The training began after the registration of participants at 08h30 hours on Monday 2nd September, 2013 through 7th September, 2013 in Ekiti State for cluster 1, Monday 30th

September, 2013 through 4th October, 2013 in Enugu State for cluster 2, and on Monday 4th November, 2013 through 8th November, 2013 in Kaduna State. The training at the different clusters kicked off with opening prayer which was said by a volunteer participant and the self-introduction of all participants followed. The Managing Director of the survey firm welcomed all participants and gave the importance of the assignment. The ground rules for the duration of the training were set to ensure discipline, decorum and to prevent chaos. It was mandatory that all the trainees attend the sessions, and on time, be recognised before they contribute to any discussion and to switch off their telephones to prevent distraction.

The goals and objectives of the survey were succinctly explained by the World Bank representative. It was to carry out baseline data collection for impact evaluation for the MCH Initiative of the SURE-P across the country. An overview of the SURE-P MCH survey was given. This included PowerPoint presentations on the general concepts of the survey and definitions of roles; introduction to Google Nexus 7 tablets and an overview of the questionnaire. The aim was to highlight the importance of the survey to the overall health development of Nigeria to create an understanding of the importance of an interviewer; and to explain the general ethics and rules of conduct of interviews.

Participants were taken through the facility and household questionnaires in the latter part of the first day at their various training halls. The questionnaires were discussed for participants to have a good understanding of the questionnaire that will engender effective administration of the survey instrument on the field with opportunity to review the survey instruments. The first role play of the training was conducted by volunteer participants. The role plays at the training focused on the introductory part of the questionnaire. Sampling strategy of the household was also discussed.

Based on the performance and contributions of participants to the questionnaires during the daily classes, there was need to design tutorial clinics to improve the knowledge and enhance the skills of participants identified to be weak. The tutorial clinics held daily between 7:30pm and 8:30pm for the duration of the Enugu and Kaduna training.

Day 2

The second day continued with the recap of activities of the first day by the pre-selected rapporteurs. This was immediately followed with the discussion of midwife and WDC questionnaires at the different training halls. As an integral part of the survey, the different games contained in the midwife questionnaire was given adequate attention and time for participants to understand.

Day 3

The cluster one participants in Ekiti State were trained on the household questionnaire, they were divided into pairs and worked through all the questions in a role play. This was for enumerators to generate good understanding of the questionnaire that will engender effective administration of the survey instrument on the field. The rest of the day was spent on sampling strategy and more role plays.

Pilot testing of the questionnaires was conducted at 4 different facilities on the 3rd day of cluster two training in Enugu State. Participants were divided into groups and according to the particular questionnaire they administered: facility, WDC, midwife and household questionnaires. This was a practical test and application of what has been taught during the trainings. The GPS coordinates of the facility visited was taken by the tablet and saved after the administration of the questionnaires. The participants returned to the training venue after the pilot test to share their experiences and concerns from the field visits.

The cluster three participants in Kaduna State were extensively trained on the midwife questionnaire on third day of the training. This was for participants to generate a good understanding of the meeting and post contract surveys that will engender effective administration of the survey instrument on the field with opportunity to review the survey instruments. To understand how the time and risk preference game will be played by the midwives, participants were taken through the games, this was in addition to role plays. The sampling strategy and house listing methodology was adequately taught in preparation for the pilot testing which took place on the fourth day.

Day 4

The cluster one participants in Ekiti had the midwife questionnaire addressed, making sure participants generate a good understanding of the meeting survey and the post contract survey, the games in addition to role plays.

Pilot testing of the questionnaires was conducted at 5 different health facilities on the 4th day for cluster three in Kaduna State. Participants returned after the field visits for experience sharing. The cluster two participants in Enugu State continued the training on the fourth day with the midwife questionnaire extensively addressed this was in addition to role plays.

Day 5

The pilot testing of the questionnaire was conducted at 4 different facilities in cluster one, Ekiti State. Participants were divided into groups and according to the particular questionnaire they administered: facility, midwife, household and WDC questionnaire. This was a practical test and application of what has been taught during the trainings. The GPS coordinates of the facility visited was taken by tablet and saved after the administration of the questionnaires. The participants returned to the training venue after the pilot test and issues were raised, discussed and resolved.

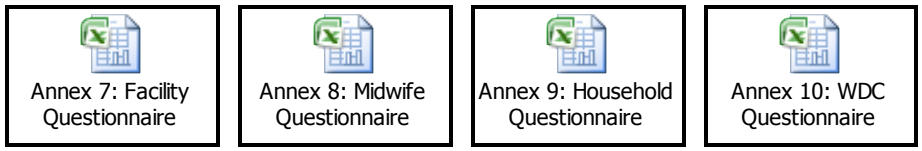
The fifth day of training in Enugu and Kaduna was dedicated to discussing all survey questionnaires with major emphasis on the midwife games, household listing and sampling strategy in cluster two and three respectively. Based on experience garnered by the interviewers during the pilot testing exercise, the facilitators were available to take all the questions asked and adequate responses were provided.

Day 6

In cluster one training held in Ekiti, there was need for an extra day to further train personnel that conducted the midwife and facility questionnaires on how to administer the questionnaire

with emphasis on the games. Logistics and field microplan was developed to effectively guide the state supervisors in sharing work among the interviewers/enumerators.

One major output of the training was the finalization of the survey questionnaires to be used for the survey. For example, the final questionnaires used for cluster three are presented as **annexes 7, 8, 9 and 10** below.



2.3 Field Work

2.3.1 Field Data Collection Plan

A survey implementation plan was developed to guide the data collection for this survey. The overall summary of the implementation is described below:

Cluster One

- Personnel distribution for the implementation
  - 26 interviewers administered 770 households questionnaires
  - 26 interviewers administered 483 midwife questionnaires
  - 13 interviewers administered 153 WDC and 153 facility manager questionnaires
  - 13 listers carried out the listing of households across the states
- Data collection timeline
  - Actual field data collection took place between 9th to 24th September, 2013

Cluster Two

- Personnel distribution for the implementation
  - 22 interviewers administered 671 households questionnaires
  - 22 interviewers administered 462 midwife questionnaires
  - 11 interviewers administered 134 WDC and 133 facility manager questionnaires
  - 11 listers carried out the listing of households across the states
- Data collection timeline
  - Actual field data collection took place between 7th to 18th October, 2013

Cluster Three

- Personnel distribution for the implementation
  - 26 interviewers administered 937 households questionnaires
  - 26 interviewers administered 331 midwife questionnaires
  - 13 interviewers administered 190 WDC and 190 facility manager questionnaires
  - 13listerscarried out the listing of households across the states
- Data collection timeline
  - Actual field data collection took place between 11th to 27th November, 2013

2.3.2 Field Data Collection Process

There are a total of 500 SURE-P facilities across the country; South West (72), South East (64), South South (72), North Central (84), North East (96) and North West (112) zones. In the 500 health facilities, the survey targeted 1,215 midwives recruited by SURE-P, 500 WDC chairs or representatives and 2,500 eligible household respondents. See **Table 1** below for summary of targeted respondents.

Table 1: Summary of targeted respondents by states

S/No	State/Zone	Targeted Respondents			
		Facility	Midwife	WDC	Household
	North Central				
1	Benue	12	41	12	60
2	FCT	12	46	12	60
3	Kogi	12	46	12	60
4	Kwara	12	46	12	60
5	Nasarawa	12	26	12	60
6	Niger	12	26	12	60
7	Plateau	12	35	12	60
	South West				
8	Ekiti	12	43	12	60
9	Lagos	12	42	12	60
10	Ogun	12	34	12	60
11	Ondo	12	43	12	60
12	Osun	12	43	12	60
13	Oyo	12	48	12	60
	South East				
14	Abia	12	46	12	60
15	Anambra	12	48	12	60
16	Ebonyi	16	57	16	80
17	Enugu	12	43	12	60
18	Imo	12	46	12	60
	South South				
19	AkwaIbom	12	48	12	60
20	Bayelsa	12	36	12	60
21	Cross River	12	22	12	60
22	Delta	12	44	12	60
23	Edo	12	46	12	60
24	Rivers	12	48	12	60
	North West				
25	Jigawa	16	14	16	80
26	Kaduna	16	38	16	80
27	Kano	16	22	16	80
28	Katsina	16	18	16	80
29	Kebbi	16	18	16	80
30	Sokoto	16	15	16	80

S/No	State/Zone	Targeted Respondents			
		Facility	Midwife	WDC	Household
31	Zamfara	16	15	16	80
	North East				
32	Adamawa	16	6	16	80
33	Bauchi	16	37	16	80
34	Borno	16	12	16	80
35	Gombe	16	8	16	80
36	Taraba	16	7	16	80
37	Yobe	16	2	16	80
	TOTAL	**500**	**1,215**	**500**	**2,500**

Facility manager survey: In the three clusters, a total of 476 facility manager questionnaires were administered. The respondents were the in-charge of the facilities visited or the most senior officer present at the facilities at the time of interview. Information collected for this survey includes the facilities general information, facility characteristics, administration and management, human resources, Maslach burnout inventory, records, community outreach, health services, user fees, national protocol, equipment and drug storage and availability.

Midwife survey: Questionnaires were administered to 1,291 midwives. All midwives interviewed were SURE-P midwives. The survey includes modules on general information, midwife practice, working conditions, Maslach Burnout Inventory, family, revenues, assets, non-experimented Measure of Intrinsic Motivation, relations and community support, work and family and games. All midwives interviewed participated in the post contract survey aimed at eliciting information of pro-social scales.

The list of all SURE-P midwives with their identification numbers was provided to the survey firm. Some midwives whose names were not on the list provided were found and interviewed during the survey. As part of the midwife survey, midwives already surveyed played different games; altruism, risk preference and time discounting games.

In the altruism games midwives were asked to divide an amount of money between them and the Nigerian Red Cross. The altruism game was in two parts. The choice of the midwife was only known to her in the first altruism game while her decision was made known to other midwives in the facility in the second altruism game. The amount won by the midwives for the altruism game was paid within 7 days after the interview.

The risk preference game assessed how the midwives made decision under uncertainty. All midwives who participated in this game were given N525 each and depending on chance and decisions of the midwives, midwives could win up to N25,000 but may also lose the N525 given at the beginning of the game.

The time preference game measured the willingness of the midwives to trade-off real money between the present and the future. Midwives received different amounts of money at different times depending on their choices. Midwives who played this game received a minimum of

N6,000 and a maximum of N12,000 depending on their choices. The amounts were payable at different periods.

Household Survey: The household survey includes modules on demographic info, education, labour, housing, assets, health status and utilization and health related knowledge attitude and practice. Women who gave birth three months preceding the survey and resides in the catchment areas around the facilities visited were interviewed.

The household survey occurred in two parts: i) the house listing and sampling; ii) the household interview.

- Household Listing: The interviewers first visited the SURE-P facilities and asked for the names of the communities within its catchment area. The list of communities provided were then written in a piece of paper; crumpled and placed in a bag. The papers were randomly drawn and two communities selected.

  All structures in communities with 50 or less structures were listed. Communities with 50 to 100 structures were split into Enumeration Areas (EAs) of approximately 25 structures and two randomly selected and fully listed. Communities with more than 100 structures were also split into EAs and three randomly selected.

  The listing was conducted using the World Bank designed listing form. All listed households with eligible women were entered into a generated sampling form. Households with the smallest numbers in the "sampling order" where chosen for sample.

  A sketch of the community maps were also obtained.

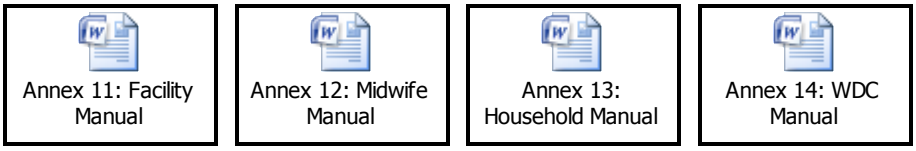
- Questionnaire administration: Interviewers found their way to the sampled households and administered the survey instrument. This was usually with the help of voluntary health workers or the community focal persons. A total 2,378 eligible respondents were interviewed at the end of clusters one, two and three fieldwork.

Ward Development Committee Survey: The WDC Survey aims to elicit information about the WDC and their engagement with the facility and community. A total of 477 WDC questionnaires were administered.

2.3.3 Quality Assurance during Data Collection

The survey firm with guidance of the World Bank IE team developed a field manual for the implementation of the assignment. The field manual for each survey types was used to guide interview procedures, data collection processes and interpretation of each question in the survey instruments. The roles and responsibilities of the interviewers were detailed in the field manual.

The facility manager, midwife, household and WDC questionnaires manuals are attached as **Annexes 11, 12, 13 and 14** respectively below.



Due to the adequate training and competence of most team members, data quality assurance was a primary responsibility of each interviewer. Each interviewer was required to take adequate time in answering each question and entering answers correctly into the tab. Interviewers also took time to review each completed survey before leaving the spot where the interview was conducted. The supervisors were available to observe some interviews conducted.

Supervisors randomly went through a couple of forms on different days to assess the data collected before despatching to the server.

Feedbacks from the World Bank on quality of data collected were shared with the survey firm. Some interviewers went back to the field to collect additional information where there were concerns.

2.3.4 Sending completed forms to the server

Completed and finalized forms were dispatched to the server three times weekly. The supervisors ensured that only the finalized forms were sent to the server and that the forms were properly saved with the right file names before dispatch. Wireless internet connection network was shared among the 5 tablets before eventual dispatch to the server. The survey firm provided each state team a mobile phone with portable hotspot.

2.4 Post Field Work

2.4.1 Data Entry

The paper-based household listing forms were electronically captured on the system. Data entry of all listing forms was done by 4 Data Entry Operators (DEOs) recruited by the survey firm. A simple data entry programme was design using Microsoft Excel. The 4 DEOs selected were trained for one day. The was to enable them get a conceptual overview of the survey and understand what the survey sought to achieve and their roles as data entry clerks. Data entry of the listing forms were completed in 2 weeks. The completed household listing forms is presented in **Annex 15** below.

2.4.2 Data Cleaning

Data cleaning was carried out in phases at the end of the field exercise. Data cleaning commenced with the correction of wrongly captured midwife identification (ID) numbers in the midwife and post contract surveys. Corrected midwife IDs in the midwife and post contract

surveys were further matched using STATA so as to identify missing midwife IDs. At the end of this exercise, a number of missing IDs were discovered and addressed by conducting fresh interviews. Plateau and Taraba states recorded the highest cases of midwives with missing post contract survey forms.

Household data was cleaned by identifying duplicate IDs within the facilities and also correction of household IDs which were not correctly recorded. The household listing and sampling order forms served as reference books for confirmation of the IDs where concerns were raised. Facility and WDC files were cleaned by identifying duplicated facility IDs within the states. Identified IDs were cleaned by calling the in-charge of the facilities and WDC chairs to clarify which facilities they fall under.

CHAPTER 3

3.0 RESPONSE RATES TO QUESTIONNAIRE ADMINISTRATION

This section documents questionnaire response rates for each survey and challenges encountered during field implementation.

3.1 Facility survey

A total of 476 facility manager questionnaires were administered in all 37 states surveyed. This figure represents 95.2% of our targeted respondents. All the 16 facility managers in Borno state were not interviewed due to existing security situation during field work. Only 9 and 14 facility manager survey interviews were conducted out of the targeted 12 and 16 facilities in Bayelsa and Adamawa respectively. Also in Plateau and Ogun, only 10 and 11 facility manager survey interviews were conducted out of the targeted 12 respectively. These were attributed to communal crisis in the host communities of the SURE-P facilities in Bayelsa and Plateau and also due to the existing security situation in Madagali LGA, the host LGA of the two SURE-P facilities not visited. The summary of the interviews is presented in **Table 2** below.

Table 2: Summary of facility survey conducted by states

S/No	States	Target	Achievement	% achievement
	North Central			
1	Benue	12	12	100.0
2	FCT	12	12	100.0
3	Kogi	12	12	100.0
4	Kwara	12	12	100.0
5	Nasarawa	12	12	100.0
6	Niger	12	12	100.0
7	Plateau	12	10	83.3
	South West			
8	Ekiti	12	12	100.0
9	Lagos	12	12	100.0
10	Ogun	12	11	91.7
11	Ondo	12	12	100.0
12	Osun	12	12	100.0
13	Oyo	12	12	100.0
	South East			
14	Abia	12	12	100.0
15	Anambra	12	12	100.0
16	Ebonyi	16	16	100.0
17	Enugu	12	12	100.0
18	Imo	12	12	100.0
	South South			
19	AkwaIbom	12	12	100.0
20	Bayelsa	12	9	75.0

S/No	States	Target	Achievement	% achievement
21	Cross River	12	12	100.0
22	Delta	12	12	100.0
23	Edo	12	12	100.0
24	Rivers	12	12	100.0
	North West			
25	Jigawa	16	16	100.0
26	Kaduna	16	16	100.0
27	Kano	16	16	100.0
28	Katsina	16	16	100.0
29	Kebbi	16	16	100.0
30	Sokoto	16	16	100.0
31	Zamfara	16	16	100.0
	North East			
32	Adamawa	16	14	87.5
33	Bauchi	16	16	100.0
34	Borno	16	0	0.0
35	Gombe	16	16	100.0
36	Taraba	16	16	100.0
37	Yobe	16	16	100.0
	TOTAL	**500**	**476**	**95.2**

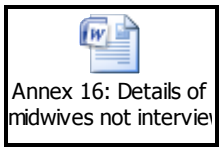
3.2 Midwife survey

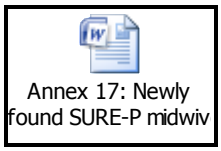
Data was collected from 1,291 out of the targeted 1,215 midwives. This figure represents 106.3% of the targeted midwives. Prior to the field visits, the interviewers were provided with the list of midwives in all the facilities assigned to them. One hundred and eighty (180) midwives whose names were on the list provided to us by the PIU were not interviewed for varying reasons **(Table 3, Annex 15)**. However, 256 SURE-P midwives whose names were not on the list provided to the interviewers were interviewed. The unique identification numbers of the newly recruited midwives were documented **(Annex 16)**. Summary of interviews conducted by state is presented in **Table 3** below.

Table 3: Summary of midwife survey conducted by states

S/ No	State/Zone	Target	Midwives in the list provided and were interviewed	Midwives recruited by SURE-P but not on the list provided	Total Midwives Interviewed	% achievement	Midwives in the list provided but not interviewed
	North Central						
1	Benue	41	40	1	41	100.0	1
2	FCT	46	42	2	44	95.7	4
3	Kogi	46	42	2	44	91.3	4
4	Kwara	46	46	0	46	100.0	0
5	Nasarawa	26	22	5	27	103.8	4
6	Niger	26	21	2	23	88.5	5
7	Plateau	35	33	0	33	94.3	2
	South West						
8	Ekiti	43	41	0	41	95.3	2
9	Lagos	42	42	2	44	104.8	0
10	Ogun	34	32	0	32	94.1	2
11	Ondo	43	39	1	40	93.0	4
12	Osun	43	35	1	36	83.7	8
13	Oyo	48	48	0	48	100.0	0
	South East						
14	Abia	46	44	0	44	95.7	2
15	Anambra	48	46	0	46	95.8	2
16	Ebonyi	57	50	4	54	94.7	7
17	Enugu	43	40	5	45	104.7	3
18	Imo	46	44	1	45	97.8	2
	South South						
19	AkwaIbom	48	47	0	47	97.9	1
20	Bayelsa	36	27	1	28	77.8	9
21	Cross River	22	22	1	23	104.5	0
22	Delta	44	41	4	45	102.3	3
23	Edo	46	41	1	42	91.3	5
24	Rivers	48	42	1	43	89.6	6
	North West						
25	Jigawa	14	1	50	51	364.3	13
26	Kaduna	38	23	11	34	89.5	15
27	Kano	22	9	24	33	150.0	13
28	Katsina	18	18	16	34	188.9	0
29	Kebbi	18	7	6	13	72.2	11
30	Sokoto	15	9	24	33	220.0	6
31	Zamfara	15	5	17	22	146.7	10
	North East						
32	Adamawa	6	2	11	13	216.7	4

S/ No	State/Zone	Target	Midwives in the list provided and were interviewed	Midwives recruited by SURE-P but not on the list provided	Total Midwives Interviewed	% achievement	Midwives in the list provided but not interviewed
33	Bauchi	37	22	19	41	110.8	15
34	Borno	12	0	0	0	0.0	12
35	Gombe	8	4	29	33	412.5	4
36	Taraba	7	6	15	21	300.0	1
37	Yobe	2	2	0	2	100.0	0
	TOTAL	**1,215**	**1,033**	**256**	**1,291**	**106.3**	**180**





Midwife Payout

All midwives interviewed participated in the different games of the midwife survey and won varying amounts. A total of N16,543,537.50 (US$106,567.49) was won by the 1,291 midwives that played the games with an average payout of N12,814.51 (US$82.55) per midwife.

Enumerators were not given cash. Rather, account details (bank name, account name, account number and type of account) and phone numbers of all midwives who participated in the games were collected and midwives were given a voucher with the amount won and expected payment dates. Electronic banking was preferred for the transfer of cash won as this allowed banking transactions without the waiting period and restriction of banking hours and considering the number of midwives involved, the electronic banking was considered the most appropriate for the payout. Hanovia dedicated a bank account for the track payments and facilitate reconciliation.

The amounts won by the SURE-P midwives were paid three times (7 days, 30 days and 60 days respectively). Amounts won in altruism game, time preference game (now) and risk preference game were all due just 7 days after the games were played while the amount won in time preference game for stage 1 and stage 2 were paid after 30 days and 60 days respectively.

As part of the survey, post contract survey (pro-social norm games) was conducted on all midwives interviewed. Analysis of the responses from all midwives interviewed was carried out by the World Bank IE Team and one question out of the responses was randomly selected. Five hundred and fourteen (514) midwives who picked the selected option was paid N1,000. The total cost of N514,000 shall be disbursed to the selected midwives by Hanovia. This cost is included in the total cost for the payout above. See details in **Table 4** below.

Table 4: Summary of payout to midwives by states

S/ No	State	No. of Midwives Interviewed	7 days	30 days	60 days	Pro-social games	Total	Average Amount per midwife
1	Abia	44	175,325.00	144,700.00	220,200.00	11,000.00	551,225.00	12,527.84
2	Adamawa	13	88,250.00	82,500.00	17,250.00	9,000.00	197,000.00	15,153.85
3	Akwa Ibom	47	249,875.00	138,100.00	122,825.00	16,000.00	526,800.00	11,208.51
4	Anambra	46	241,275.00	182,800.00	132,800.00	27,000.00	583,875.00	12,692.93
5	Bauchi	41	364,950.00	101,175.00	104,700.00	21,000.00	591,825.00	14,434.76
6	Bayelsa	28	154,825.00	61,275.00	116,825.00	12,000.00	344,925.00	12,318.75
7	Benue	41	204,805.00	146,900.00	155,850.00	22,000.00	529,555.00	12,915.98
8	Cross River	23	142,225.00	85,000.00	59,075.00	14,000.00	300,300.00	13,056.52
9	Delta	45	201,050.00	200,725.00	114,250.00	18,000.00	534,025.00	11,867.22
10	Ebonyi	54	290,330.00	237,000.00	173,875.00	12,000.00	713,205.00	13,207.50
11	Edo	42	257,200.00	139,375.00	132,950.00	18,000.00	547,525.00	13,036.31
12	Ekiti	41	233,250.00	166,350.00	103,200.00	17,000.00	519,800.00	12,678.05
13	Enugu	45	233,295.00	115,675.00	182,525.00	28,000.00	559,495.00	12,433.22
14	FCT	44	199,600.00	167,975.00	122,200.00	15,000.00	504,775.00	11,472.16
15	Gombe	33	194,125.00	60,300.00	129,100.00	14,000.00	397,525.00	12,046.21
16	Imo	45	252,600.00	128,625.00	160,175.00	22,000.00	563,400.00	12,520.00
17	Jigawa	51	317,825.00	135,650.00	117,100.00	15,000.00	585,575.00	11,481.86
18	Kaduna	34	227,085.00	231,050.00	47,375.00	8,000.00	513,510.00	15,103.24
19	Kano	33	189,900.00	94,725.00	107,400.00	16,000.00	408,025.00	12,364.39
20	Katsina	34	518,505.00	68,650.00	18,000.00	10,000.00	615,155.00	18,092.79
21	Kebbi	13	131,020.00	27,900.00	68,450.00	2,000.00	229,370.00	17,643.85
22	Kogi	44	258,880.00	95,750.00	130,800.00	27,000.00	512,430.00	11,646.14
23	Kwara	46	289,337.50	136,500.00	150,425.00	11,000.00	587,262.50	12,766.58
24	Lagos	44	245,150.00	119,800.00	164,625.00	25,000.00	554,575.00	12,603.98
25	Nasarawa	27	169,575.00	128,550.00	73,175.00	9,000.00	380,300.00	14,085.19
26	Niger	23	128,775.00	98,950.00	93,500.00	7,000.00	328,225.00	14,270.65

S/ No	State	No. of Midwives Interviewed	7 days	30 days	60 days	Pro-social games	Total	Average Amount per midwife
27	Ogun	32	143,925.00	70,125.00	128,975.00	10,000.00	353,025.00	11,032.03
28	Ondo	40	229,000.00	126,525.00	112,050.00	7,000.00	474,575.00	11,864.38
29	Osun	36	208,875.00	99,875.00	154,875.00	16,000.00	479,625.00	13,322.92
30	Oyo	48	258,750.00	147,850.00	141,850.00	12,000.00	560,450.00	11,676.04
31	Plateau	33	201,115.00	136,600.00	59,150.00	15,000.00	411,865.00	12,480.76
32	Rivers	43	216,075.00	182,215.00	117,050.00	18,000.00	533,340.00	12,403.26
33	Sokoto	33	248,275.00	39,875.00	120,825.00	14,000.00	422,975.00	12,817.42
34	Taraba	21	120,975.00	101,100.00	65,100.00	9,000.00	296,175.00	14,103.57
35	Yobe	2	26,325.00	6,000.00	0	0	32,325.00	16,162.50
36	Zamfara	22	135,950.00	82,300.00	74,250.00	7,000.00	299,500.00	13,613.64
	TOTAL (NGN)	**1,291**	**7,748,297.50**	**4,288,465.00**	**3,992,775.00**	**514,000.00**	**16,543,537.50**	**12,814.51**
	TOTAL (USD)	**1,291**	**49,911.73**	**27,624.74**	**25,720.01**	**3,311.00**	**106,567.49**	**82.55**

Details of the payment by cluster is presented in our accounting report presented in **Annex 17.**

Annex 18: Accounting report for

3.3 Household survey

From the 2,500 eligible respondents expected to be sampled from at least 1,015 communities, only 2,378 women who gave birth in the last three months were interviewed. The respondents interviewed were sampled from 4,945 eligible respondents found in 45,194 listed households. The listing of households also found 5,225 pregnant women spread across the 951 communities in the 36 states visited. See details in tables 5 and 6 below.

As reported earlier in other survey components, low coverage was recorded in Adamawa and Bayelsa states due to insecurity in the areas. It was also reported that the host communities of Faya and Karkashi PHCs in Plateau State could not be accessed due to the on-going crisis in these communities during the survey. Borno state was not visited due to the peculiar security situation.

The summary of the interviews is presented in table 5 below.

Table 5: Summary of household survey conducted by states

S/No	States	Target	Achievement	% achievement
	North Central			
1	Benue	60	60	100.0
2	FCT	60	60	100.0
3	Kogi	60	60	100.0
4	Kwara	60	60	100.0
5	Nasarawa	60	60	100.0
6	Niger	60	60	100.0
7	Plateau	60	50	83.3
	South West			
8	Ekiti	60	60	100.0
9	Lagos	60	60	100.0
10	Ogun	60	60	100.0
11	Ondo	60	60	100.0
12	Osun	60	60	100.0
13	Oyo	60	60	100.0
	South East			
14	Abia	60	60	100.0
15	Anambra	60	60	100.0
16	Ebonyi	80	80	100.0
17	Enugu	60	60	100.0
18	Imo	60	60	100.0
	South South			
19	AkwaIbom	60	60	100.0
20	Bayelsa	60	52	86.7

S/No	States	Target	Achievement	% achievement
21	Cross River	60	60	100.0
22	Delta	60	60	100.0
23	Edo	60	60	100.0
24	Rivers	60	59	98.3
	North West			
25	Jigawa	80	80	100.0
26	Kaduna	80	80	100.0
27	Kano	80	80	100.0
28	Katsina	80	80	100.0
29	Kebbi	80	80	100.0
30	Sokoto	80	80	100.0
31	Zamfara	80	80	100.0
	North East			
32	Adamawa	80	60	75.0
33	Bauchi	80	80	100.0
34	Borno	80	0	0.0
35	Gombe	80	80	100.0
36	Taraba	80	80	100.0
37	Yobe	80	77	96.3
	TOTAL	**2,500**	**2,378**	**95.1**

Table 6: Summary of household listing conducted by states

S/No	State	No. of communities sampled	No. of structures listed	No. of households listed	No. of eligible women found	No. of pregnant women found
	North Central					
1	Benue	24	600	747	74	100
2	FCT	24	1,156	1,112	112	141
3	Kogi	24	757	957	102	152
4	Kwara	24	655	1,007	111	107
5	Nasarawa	26	836	874	73	101
6	Niger	25	750	1234	143	217
7	Plateau	20	559	798	78	118
	South West					
8	Ekiti	30	323	674	84	50
9	Lagos	24	479	940	123	92
10	Ogun	24	1044	650	97	36
11	Ondo	24	643	1,124	139	154
12	Osun	24	1035	961	87	45
13	Oyo	34	764	1622	91	92

S/No	State	No. of communities sampled	No. of structures listed	No. of households listed	No. of eligible women found	No. of pregnant women found
	South East					
14	Abia	24	1,180	1,666	171	69
15	Anambra	23	723	779	80	47
16	Ebonyi	23	1,397	2,414	91	125
17	Enugu	26	1,787	1,871	84	74
18	Imo	24	1,339	2,147	124	89
	South South					
19	AkwaIbom	28	1,296	1,198	92	69
20	Bayelsa	17	703	2,335	87	54
21	Cross River	25	1,082	1,272	90	125
22	Delta	24	570	1,101	102	100
23	Edo	13	761	1,052	93	79
24	Rivers	24	852	951	85	44
	North West					
25	Jigawa	34	598	864	269	200
26	Kaduna	16	1,600	1,846	204	246
27	Kano	32	1,592	1,236	235	406
28	Katsina	32	1,909	1,809	219	179
29	Kebbi	54	1,092	1,205	110	197
30	Sokoto	34	985	1,378	237	242
31	Zamfara	18	1,474	1,474	308	508
	North East					
32	Adamawa	25	1,382	1,047	251	203
33	Bauchi	32	1,595	1,376	245	375
34	Borno	0	0	0	0	0
35	Gombe	32	1,062	1,422	267	269
36	Taraba	32	695	1,022	80	55
37	Yobe	32	859	1,029	107	65
	TOTAL	**951**	**36,134**	**45,194**	**4,945**	**5,225**

3.4 WDC survey

Although, 500 WDC chairs or their representatives were expected to be interviewed, only 477 were interviewed. This represents 94.2% of the targeted respondents. Out of the 23 WDC chairs or their representatives not interviewed, 16 were in Borno state which was not visited due to the security situation in the state at the time of the survey. Others are Bayelsa (2), Plateau (2) and Adamawa (2) which reasons were also attributed to security situation. WDC chair for PHC Mangar in Nasarawa State was not reached during repeated visits to the community. No representative was also available, hence the interview was not conducted.

Table 7: Summary of WDC survey conducted by states

S/No	States	Target	Achievement	% achievement
	North Central			
1	Benue	12	12	100.0
2	FCT	12	12	100.0
3	Kogi	12	12	100.0
4	Kwara	12	12	100.0
5	Nasarawa	12	11	91.7
6	Niger	12	12	100.0
7	Plateau	12	10	83.3
	South West			
8	Ekiti	12	12	100.0
9	Lagos	12	12	100.0
10	Ogun	12	12	100.0
11	Ondo	12	12	100.0
12	Osun	12	12	100.0
13	Oyo	12	12	100.0
	South East			
14	Abia	12	12	100.0
15	Anambra	12	12	100.0
16	Ebonyi	16	16	100.0
17	Enugu	12	12	100.0
18	Imo	12	12	100.0
	South South			
19	AkwaIbom	12	12	100.0
20	Bayelsa	12	10	83.3
21	Cross River	12	12	100.0
22	Delta	12	12	100.0
23	Edo	12	12	100.0
24	Rivers	12	12	100.0
	North West			
25	Jigawa	16	16	100.0
26	Kaduna	16	16	100.0
27	Kano	16	16	100.0
28	Katsina	16	16	100.0
29	Kebbi	16	16	100.0
30	Sokoto	16	16	100.0
31	Zamfara	16	16	100.0
	North East			
32	Adamawa	16	14	87.5
33	Bauchi	16	16	100.0
34	Borno	16	0	0.0

S/No	States	Target	Achievement	% achievement
35	Gombe	16	16	100.0
36	Taraba	16	16	100.0
37	Yobe	16	16	100.0
	TOTAL	**500**	**477**	**95.4**

3.5 Field challenges, Conclusions and Recommendations

3.5.1 Challenges

Some of the challenges experienced during the survey are summarised as:

a) Insecurity in some communities where the SURE-P facilities are located prevented the conduct of some interviews.
b) The zonal coordinators of the SURE-P MCH programme were not aware of survey hence access to some facilities were first denied
c) Difficulty in locating some health facilities due to inadequate information of their exact locations in the list provided by PIU
d) Some midwives provided wrong account details on the games sheet
e) Sending completed interviews to the server was difficult due to poor internet connection at the communities
f) Server downtime was experienced for few days during the second cluster survey
g) Some names of the facilities programmed on the tablet were different from what was on the list provided by SURE-P
h) Availability of the SURE-P midwives: in some states, the midwives were concurrently undergoing mandatory trainings. It was therefore very difficult to meet all the midwives in the PHCs at the same time resulting in the interviewer having to occasionally revisit the same PHC on another day or having to re-schedule interviewers at odd times of the day
i) Access to some facilities were first denied until the LGA PHC coordinator waded in
j) Some midwives provided to the interviewers with wrong account details

3.5.2 Conclusions and Recommendations

The challenges highlighted above were however surmounted. In areas of insecurity, midwives, facility managers and WDC chairs were invited to the states capital for the interviews. This was not the case in Borno State.

Through the assistance of the different SURE-P programme assistants, access to health facilities initially refused was granted. Midwives who provided wrong/invalid account details were followed up with phone calls and correct account details were obtained.

The World Bank with the help of the ODK team were able to restore the ODK aggregate server one week after failure. The technical issue on the facilities programmed on the tablets resolved.

We strongly recommend that an updated database of SURE-P facilities and midwives be used for subsequent surveys. There is also need to involve the SURE-P zonal coordinators during survey implementation.