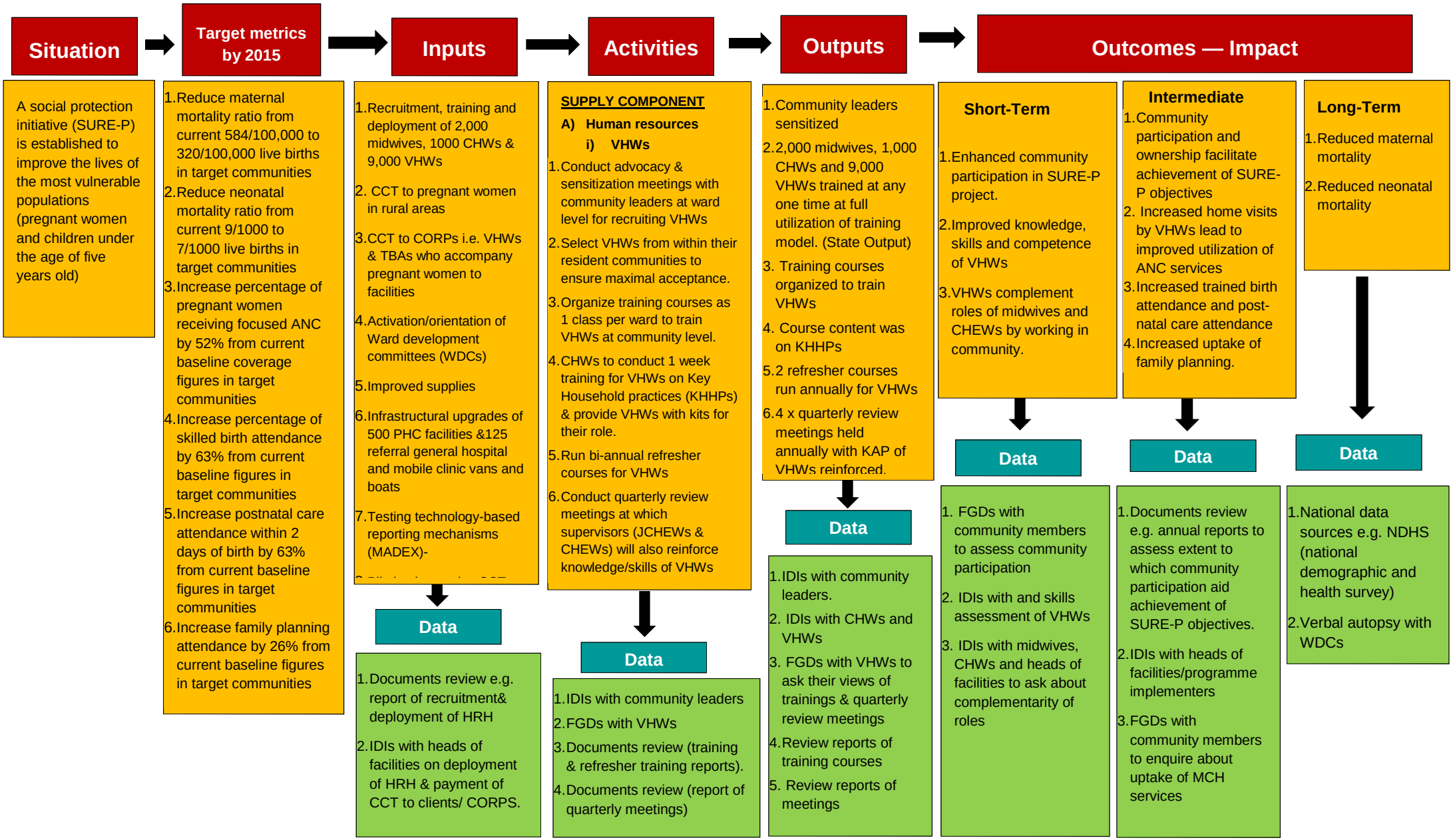
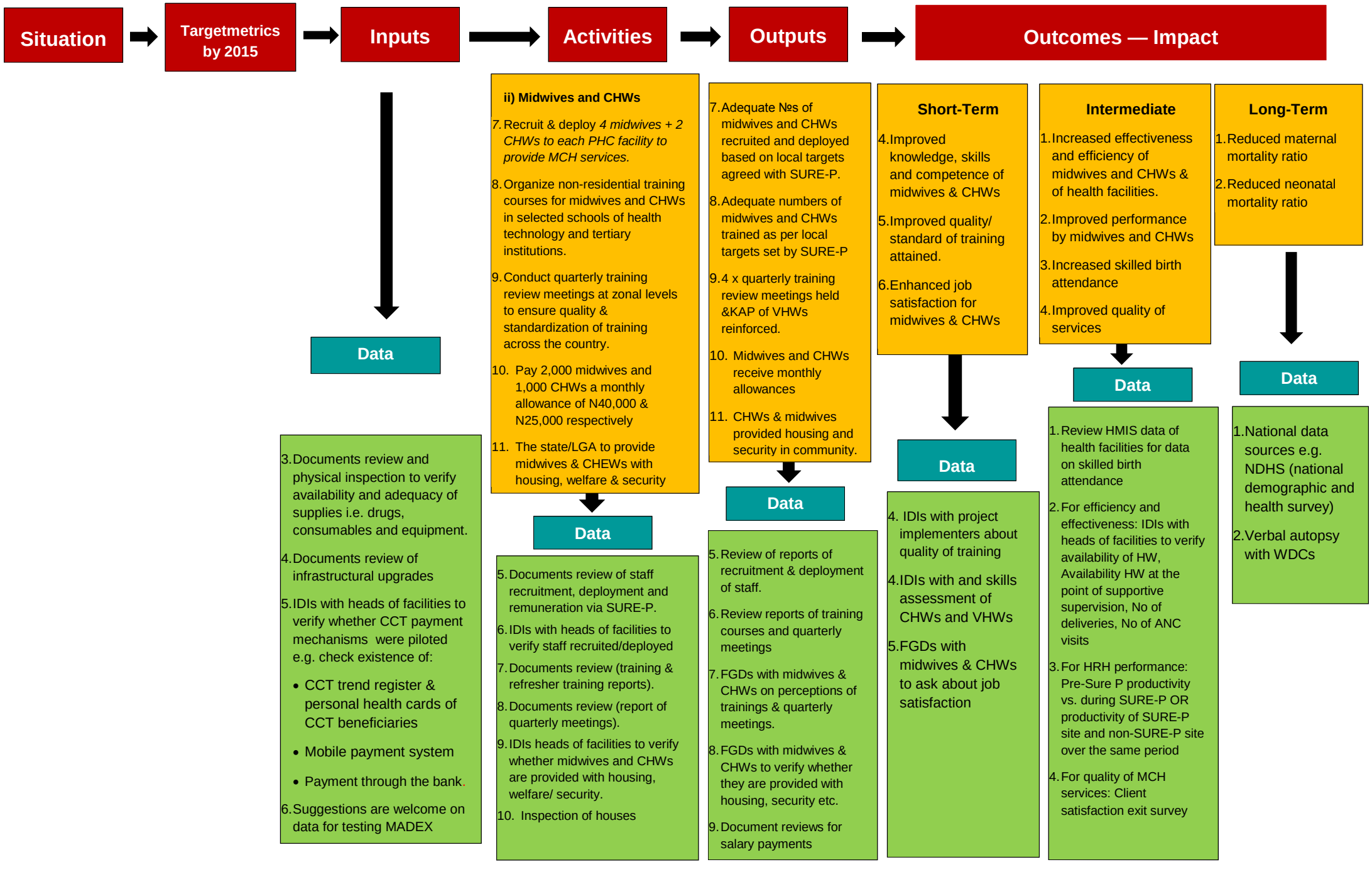
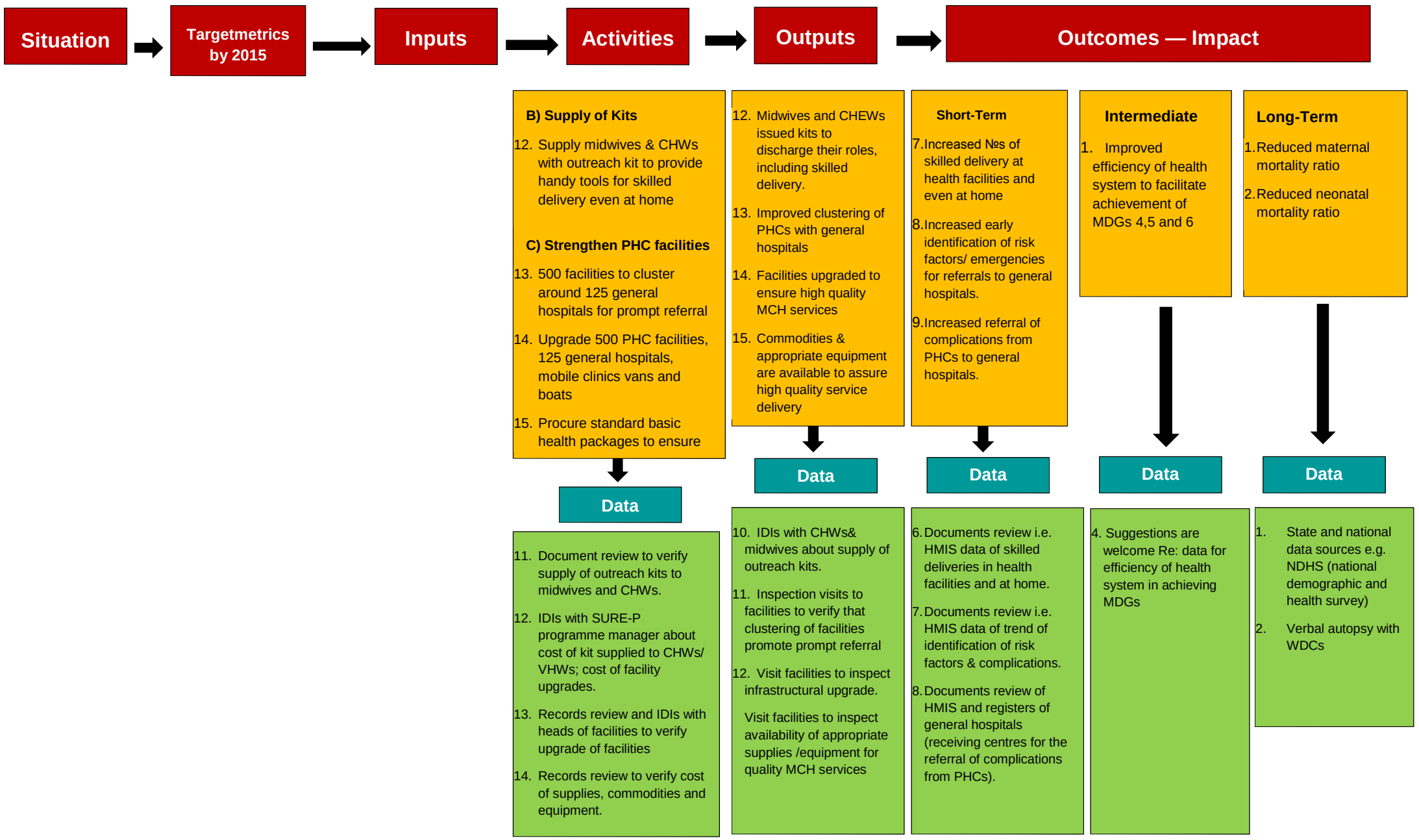
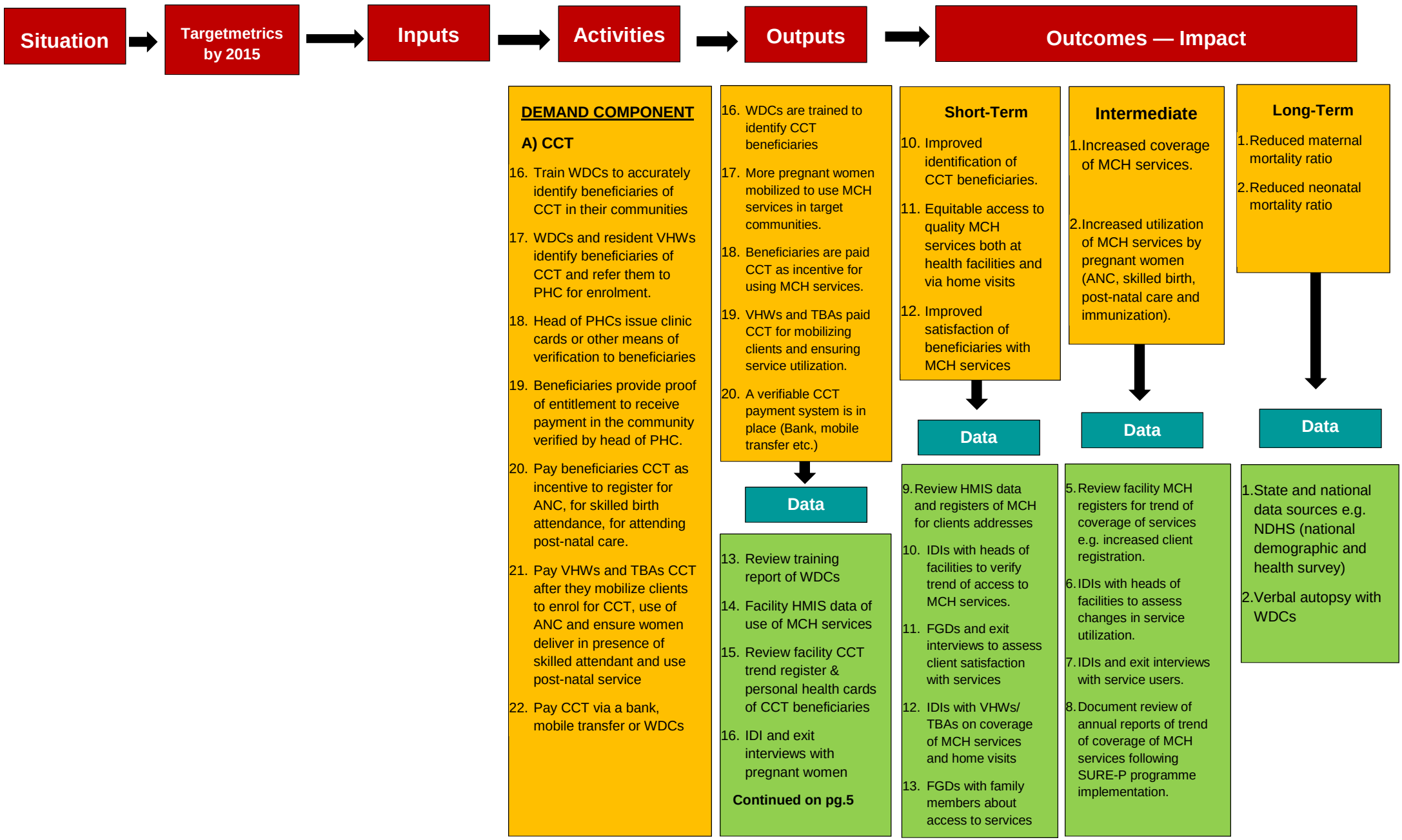
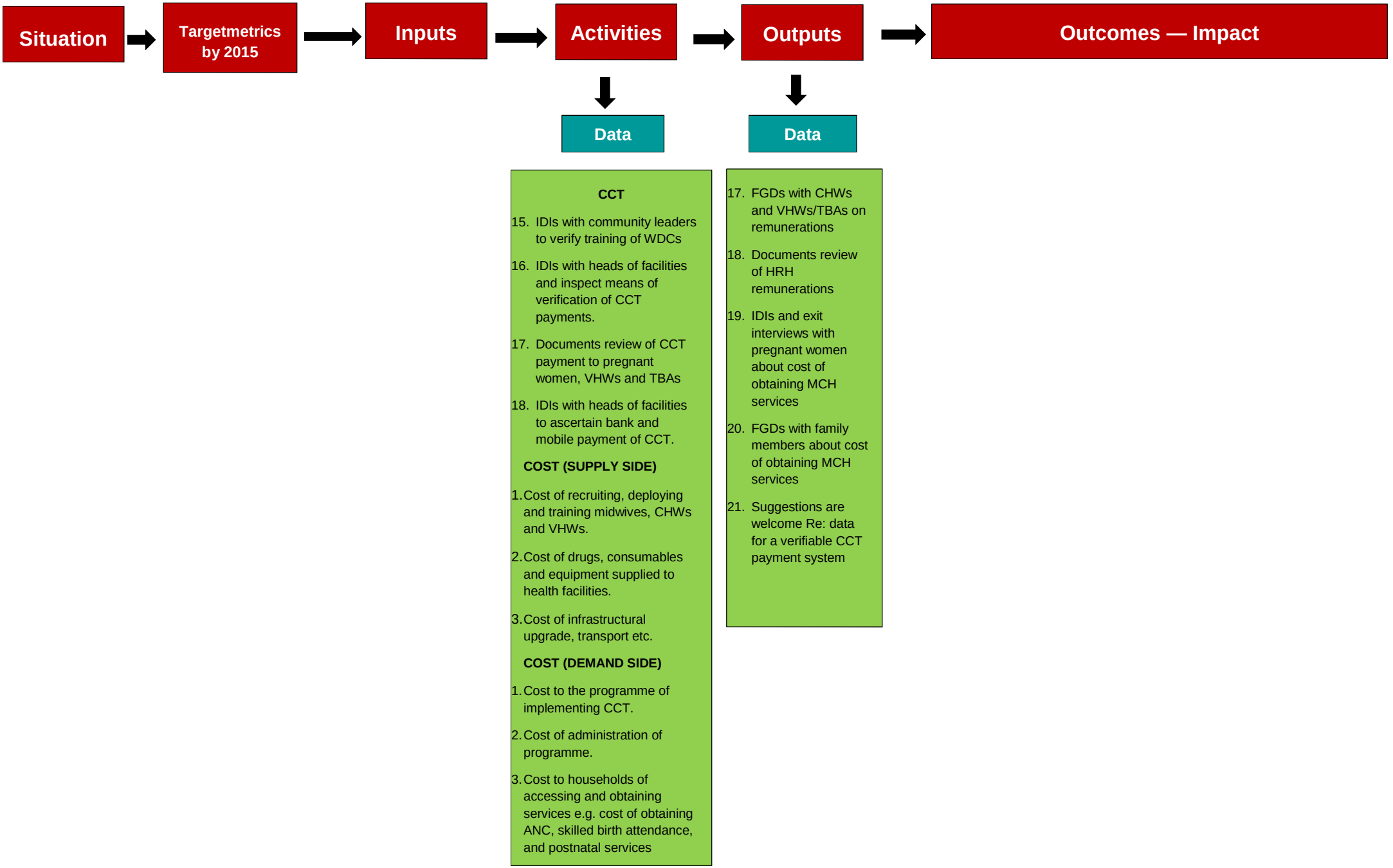
Additional file 5: Pre-implementation Logic Map for SURE-P/MCH




Situation
Targetmetrics by 2015
Inputs
Activities
Outputs
Outcomes — Impact
Data
3. Documents review and physical inspection to verify availability and adequacy of supplies i.e. drugs, consumables and equipment.
4. Documents review of infrastructural upgrades
5. IDIs with heads of facilities to verify whether CCT payment mechanisms were piloted e.g. check existence of:
• CCT trend register & personal health cards of CCT beneficiaries
• Mobile payment system
• Payment through the bank.
6. Suggestions are welcome on data for testing MADEX
ii) Midwives and CHWs
7. Recruit & deploy 4 midwives + 2 CHWs to each PHC facility to provide MCH services.
8. Organize non-residential training courses for midwives and CHWs in selected schools of health technology and tertiary institutions.
9. Conduct quarterly training review meetings at zonal levels to ensure quality & standardization of training across the country.
10. Pay 2,000 midwives and 1,000 CHWs a monthly allowance of N40,000 & N25,000 respectively
11. The state/LGA to provide midwives & CHEWs with housing, welfare & security
Data
5. Documents review of staff recruitment, deployment and remuneration via SURE-P.
6. IDIs with heads of facilities to verify staff recruited/deployed
7. Documents review (training & refresher training reports).
8. Documents review (report of quarterly meetings).
9. IDIs heads of facilities to verify whether midwives and CHWs are provided with housing, welfare/ security.
10. Inspection of houses
7. Adequate №s of midwives and CHWs recruited and deployed based on local targets agreed with SURE-P.
8. Adequate numbers of midwives and CHWs trained as per local targets set by SURE-P
9. 4 x quarterly training review meetings held &KAP of VHWs reinforced.
10. Midwives and CHWs receive monthly allowances
11. CHWs & midwives provided housing and security in community.
Data
5. Review of reports of recruitment & deployment of staff.
6. Review reports of training courses and quarterly meetings
7. FGDs with midwives & CHWs on perceptions of trainings & quarterly meetings.
8. FGDs with midwives & CHWs to verify whether they are provided with housing, security etc.
9. Document reviews for salary payments
Short-Term
4. Improved knowledge, skills and competence of midwives & CHWs
5. Improved quality/ standard of training attained.
6. Enhanced job satisfaction for midwives & CHWs
Data
4. IDIs with project implementers about quality of training
4. IDIs with and skills assessment of CHWs and VHWs
5. FGDs with midwives & CHWs to ask about job satisfaction
Intermediate
1. Increased effectiveness and efficiency of midwives and CHWs & of health facilities.
2. Improved performance by midwives and CHWs
3. Increased skilled birth attendance
4. Improved quality of services
Data
1. Review HMIS data of health facilities for data on skilled birth attendance
2. For efficiency and effectiveness: IDIs with heads of facilities to verify availability of HW, Availability HW at the point of supportive supervision, No of deliveries, No of ANC visits
3. For HRH performance: Pre-Sure P productivity vs. during SURE-P OR productivity of SURE-P site and non-SURE-P site over the same period
4. For quality of MCH services: Client satisfaction exit survey
Long-Term
1. Reduced maternal mortality ratio
2. Reduced neonatal mortality ratio
Data
1. National data sources e.g. NDHS (national demographic and health survey)
2. Verbal autopsy with WDCs


Situation
Targetmetrics by 2015
Inputs
Activities
Outputs
Outcomes — Impact
B) Supply of Kits
12. Supply midwives & CHWs with outreach kit to provide handy tools for skilled delivery even at home
C) Strengthen PHC facilities
13. 500 facilities to cluster around 125 general hospitals for prompt referral
14. Upgrade 500 PHC facilities, 125 general hospitals, mobile clinics vans and boats
15. Procure standard basic health packages to ensure
Data
11. Document review to verify supply of outreach kits to midwives and CHWs.
12. IDIs with SURE-P programme manager about cost of kit supplied to CHWs/ VHWs; cost of facility upgrades.
13. Records review and IDIs with heads of facilities to verify upgrade of facilities
14. Records review to verify cost of supplies, commodities and equipment.
12. Midwives and CHEWs issued kits to discharge their roles, including skilled delivery.
13. Improved clustering of PHCs with general hospitals
14. Facilities upgraded to ensure high quality MCH services
15. Commodities & appropriate equipment are available to assure high quality service delivery
Data
10. IDIs with CHWs& midwives about supply of outreach kits.
11. Inspection visits to facilities to verify that clustering of facilities promote prompt referral
12. Visit facilities to inspect infrastructural upgrade.
Visit facilities to inspect availability of appropriate supplies /equipment for quality MCH services
Short-Term
7. Increased №s of skilled delivery at health facilities and even at home
8. Increased early identification of risk factors/ emergencies for referrals to general hospitals.
9. Increased referral of complications from PHCs to general hospitals.
Data
6. Documents review i.e. HMIS data of skilled deliveries in health facilities and at home.
7. Documents review i.e. HMIS data of trend of identification of risk factors & complications.
8. Documents review of HMIS and registers of general hospitals (receiving centres for the referral of complications from PHCs).
Intermediate
1. Improved efficiency of health system to facilitate achievement of MDGs 4,5 and 6
Data
4. Suggestions are welcome Re: data for efficiency of health system in achieving MDGs
Long-Term
1. Reduced maternal mortality ratio
2. Reduced neonatal mortality ratio
Data
1. State and national data sources e.g. NDHS (national demographic and health survey)
2. Verbal autopsy with WDCs


Situation
Targetmetrics by 2015
Inputs
Activities
Outputs
Outcomes — Impact
DEMAND COMPONENT
A) CCT
16. Train WDCs to accurately identify beneficiaries of CCT in their communities
17. WDCs and resident VHWs identify beneficiaries of CCT and refer them to PHC for enrolment.
18. Head of PHCs issue clinic cards or other means of verification to beneficiaries
19. Beneficiaries provide proof of entitlement to receive payment in the community verified by head of PHC.
20. Pay beneficiaries CCT as incentive to register for ANC, for skilled birth attendance, for attending post-natal care.
21. Pay VHWs and TBAs CCT after they mobilize clients to enrol for CCT, use of ANC and ensure women deliver in presence of skilled attendant and use post-natal service
22. Pay CCT via a bank, mobile transfer or WDCs
16. WDCs are trained to identify CCT beneficiaries
17. More pregnant women mobilized to use MCH services in target communities.
18. Beneficiaries are paid CCT as incentive for using MCH services.
19. VHWs and TBAs paid CCT for mobilizing clients and ensuring service utilization.
20. A verifiable CCT payment system is in place (Bank, mobile transfer etc.)
Data
13. Review training report of WDCs
14. Facility HMIS data of use of MCH services
15. Review facility CCT trend register & personal health cards of CCT beneficiaries
16. IDI and exit interviews with pregnant women
Continued on pg.5
Short-Term
10. Improved identification of CCT beneficiaries.
11. Equitable access to quality MCH services both at health facilities and via home visits
12. Improved satisfaction of beneficiaries with MCH services
Data
9. Review HMIS data and registers of MCH for clients addresses
10. IDIs with heads of facilities to verify trend of access to MCH services.
11. FGDs and exit interviews to assess client satisfaction with services
12. IDIs with VHWs/ TBAs on coverage of MCH services and home visits
13. FGDs with family members about access to services
Intermediate
1. Increased coverage of MCH services.
2. Increased utilization of MCH services by pregnant women (ANC, skilled birth, post-natal care and immunization).
Data
5. Review facility MCH registers for trend of coverage of services e.g. increased client registration.
6. IDIs with heads of facilities to assess changes in service utilization.
7. IDIs and exit interviews with service users.
8. Document review of annual reports of trend of coverage of MCH services following SURE-P programme implementation.
Long-Term
1. Reduced maternal mortality ratio
2. Reduced neonatal mortality ratio
Data
1. State and national data sources e.g. NDHS (national demographic and health survey)
2. Verbal autopsy with WDCs


Situation
Targetmetrics by 2015
Inputs
Activities
Outputs
Outcomes — Impact
Data
Data
CCT
15. IDIs with community leaders to verify training of WDCs
16. IDIs with heads of facilities and inspect means of verification of CCT payments.
17. Documents review of CCT payment to pregnant women, VHWs and TBAs
18. IDIs with heads of facilities to ascertain bank and mobile payment of CCT.
COST (SUPPLY SIDE)
1. Cost of recruiting, deploying and training midwives, CHWs and VHWs.
2. Cost of drugs, consumables and equipment supplied to health facilities.
3. Cost of infrastructural upgrade, transport etc.
COST (DEMAND SIDE)
1. Cost to the programme of implementing CCT.
2. Cost of administration of programme.
3. Cost to households of accessing and obtaining services e.g. cost of obtaining ANC, skilled birth attendance, and postnatal services
17. FGDs with CHWs and VHWs/TBAs on remunerations
18. Documents review of HRH remunerations
19. IDIs and exit interviews with pregnant women about cost of obtaining MCH services
20. FGDs with family members about cost of obtaining MCH services
21. Suggestions are welcome Re: data for a verifiable CCT payment system