Community Engagement in Public Sector Healthcare

PATHS2 Qualitative Baseline Research Report

Kaduna

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Partnership for Transforming Health Systems (PATHS2)

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Contents

Acronyms

ACED	Assistant PHC Coordinator- Essential Drugs
CIMCI	Community – IMCI
CWC	Child Welfare Committee
DRF	Drug Revolving Fund
HAC	Hospital Advisory Committee
HC	Health Centre
HMC	Hospital Management Committee
HMIS	Health Management Information Systems
IMCI	Integrated Management of Childhood Illnesses
JCHEW	Junior Community Health Extension Worker
KADSEEDS	Kaduna State Economic Empowerment and Development Strategy
LGA	Local Government Area
LGSB	Local Government Service Board
MCH	Maternal and Child Health
MO i/c	Medical Officer in Charge
NPI	National Programme on Immunization
OIC	Officer in- Charge
PATHS	Partnership for Transforming Health Systems
PLACO	Participatory learning and action for committee ownership
PHC	Primary Health Care
PHCC	Primary Health Care Coordinator
PHCDA	Primary Health Care Development Agency
SDSS	Sustainable Drugs Supply System
SHC	Secondary Health Care
SMOH	State Ministry of Health
SMOLG	Ministry of Local Government
SRIK	Support to Routine Immunisation in Kano
TBA	Traditional Birth Attendants
TOT	Training/Trainer of Trainers
VHW	Volunteer Health Workers

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Nagla Bashir

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Executive Summary

In general the data presents a positive picture of a diverse, vibrant and active civil society, concerned about health issues and willing to engage with government and service providers. The data also indicates a willingness on the part of service providers to work with community structures to improve the health status of the population; most committees have a good working relationship with their local facility.

The data does indicate a limited sense of *entitlement* amongst the community. Necessarily interventions need not only to facilitate *voice*, but also focus on building a sense of entitlement; a right to quality services.

There is a widespread perception that facilities are poorly maintained, staffed and capitalised by *government;* with implications for work to strengthen short route accountability. Where facilities themselves do not have the capacity to be responsive, there is a danger of creating antipathy between community and facility, rather than building on constructive partnerships to demand long route accountability. In many cases PHCs are already voicing their need for support to Local and State Government. PATHS2 support to committees will need to consider how to capitalise on existing structures to encourage greater responsiveness in a system with multiple and complex accountability failures.

The lack of a sense of entitlement, together with heavy influence of traditional elites may explain the present narrow conceptualisation of committees' remits. The data describe a predominant focus on 'sensitisation', community mobilisation for immunisation and minor infrastructure improvements. Whilst committees do actively lobby government for increased support for facilities, there role in addressing complaints or holding the supply side to account is extremely limited.

Committees do to some extent provide a conduit between communities and government. However, they do so in a way that reinforces existing power relationships with committee composition strongly reflecting existing informal and formal ('traditional' and 'political') power structures. Officers are generally appointed by, and constituted from existing male elites. There is little active canvassing of community opinions and the voices of women and the poor are rarely heard. Information flows one way, from committees to community, with a strong focus on urban mature males. The involvement of women is generally tokenistic, often assuming a subordinate role of

mobilisation. Committees are not active in identifying and addressing barriers to access by poor and marginalised groups. The data provides little insight into the role of CHVs, indicative of the current lack of support or acknowledgement of this carder.

For all committee types, there is a marked interplay between formal and informal, traditional and non traditional structures. These relationships are clearly of central importance to effecting change. Where support is received, it is often perceived more as a gift or act of charity from a patron, than a right. Accountability relationships are expressed in complex webs of patronage, roles and responsibilities are far more complex than a classic accountability triangle might suggest. Traditional structures have a role in both short and long route accountability with personal contacts by committee members a central determinant of their ability to leverage resources.

Whilst there are impressive examples of the capacity of some committees; administrative capacity, for example to hold and minute meetings appears far more advanced than operational capacities to develop action plans, work strategically and consult with a broad constituency of community members.

Ward and Village Development Committees have roles defined by the NPHCDA. Any intervention design must be cognisant of these guidelines.

There is good evidence that DRF and F-MCH are having a significant impact on service utilisation, with impressive examples of support from Facility Committees.

There is an urgent need to develop a sense of entitlement among both marginalised and mainstream communities, in tandem with initiatives to support voice. Given LGA capacity constraints, this must be linked to systems strengthening initiatives that support responsiveness at every level. In the current context it may be unrealistic to expect community based mechanisms that hold providers accountable to significantly improve services.

Secondary Facilities present a very different proposition than support to PHCs. The operational complexity and large catchment area, covering multiple Wards, requires a higher order of governance system than can be provided by improved community oversight alone. Similarly that the

primary support base is the SMoH and high profile political donors, necessitates a very different membership profile.

Methods

The study used a multiple case study approach. Case study method is used where the phenomena under investigation, (Facility Health Committees), cannot be easily separated from the context in which they operate. The 'case' was defined as the health facility in full local social and institutional context with particular focus on the most active committee working on health issues as identified by the facility Officer in Charge. Facilities with no active committee of any kind in the vicinity were excluded and replaced.

Multiple stakeholders were interviewed using semi-structured interview and focus group discussion guides. Interviews were administered in the preferred language of the respondent by trained interviewers recruited principally from NGOs within the respective state. Guides were developed during a 4 day participatory training and design workshop, which included extensive field testing of instruments. To minimise the likelihood and impact of normative responses an emphasis was placed on narrative accounts including stories and examples in the data. Where the respondent was female, they were interviewed by a female data collector. Detailed interview notes and in many cases full transcripts, together with field notes from data collectors formed the primary data set for the study.

Purposive sampling was used to identify facilities and surrounding communities as 'cases'. In each state 2 LGAs were selected from each of the 3 Senatorial Districts. Selection was made to ensure as far as possible a representative geographic spread, whilst including areas with known active committees. In each of these 6 LGAs the most urban (usually the LGA HQ) and the most rural (by distance from LGA HQ) primary facilities were selected to prevent any bias in favour of easy to reach facilities. In Jigawa, the study selected 5 of the 9 Gunduma across the state. Similarly, purposive sampling was used to ensure an even selection across senatorial zones, whilst focusing on areas known to have some Facility Health Committees in operation.

One secondary facility per senatorial district was also selected. The final sample comprised of approximately 30 'cases' - 12 PHC and 3 SHC in each state. In each case, stakeholders interviewed are shown in the table below. Where the individual was not available substitutions were made in accordance with these guidelines. Data collection was undertaken by a team of 4 persons in each state over a one month period.

Facility Officer in Charge / Medial Director
The chairperson of the most active committee, as identified by the facility officer in charge.
Female community member of the most active committee or CBO Chair/member
Where time allows, a female community member on another relevant committee.
Traditional Leader or Religious Leader
Female Community FGD, conducted away from the facility
PLACO Chairperson (Kano) or WDC Chair or VDC Chair. CDC Chair (Enugu)
LGA PHC Coord. or Dep. Director (LGA replaced by Gunduma or District where appropriate)
M & E Officer or Asst. Coordinator, Essential Drugs Health Education

Interviews with senior state level policymakers were deliberately omitted in this research exercise for two reasons. Firstly, a significant amount of policy background had already been captured during the 2009 state scoping exercise. Secondly, to avoid capturing likely normative responses to pre-defined semi-structured questions when administered by relatively junior staff. We envisage these stakeholders be given an opportunity to input during the FHC design process and their perspectives incorporated into the final version of this report.

Report Structure

The report has been designed to capitalise on the impact and authenticity of statements made by community members themselves. Where possible, points are illustrated with quotations rather than lengthy narrative description. The quotations selected typify the data set for the state as a whole. As such they are not simply anecdotal, but rather representative of broad currents flowing though the narrative data. Each quote used is representative of numerous other similar examples, unless otherwise stated.

From the original data set which runs to approximately 1000 pages for each State, a thematic synthesis was conducted to extract and categorise approximately 1000 key quotations. This data sub-set provided the basis for this report, which in many cases reports the findings in the words of the respondents themselves. The quotations in this report in themselves represent a resource for PATHS2 as authentic and credible raw material for advocacy.

The intended audience for this report are the FHC design team; the next task is to agree on the key advocacy issues and messages for our various stakeholder audiences. A condensed technical report, and/or possibly condensed state-wise reports may then be developed in line with our knowledge management and advocacy objectives.

To date, discussion around voice and accountability both within PATHS2 and externally has necessarily been rather abstract. These data present the opportunity to foreground specific illustrative quotes representing accountability failures- and ask the questions – 'Why has this happened?', and 'What might we do to change it? PATHS2 will use these data to ground these abstract issues in the more accessible context of the lived realities and voices of service providers and users.

Context

Kaduna state has a population of approximately 6 million, with 23 LGAs, 255 political wards. The health system has an estimated 118 MOs with only 8 Specialists. In terms of facilities, on paper there are 642 health clinics, 89 primary health centres, 1 comprehensive health centre, 12 model primary health centres, 28 secondary care centres (hospitals), 5 tertiary hospitals, 656 private health facilities and 2500 registered patent medicine shops. Due to inadequate reporting and monitoring systems, the SMoH does not have a coherent and up to date picture of the level of functionality or staffing of specific facilities.

Structure and organisation of state health sector

As in other states, the main public sector health providers are the State Ministry of Health (providing mainly secondary health services) and the Local Government Authority (providing mainly primary health care services). Coordination between the various MDAs involved in the provision and regulation of health services presents a major challenge.

Revised Classification of Facilities, Kaduna

Facility type	Geographical or Population indicator
Health Clinic	Serving a community or settlement with a population of around 2,000
Primary Health Care Centre	Serving a political ward with a population of around 10 - 30,000
Rural Hospital	Serving a rural LGA with a population of around 200,000 – 300,000
General Hospital	Serving an urban or peri-urban LGA with a population of around 300,000 – 500,000

According to the 2008-2011 Medium Term Plan 'The SMOH and the LGA appear to work in competition (with duplicated services within a resource constrained environment) rather than as complementary public sector agencies. Links with the private sector is even more tenuous and tend to be on ad hoc basis.'

There is an acute shortage of medical, nursing and other health staff especially at primary health care level; additionally, the supply of drugs to facilities is irregular and ineffective; essential drug items are often out of stock in public hospitals, and PHC often without Government procured drugs. There is no effective D+E scheme in place and the FMCH policy is seriously constrained.

In addition to structural deficits within the MoH, there are similarly significant challenges facing the state. A very significant proportion of the State budget is allocated to projects initiated directly from the office of the Governor (one being Free MCH). The remaining budget to support routine service provision is inadequate, and historically only a proportion of this is actually dispersed. In early 2009 various factors combined resulting in a budgetary crisis in the State which may have serious implications for the potential to co-fund initiatives, and for the sustainability of planned interventions.

Health status

According to the 2008-2011 Plan 'Kaduna state has unacceptably high mortality rates and burden of diseases profile. In 2003, the infant mortality rates (IMR) was 115 per 1000 live births; under-fives mortality (U5MR) was 205 per 1000 live births and maternal mortality ratio (MMR) was 1000 deaths per 100,000 live births. More alarming is the fact that these figures represent a worsening trend over the previous five years. Corresponding figures for 1999 were 91, 191 and 950 respectively.'

Table of Health Indices (Source 2009 AOP)

Health Indices	**Kaduna**	**Nigeria**
Infant Mortality Rate (IMR)	115/1000	115/1000
Maternal Mortality	1000/100000	1000/100000
Under 5 Mortality	205/1000	205/1000
Doctor : Patient Ratio	1:37,500	1:3570
Nurse : Patient Ratio	1:4, 230	1:590

Facility Health Committees

The central institutional building block upon which to build stronger short route accountability in the state are FHCs, which are broadly supported by government, and have an established presence in key LGAs. The policy environment is positive; with the 2008-2011 MTP and 2009 AOP making a clear commitment to the strengthening and scaling up of both FHCs and Community Health Volunteers.

Under PATHS1, 8 selected FHCs in *each* of 6 of Kaduna's 23 LGAs were specifically strengthened though capacity building. Moreover, across the entire state every PHC and secondary facility *Officer in Charge* were required to establish FHCs under the Kaduna Facility Health Committee Strengthening Initiative, in line with the Kaduna Guidelines on FHC[1]. The status of these (and indeed the 60 PATHS1 supported FHCs) is largely unknown[2]. Under PATHS1 monitoring and supervision of FHCs was conducted centrally from the SMoH, an arguably unsustainable approach given the number of PHCs in the State (approximately 900). Detailed Training and Operational manuals are in existence, although few of the original trainers or TOTs remain in post.

Selected points from the Template for FHC functions under PATHS 1 in Kaduna State

FHC Members are to :

- Be selected following specified criteria listed in a template
- Supervise of DRF functions of the health facility
- Build Linkages with LGA e.g. posting of staff
- Oversee the activities of the Officer in Charge (OIC) and other staff of the health facility and provide them with the necessary supporting environment to function properly.
- Meet once every month to review activities of the health facility.
- Manage SDSS programme
- Keep community involved with the financial status of SDSS
- Issue appropriate sanctions to erring officers via appropriate authorities
- Lobby Policy makers to support health projects
- Ensure that community members have access to health irrespective of whether or not they have money to pay
- Use appropriate sub-committees to effect changes at the facility and community levels

The Community is to:

- Assume ownership function position in relation to health facilities e.g. own the SDSS scheme
- Complement the efforts of the LGA to carry out minor maintenance work on the facility
- Actively engage in activities as may be required of them by the FHC and the LGA
- Ensure proper functioning of the FHC
- Supervise the activities at the facility through the FHC

1 Operational Manual For Facility Health Committees In Kaduna Primary Health Care Level

2 The moribund Kaduna Demand Side Coordination forum inaugurated in 2007 reports 152 'communities covered by FHC' in 2008. The PATHS2 baseline survey will provide additional data in this regard.

The PATHS1 handover notes state:

".. with PATHS support PHC Facility Health Committees were revitalised...committee members were trained on: involving the community in health and increasing their voice; increasing access to services and reaching the poorest; improving the health facility, and improving facility performance; and mobilising finance and other resources. Training also focused on the FHC's role in management of Sustainable Drugs Supply Systems and in ensuring the transparency and accountability of the Free MCH programme. This initiative provided opportunities for communities to engage more actively in the management, delivery and monitoring of quality health services"

The capacity remaining on the ground has until now been unclear, with SMoH monitoring having stopped some time ago, although some details will have been captured from PPRHAA and ISS, the reviews undertaken by PATHS2 indicate these data are not well utilised.

Findings

Overview

The data indicate a vibrant civic life within communities, and despite many shortcomings FHCs have clearly been adopted as important and legitimate structures within this context. There is clearly a solid foundation upon which to build further capacity. The extent to which the State Ministry of Health has been able to embed these committees within existing accepted structures presents both challenges and opportunities. Moving forward we are presented with the opportunity of building on well respected and established structures together with the constraint that many of these structures replicate and reproduce existing unequal power relationships, serving to further marginalise a number of groups, particularly women.

Attitudes to government health care provision

Taking the data set as a whole, we see an alarming picture of chronically under resourced services, yet the community interviews present surprisingly few criticisms regarding the quality of services. Facility Health Committees regularly report deficiencies in staffing, infrastructure and drugs, but rarely express direct criticism of government. Despite the scarcity of critical comments, notable exceptions do appear thought the data.

> "these PHCs are not adequately taking care of by the government. It is the government's responsibility to provide the needs of the facilities. These diseases are sometimes new ones coming into the community and there are no facilities to take care of people. People want to support government but the people are not heard. In the world today, the most important things are health and wealth .The government will enjoy its people when health care is provided." (trad leader) (Kad15)

There is a common perception that things are getting better over time; however, there is often an unwillingness to publically acknowledge problems and challenges, at least in the public sphere. This is a complex phenomenon requiring more detailed ethnographic investigation. The many factors in play include:

- Taking a historical view, the development of the Nigerian state through for example, exploitive colonial regimes has not lead to the development of shared notions of a 'welfare state'[3], resulting in low expectations from state structures.
- A legitimate fear of repercussions from complaint, from being denied treatment at the clinic concerned to more serious repercussions from powerful formal and traditional actors.
- The deeply engrained and extremely hierarchical traditional structures clearly defining social norms around who has a right to voice complaints, how and when. And, who has entitlements to what and when.
- Limited individualized notions of the consumer-client relationship in relation to public services. A notion that has only relatively recently emerged, primarily in 'mature' northern democracies.
- A resulting lack of self efficacy in the population; an individual's position in the social order clearly defines their own perceived ability to voice dissent.

> "We have never had a complaint from any community member" (female FHC member) (56)

> "There has never being a complaints/problem in the PHC. In case someone has a problem he will have to keep it to himself because we are not aware of where to lodge our complaints" (women leader) (63)

3 The historical development of the Nigerian State and implications for development has been well described in the 2003 DFID Drivers of Change Paper.

> P1:"There is no place to make complaints.
> P3: We only endure whatever nonsense comes from the workers.
> P7: We don't know any where to go and complaint.
> P6: We are in darkness we don't know. The women all agreed that they don't know where to go and lodge their complaints about happenings in the facility" (women community members) (60)

Health facilities do appear however to be a potential source of civic pride, FHCs report considerable success in mobilising labour to provide security, maintain facility grounds, and even providing orderlies (and other staff) to support the facility.

> The facility renovation is another thing the influential people did to bring changes, this renovation really made us proud as the facility is now very neat one can pick an item and eat without having any fear of infection. The emir also ensured that workers are deployed to the facility to increase manpower so that solved a lot of problems and this resulted in bringing changes in the facility" (village head)

> Talk of quite a few volunteers from the community helping out inside facilities due to shortage of staff – "most of the health workers here are volunteers from the community… this is an effort we've made to address the issue of staff shortage. (female FHC member) (56)

FHCs on the ground

Every PHC in Kaduna was required by the SMoH to form an FHC; however, the reality on the ground is extremely variable with multiple committees in existence. By far the most dominant model is indeed a Facility Health Committee formulated to be broadly in line with the Kaduna guidelines. These may have an integrated or separate committee focusing on drugs, variously named DRF or SDSS committee (SDSS being an umbrella term for DRF, D+E and Free MCH package designed under PATHS1[4]). Where separate, this will often have a smaller but shared membership with the FHC. Since this study focused on *active FHCs* the exact number of active/inactive committees will be assessed using data from the forthcoming quantitative baseline survey. A comment from one LGA coordinator may sum up the situation well:

4 See Ministry of Health, Kaduna State: Sustainable Drugs Supply System, Operational Guidelines for Primary Health Care Facilities. 2007.

> All the facilities have FHCs but only functional at the PATHS facilities" (LGA PHC Coordinator)

The fact that PATHS1 supported FHCs, and DRF capitalised operational clinics are so closely linked makes it difficult to attribute success to FHCs alone.

> "Active communities are those that operate SDSS" (M and E officer) (Kad1)

It is also important to note that FHCs are strongly associated with PATHS1, indeed many of the systems strengthening interventions discussed in the data are linked far more directly with PATHS1 than the State Government, Ministry of Health or LGA.

Beyond the facility health committee a range of other traditional and government committees exist at every level, with the division between traditional and government structures often indistinct, and shared membership relatively common. Additionally, the many committees in existence have unclear roles and responsibilities, and opaque delineations between them. Village Health Committees (VHCs) in some cases have been collapsed with the FHC. The VHCs pre-date FHCs and are largely associated with community mobilization for various vertical programs, immunization in particular. Additionally, Ward and Village Development Committees are in existence together in a few cases Ward Health Committees.

In Kaduna, **LGA Health committees** represent the highest level of community engagement apparatus, and a potentially important accountability mechanism. At present, these committees have a poorly defined role with little or no statutory power. The composition of the committees varies significantly from LGA to LGA, with an approximate average of 4 'community representatives' out of 8 members

Secondary facilities universally have a Hospital Management Board who in most cases provides oversight to a Hospital Technical Committee. Some secondary facilities also have a Community Committee; the data indicate that these often function poorly, hospital management citing lack of sitting allowances etc as the primary cause.

Composition

In general PHC FHCs have around 13 members (occasionally significantly more) and for those functional FHCs, the majority attend regularly at monthly or bi-monthly meetings. The Kaduna state government issued specific guidelines membership, which are only partially adhered to:

> Health Committees will be made up of up to 10-12 members drawn from various interest and socio-economic groups within the catchment area of the health facility. Every attempt should be made to involve women as committee members. Ideally, Health Committees should aim for at least ***one third female membership***.
>
> The following representatives will be invited to participate on the Committee.
>
> Community Representatives (Health Users)
>
> Traditional authority representatives
>
> Religious leaders
>
> Headmaster or headmistress (i.e. representative from education sector)
>
> Women's representatives
>
> Youth representative (aged 18-25)
>
> Non indigene (although they must be able to speak the main language)
>
> Representatives of less privileged or vulnerable groups (for example people living with HIV/AIDS, individuals with physical disabilities etc)
>
> Health Provider Representatives
>
> Officer in Charge of the Facility
>
> Assistant OIC

Kaduna State FHC Membership Guidelines

Whilst there are numerous examples of memberships broadly following this pattern, the dominant model is far more ad hoc. There are occasional cases of communities holding more formal elections, more commonly members are appointed by traditional leaders. The chair of the FHC may appoint members from the local area around the facility; alternatively leaders of various local Ward or Village health/development committees may appoint representatives. Whilst there are numerous instances of members praising the appointment procedure leading to their involvement, the data indicates a broad acceptance that it is the role of the local leader to appoint whoever he sees fit.

> Membership "is thorough selection on merit of hard work or accountability. Any person interested in the community can join when he/she speaks to the chairman of this committee" (trad leader) (Kad6)

> I am vocal in the community, as a result when the issue of woman participation came up, the community nominated me" (female committee member) (26)

> Some are just appointed – "I was appointed. The chairman came to informed me of my appointment as the female member of the committee" (female FHC member) (84)

> "The LGA passed a paper to us that there is need to form this committee and list/set up criteria for selection of members. As the OIC, the directive is that I become the secretary…Yes the selection was the same for every member. We pass the information to the Sariki (traditional leader) who reached the other groups and at their level each group selected their representatives. However, the Sariki becomes the chairman because of his position" (OIC) (104)

> "Women help in ensuring women's issues are adequately represented. However, I think we have limited number of women involved as FHC members" (LGA HE officer) (Kad2)

Whilst there is a legitimate need to develop FHC memberships with the standing and capacity to mobilise community and government resources, the result is that presently they are not inclusive. The data indicate a common requirement for members to be of good standing in the community, but the narratives indicate predominantly people who are not only respected, but also have the ability to 'serve the community', literate and with the ability to speak English. The poor and women often do not fit into this category and there are serious questions over the potential for these facilities to meaningfully include a more representative cross section of the community. Additionally, in some cases the lack of transport allowances appear to preclude membership from anywhere other than the immediate vicinity of the facility.

Tenure

Whilst the guidelines indicate tenure of four years, the evidence suggests this is rarely enforced, and awareness of the regulation is low. Where individuals were aware, the idea of a maximum tenure was rarely supported.

> "there is limited period based on the guideline, but it's not working in these committee because everyone is committed to the committee there is no way we can change any member except if there is problem" (OIC) (53)

Main functions of the FHC

Given the fact that PATHS1 only directly supported a small proportion of FHCs in the State, and provided limited or no support to other facilities, it is perhaps not supporting that in most cases the memberships do not have a consistent understanding of roles and responsibilities. There is no universal mode of operation, but there are commonalities. Although the existing Kaduna framework presents somewhat overlapping delineations, here it is used to explore the operation of the FHC as perceived by their membership:

The main functions of the Health Committee are to:

- Support and facilitate the health facility to deliver against its remit
- Help build a good relationship between the facility and local communities
- Help increase access to services, especially by the very poor
- Be champions for community level health activities
- Act as first point of contact for all service delivery and quality improvement activities that require community input
- Monitor overall facility performance
- Help manage and monitor a drug revolving fund or system for free MCH drugs (where these exist)
- Advocate for increased government financial and other support to the facility

Membership of the Health Committee includes community representatives and health providers. The aim is for the Health Committee to develop an effective and sustainable partnership with providers at the health facility, with the Local Government Authority, with the SMOH and with other health and health-related committees in the locality.

Note that the role of the Health Committee is:

- NOT to manage the health facility on a day-to-day basis. This is the job of the Health Officer In-Charge.
- NOT to supervise the health facility providers and manager. This is the responsibility of the LGA health department.
- NOT to get involved in the clinical aspects of service delivery. This is the specialist role of the health providers.

Box 1 Operational Manual for FHCs in Kaduna Primary Health Care Level

1. Support and facilitate the health facility to deliver against its remit

This role is significantly hampered by accountability relationships between facility and LGA, which whilst unclear, effectively bypass the FHC structure. FHCs report a lobbying role rather than providing a statutory body to which both the facility and the LGA are answerable. Their requests frequently go unanswered, and unfulfilled.

> Often, the main challenges that facilities face are beyond control of committees: Main challenges include: Lack of equipment: beddings and chairs, blood pressure apparatus, staff are made to buy their own. Limited drugs especially FMCH drugs. No standby generator, sometimes we have 2 -3 deliveries (birth) at night and we are forced to used lantern to conduct delivery. The committee is incapable to do anything concerning these challenges, though we have complained to them" (OIC) (57)

> The facility faced challenges such as lack of doctor, roof leakages, wards were dilapidated and the solar fridge for keeping injections was not in working condition. About the challenges, the committee wrote to the LGA chairman but still no response…The delay of the response might be political according to the OIC." (data collector following interview with OIC) (22)

Although in the minority, the successful committees are typically those which have the capacity and connections to mobilise resources, often from politicians with some impressive results. These narratives provide good examples of what committees are capable of achieving.

> "The FHC has achieved quite a lot. They built the store for storage of medicines; they also built the injection room, labour room, septic tank, as well as water (tank stand for the storage of water) stand…The committee was able to achieve this by tasking itself; we contribute money and use it to work. In addition, we also write letters to politicians and rich people in the community, and sometimes they respond. We also use the DRF mop-up to carry out this task. Generally, we identify a problem and this is discussed in a meeting and we agree on the plan of action to take" (OIC) (Kad13)

> "[The PHC] receive drugs from two sources, the Ministry of health and PATHS. Both are gotten via the local government area. [We] set up records for the drugs before use, monitor the activities of the staff [and hold] monthly meetings [and] deposit money from DRF sales in the bank. [We] monitor infrastructure-light/water, Discussions were made at meetings to lobby the politicians especially councillors from wards and the influential people in the community... [we got] ...the provision of toilet, bed etc, [an] additional ward for delivery, [They] gave the facility 2 generator sets, benches for the clients, [and] Dug a well" (Chairman) (Kad14)

> "If there is problem in the facility that is not beyond the committee capacity, we solve it but if it is the one that is beyond us we table the problem to the Emir for further action. For example before the facility has no proper labour room and

> the issue could not be tackled by the committee so we present it to the Emir who took it to the concerned authority and now you can see the changes." (female FHC member) (56)

> "A lot of our assistance came from our wealthy members of the community and some from our politicians. In fact even the ordinary members of the community do come to us to render assistance. For example, this time we are erecting the facility pole to draw electricity, they turn out en mass to help in the digging" (FHC Chairman) (Kad4)

2. Help build a good relationship between the facility and local communities

There was some limited evidence for FHC's role in building links with communities, beyond mobilisation for vertical programmes. Their limited role in facilitating this engagement to some extent reflects the unwillingness of communities to complain or voice dissent around government services. However, a number of positive examples exist, particularly in increasing transparency of capitalisation and drug discernments. These have become politicised particularly given the difference between rhetoric and reality in relation to Free MCH drugs, with non-availability leading to accusations of corruption against facility staff.

> "the committee tried to solve the problem of the free MCH drugs issue by creating awareness among the people. So accusation of the health workers by the community has tremendously reduced" (OIC)(71)

> "What I like most is that it makes me to move freely in the community. Working with the committee has given me opportunity of being accepted in this community" (OIC) (57)

A clear drawback in the reliance on traditional leaders as the primary conduit between community and FHC, and in some cases FHC and LGA is that communication is beyond the control of statutory structures, and feedback to the community cannot be assured. Whilst these traditional institutions are 'formal', their functions as regards FHCs are not formalised. There is for example no routine community consultation[5], and no formalised channels for FHCs to conduit complaints, suggestions or concerns. This has particular implication for women, who often have no ability to input or complain.

> "we mainly get feedbacks from our husbands".." and mostly in the hospital during our clinic days".."our husbands get the information from the mosque" (female community members) (Kad9)

[5] Whilst PPRHAA does have a consolation component, it is not considered a formal, integrated or effective routineised mechanism in this analysis.

> We don't know [about the FHC] as we are in purdah. We need feedback through our leader" (women community members) (95)

Awareness of communities in the vicinity of active FHCs was however, high. FHCs are in part used as a mechanism to extend patronage, and it is clear there is potential motivation on the part of the members to ensure their activities are publicised. The data presents a significant number of examples of such awareness, and examples of feedback taking place in some contexts.

> "Yes, we are aware of ways people in which community get involved in FHC activities..We are aware of such committee..They always discuss the issues concerning, the health of community and the people….They have done a lot, supply of drugs, renovation of facility and the supply of water.. Yes. We know them, educated ones, honesty and cooperation." (female community members) (Kad18)

> .. "we get feedback on issues concerning the facility through our women leader", "the committee members inform her and in turn she informs us", "sometime from the village heads", "sometimes they use the town criers to tell us if something is happening" (FHC member and youth leader)(Kad8)

> "the community learns about the committee's activities mostly during market days, Friday prayers using the Imams and during naming/wedding ceremonies where our woman member interacts with her female counterpart. Sometimes we have town criers who go around informing people of our activities." (FHC Chairman) (Kad4)

The extent to which all community members might become more directly involved is open to question. The data present a number of potential barriers such as social standing, education, gender, physical distance from the facility in the context of no transport or sitting allowances. The data indicate that membership is rather restricted to high status individuals in the vicinity of the facility. This is corroborated both by data from OICs, and communities themselves.

The way in which many communities discuss the committees in abstract terms, often unaware of the name, membership or exact function indicates that they are either badly publicised, or perceived as the realm of 'other people'. The reality is likely a mixture of both, although the data does not indicate any resentment or perception of elitism; the likelihood being that these structures are accepted as legitimate and immutable.

> "Yes I know some of them they are in our community but most of them are our leader and so have position in government like the secretary is a top officer in government" (women leader) (74)

3. Help increase access to services, especially by the very poor

Despite a strong emphasis on philanthropy in terms of support to facilities, the poor a rarely discussed in the data, and where they are, often in a negative light. Importantly the Deferral and Exemption Scheme is very rarely mentioned by either the OIC, FHC or community respondents. Access is commonly discussed by committees in terms of awareness rather than ability to leave the home, access transport or afford drugs. There are however a number of examples of FHCs providing transport for clients unable to travel to hospital.

Despite limited explicit involvement in demand side access, the FHCs did go and in hand with the DRFs under PATHS1, and have in many cases been themselves credited by respondents with the dramatic increase in utilisation rates (commonly attributed to increased availability of drugs). Whilst it is impossible to separate the DRF from additional FHC efforts around community mobilisation, it is important to note this fairly common, positive perception at community level

> "The (FHC) committee is in charge of purchase of drugs for the facility; they mobilize community members to patronize the clinic instead of traditional healers or practicing self medication; they also carry out enlightenment programs around health issues; engage in maintenance of the facility." (OIC) (39)

> There has been tremendous increase in number of people who access services in the clinic" (OIC)

It is important to note that LGAs have to date had limited involvement in the DRFs and FMCH. Consequently whilst they are the natural upward accountability link for FHCs, LGAs presently have a limited ability to be responsive on what is perhaps the central activity of the FHC.

> "We are not involved in any way, no LGA official is directly involved in FMCH" (LGA M and E officer) (91)

4. Be champions for community level health activities

There is a considerable amount of evidence that FHCs are working to actively link with other community based organisations for mobilisation around health issues.

> "The committee is noted for the works it has been doing like the different projects it has implemented, also for the up-keep of peace and orderliness during immunization days which is usually a busy and tasking day.

> FHC often uses them (VDC) to pass information to the community and for mobilization on health issues." (female FHC member) (Kad12)

> "FHC often uses them (WDC) to pass information to the community and for mobilization on health issues" (Chairman FHC/DRF) (Kad14)

5. Act as first point of contact for all service delivery and quality improvement activities that require community input

The data contain surprisingly few references to PPRHAA or ISS, only a handful in approximately 1000 pages of transcripts. It is difficult to make inferences from an absence of data, but this is clearly an issue worth of further investigation. There were however a small but significant number of examples of FHCs operating their own QA mechanisms via spot checks, indicating an impressive level of autonomy and confidence.

> We normally visit the hospital at odd hours to see what is happening with the view of trying to address the issues" (female Hosp DRF committee member) (78)

The data present a mixed picture of the utilisation of suggestion boxes. Community members report their existence, and in some cases that they are used. They also report that the required literacy is a problem, particularly for women. Suggestion boxes were a key component of PATHS1 Voice and Accountability interventions, explaining the consistent references in the narratives. Interestingly, the vast majority of references came from OICs, with very few community members or FHCs mentioning their existence. There were however a small but significant number of positive exceptions, both of communities using them and of more than one FHC reading them.

> " at... committee meetings[me mostly discuss health related issues like ANC, deliveries, immunization and staff behaviour towards patients and readings of all the complaints in the suggestion box" (OIC) (53)

> A suggestion box is provided in the facility premises where we lodge our complaints but this box is mainly for those that can write, those of us that cannot write go directly to the district head, ward head or any of committee member (Female FGD)

Despite the more common response:

> "We have a suggestion box and we'd open the box once a month. However, nobody has ever made use of it" (OIC) (104)

FHC's ability to respond to complaints is not significantly addressed in the data, reflecting the fact that FHCs generally do not consider this an important part of their remit. From the data we can easily hypothesise about their ability to respond however. The data indicate that a good degree of lobbing for basic issues such as drugs, staff, equipment and infrastructure is already taking place. However this coexists with an unwillingness to complain or campaign vociferously. FHCs do however report intervening around HR issues such as 'patient friendly' care and punctuality. There is clearly a potential role for FHC in quality improvement, but voice is heavily mediated by the complex political realities on the ground. Consequently, effective accountability mechanisms will be required to turn voice into agency in this context.

6. Monitor overall facility performance

Whilst committee involvement in long route accountability is more a matter of requesting than demanding, there is good evidence of a willingness to intervene at facility level. It is interesting to note that this co-exists with a usually positive relationship between OIC and facility.

> (If there is a problem at the facility) "we quickly call for a meeting to address it. For example there was a time a staff had a problem, we called him, address him, warned him and asked him not to repeat it." (female FHC member) (Kad12)

> Common issues we discuss are staff punctuality, Patience to our patient, drugs issue too are normally discussed." (OIC) (28)

7. Help manage and monitor a drug revolving fund or system for free MCH drugs

The data indicated that FHC oversight of the DRF (or by separate but linked DRF/SDSS committee) is perceived by members as a core, and possibly the primary function of the committees. It is also the task for which the majority of those that have received training have been prepared. Whilst the functionality FHCs is in general highly variable, where they are working (the focus of this study), they can clearly be very effective stewards of the scheme. What is also striking (with a few exceptions) is a dominantly positive attitude of the Officers in Charge of PHCs to their stewardship of the scheme.

> "we discuss problems facing the facility, and problem arising from both client and staff".."the committee oversees the purchase of drugs, the maintenance of the facility. The committee is in charge of supervision of drugs, its purchase and sale, it signs the form which the OIC takes to the medical store at the LGA to buy the drugs" (OIC) (Kad5)

> "If a problem comes up the committee try to solve it unless it is beyond its power. For example, the SDSS drugs were believed by the community to be for

> the free maternal and child health drugs that we are selling when it is suppose to be free, and the committee came to witness for itself what was actually going on" (OIC) (28).. For example, a community members complained that the facility staff are selling drugs that are supposed to be free, so the committee took action by asking the patients and they stationed two members to watch over our activities during sales of drugs" (OIC) (28)

8. Advocate for increased government financial and other support to the facility

Lobbying for resources emerges as the highest priority among more active FHCs. Indeed, a striking feature of the data is the important role of patronage networks and philanthropy in sustaining Health Facilities, and the role of the FHC in mobilising such resources. This serves to emphasise the common perception of support to health facilities not as an entitlement or right, but more as a cause worthy of patronage. The data also indicates implications for the role of women, often restricted to the resources they are perceived to be able to mobilise, principally sensitisation of women for behaviour change, and little else.

> "The committee members, wealthy individuals, religious and traditional leaders, but If you are a woman, you have a little influence or if you are poor, you have no influence at all. Like me now, I have no money so I do not have influence." (female community member and TBA) (Kad11)

> "they (the influential people in the community) have touched the life of this community so many ways..they have settled so many health issues..for example before, we don't allow our children to be immunized but with their advice and counselling almost everyone here submit his child for immunization.. they also..intervene when there is a problem between facility health workers and the patients.. particularly the district head whose residence is very close to the facility" (female community members) (Kad9)

Additionally we see how the FHC itself may itself be used as a vehicle to extend patronage. The data contains many references to committee members contributing out of their own pocket, creating clear benefits for the facility, but clear challenges in terms of expanding membership to be more representative.

> "we thank God, the people, see vividly the work of this committee. The committee bring drugs if unavailable. They bought buckets and scale for babies, brooms etc. The people commended the committee for the items provided" (trad leader) (Kad 6)

> "I personally inform the committee about the activities of this healthy centre, for instance, when we lack staff, equipment etc. And the information I provide

helps the committee to plan better. As a member of the committee, I join in contributing money from my salary when we levy ourselves. " (OIC) Kad13)

"FHC committee members contributed money monthly i.e. monthly dues in case something happens for example we use part of the money to fuel the vehicle used today for the drugs collection from Kaduna". (OIC) (53)

Hospital Management Boards and committees

The State Government, with support from PATHS1 constituted HMBs for the 7 large secondary hospitals in the stat and HMC for the smaller hospitals. Both organs are constituted to include community representation; however the Gazetted guidelines differ from those proposed by the SDSS guidelines. Predictably the reality on the ground presents a mixture of the two and the data indicate varying levels of citizen representation, and very limited community participation (other than mobilisation for vertical programmes). This is not to say they are ineffective and positive examples are consistently presented in the data, particularly around civil society (in the broadest sense) involvement in hospital affairs and lobbying:

Most of the committee members (of the hosp management board) are politicians and with their connection they go out and seek support on behalf of the hospital" (OIC/medical director) (50)

It oversees the entire activities of the hospital… But what it cannot do is referred to the Ministry of Health" (OIC/medical director)

The usual decisions that the board takes which if properly utilized bring development to the hospital. We do not have to come to the ministry; we sort it out as they are all politicians [but] the board has not been given full autonomy; they still have to take permission on certain things from the ministry" (OIC/sec of hosp management board) (50)

"The HOD's report to me as the chairperson of the Technical committee and bring forward their observations, request and suggestions. A memo is now drawn up and which I present at the Board meeting. Issues that couldn't take care of at the technical committee meetings are referred to the HMB Meeting for further deliberation and ratification" (Hosp OIC) (77)

The HMB/Cs clearly has an important oversight function, and unlike FHCs, may utilise state funds to support minor improvements.

> "The committee goes round the facility to inspect the facility and try to assess cleanliness, projects and sighting of equipments. If there are repairs to be made, the committee go to the sites to see for themselves" (Hosp OIC)(77).

> The Board "give approvals of purchases as long as it is within the Board limit. The ones above the limit of the board are sent to the state ministry of health…The response is usually positive when the Ministry realise we are trying to bridge a gap" (Hosp OIC) (77)

The data however present few examples of more meaningful community engagement, beyond involvement in vertical campaigns.

> Hosp management boards also get involved in awareness raising/community mob (as FHCs seem to do) – "The board participated in the awareness raising on polio exercise, we called for meeting of the leaders and also the community at the hospital OPD" (hosp management board member) (65)

The role of traditional structures

The interaction of formal and informal, traditional and non traditional structures and relationships is of central importance to effecting change in Nigeria. Accountability relationships form complex webs of patronage, roles and responsibilities far more complex than a classic accountability triangle might suggest. Traditional structures have a role in both short and long route accountability. The data provides a number of consistent examples.

> There most influential out of the people I earlier mentioned are the two religious leaders i.e. the Imam and the pastor. They try always to use the word of God in convincing the community on issues and the people hear and respect their talks, so they are very influential. The leaders too, the Emir the district heads and word heads are all influential.

> "[The influential people are] the committee members, wealthy individuals, religious and traditional leaders, but If you are a woman, you have a little influence or if you are poor, you have no influence at all. Like me now, I have no money so I do not have influence." (female community member and TBA) (Kad11)

> "There was a time when patients complained about the way some of the workers behaved aggressively to them, so I came personally to see the OIC. A few weeks later, the same complainants came to me again so I got fed up and directly went to the district head that came and addressed all the workers. He threatened to take the matter up to the state ministry of health that was how we were able to stop the harassment the patients faced when they visited the facility" (village head) (58)

This clearly has implications for interventions seeking to promote the agency of poor and excluded groups. In order to work with the existing structural framework, interventions must take account of the ways in which pathways of influence operate at community level. Simplistic interventions to include these groups by for example, requiring a quota of membership on an FHC may run directly against established norms that define roles and responsibilities of different socio-economic constituencies. This is not to say that norms that reinforce existing inequalities should not be challenged, but that attempts to foster change must be based on evidence, a well defined and evidence based theory of change. The following quote serves to illustrate further the way in which civic and traditional structures co-exist.

> "The poor are not heard, the poor have no government, we [traditional leaders] are the government [for them]. Like the cart pusher has no concern with government, he is after his daily bread so he complain to us and we complain to the government. In case of women; the politicians among them are influential or if they belong to the same political party with the government in power, their voices may be heard." (trad leader) (Kad15)

The important role of traditional leaders from Emirs to village leaders is a consistent theme throughout the data.

> "Those that are influential in dealing with problems in the facility are the traditional leaders of this village and the district head of Soba" (religious leader) (27)

> We have the Emir of [removed], district head, village head, ward head, LGA chairman, the community councillor and religious leaders are in influential in dealing with problems in government health facilities" (village head) (58).

> "The Emir makes sure that people living near this facility (PHC) receive treatment from it. He instructs us leaders under him to go to any community member he learnt is sick but doesn't want to go to the hospital to ensure he/she go to this facility…The facility renovation is another thing the influential people did to bring changes, this renovation really made us proud as the facility is now very neat one can pick an item and eat without having any fear of infection. The emir also ensured that workers are deployed to the facility to increase manpower so that solved a lot of problems and this resulted in bringing changes in the facility" (village head) (58)

These relationships are evident both in the way FHCs lobby and interact with LGAs, and in interactions within the FHC.

> "The person that doesn't talk much is the ward head. I think is because the traditional leader's presence is enough to make decisions for the community and as his subordinate he can't take decisions" (interesting..) (OIC) (28)

> We usually meet and agree on what we want to do, we invite village heads and agree on the budget for the activity and then we share the money. Each village head raises money from their wards through levy" (FHC Chairman) (83)

Religion provides a conceptual backdrop not only for determinants of health, but also health *systems*

> "P1:The hospital is very close to us, we thank God. It takes us like 10 – 20 minutes to get there. P2: True to God we are grateful. P3: 'May God help us and guide it for us" [Female FGD].

'The poor' are consistently compared and conflated with 'the irresponsible youth' or 'those who are not trustworthy', 'drunkards' or 'thieves'. An external perception of impotence is reinforced by emic (insider/self) perceptions of limited self efficacy among poor people. These deeply embedded belief systems will need to be explicitly addressed in supply and demand side interventions to promote equitable voice, access and responsiveness. Shifting a perception of the poor from obstacles to development, to participants in development.

> "[Man laughs] Hey! Hey!! Hey!!! This is really funny but I will answer it, the commoners [that is] the poor have no influence; they don't have the right to talk" [village head]

Gender

An accurate picture of the numerical gender balance within active FHCs will be provided by the quantitative baseline survey, however a clear picture emerging from the data points to underrepresentation of women. Tokenism and the restriction of women's inputs to a limited range of demand-side issues currently excludes their taking a role in the effective functioning of the facility itself.

> "[women play a role] to some extent: women play the role of sensitizing women in a mass campaign. The women (committee) member is always giving such responsibilities" (M and E officer)(Kad21)

> Meetings are sometimes reschedule or cancelled, but what I learnt is that sometimes I will find out that an urgent meeting was held, and I was not informed, may be because I am a woman."…and "The male members prepare an

> agenda but I am not always contacted for agenda preparation" (female FHC member) (72)

Additionally there are examples of women members being marginalized by the use of English during meetings when they themselves are not confident in the language.

> Everyone participate during meeting, but the only problem I have is my inability to communicate in English Language, so sometimes, they will be discussing while I will be looking." (female FHC member) (72)

> "I didn't know whether or not other issues were addressed because most of the meeting they do speak English and I won't understand exactly what they are discussing" (female FHC member) (72)

The data indicate a clear distinction between women's representatives who have the education and confidence to act as influential committee members in their own right, and others who, in the absence of necessary support are marginalised, unable to contribute and involved only for mobilising women around vertical campaigns.

> "The women in the group are very outspoken. I guess selection of members was more of elitist considering that they did not just pick any woman to be in the committee but those that are exposed and enlightened and this might be the reason why the women contribute meaningfully during meeting. (Kad13)

> The fact that women in this community live in purdah, of them are not influential, but we have one influential woman" (village head) (89)

> Being the only woman in the committee, I found it very difficult to relate freely with the other men. I think I would say I myself [talk the least] because of my gender, and you know they are more educated and exposed than myself, so I always get shy to talk but I'm trying now unlike before" (women rep hosp management board) (51)

> Women would have involved themselves fully in the affairs of the community, but most women here are not educated, so we have limitations. (women leader) (32)

There is however a clear acknowledgement among women of the desirability of women having a greater voice, and the potential role of women. This is however limited in scope, again largely focused around community mobilization.

> Women leaders are influential in the sense that women might even listen to their leaders more than their own husband because of the way a woman will present issues might be more welcoming to other fellow women" (women leader) (59)

Despite the many examples of women being marginalised by health structures, there were a significant number of positive examples of women working collectively, demonstrating the potential of more focused mobilisation efforts beyond the realm of immunisation. This role is often acknowledged among men, the data consistently indicating women as an important constituency as the predominant service users.

> The non influential are the poor and those that don't have concern about community development and the irresponsible youths. The women are influential because they are the ones that take care of the children so they know what the children need and they are the ones that go for antenatal and deliveries therefore all the women are influential" (village head 58)

> "They have brought changes, for example initially in this facility, the women deliver in a particular room where every passers bye can see them, but now through women intervention you can see a well comfortable structure. women that came for immunization, used to have problem during rainy season because the centre is not well covered but when the woman raised the issue to the community leaders they were able to solve the issue.

Links to external structures

There is good evidence that in active FHCs, effective links have been formed with other formal structures such as Village and Ward Development Committees and religious institutions. The membership of traditional leaders helps to support these linkages. Whilst this provides these representatives a significant amount of power to set agendas, it also provides an important link into a broader constituency of stakeholders. Primarily however, these linkages are used to facilitate vertical public health campaigns, rather than to improve short route accountability functions.

> "The (FHC) committee is linked with local bodies where feedback is channelled. They have links with the word development committee (WDC) and a community based committee called "Fityanul Islam". (female FHC member) (26)

> The Ward Development Committee (WDC) is used as a linkage between the ward and the PHC department…- PHC has staff to liaise with ward focal person. The VDC links up with WDC and WFP (Ward focal person) who links up with PHC dept (LGA)" (LGA PHC Coord) (36)

Whilst traditional (formal and informal) structures are well linked in to FHCs and civil society participation is high, there was little evidence of involvement with Local or State level NGOs.

The role of LGAs

The original Kaduna guidelines clearly envisage that the LGA would be the primary reporting authority and there are a significant number of examples of usually ad-hoc contacts between FHCs and the LGA. The data present a mixed picture regarding the results of this engagement with numerous positive outcomes, but more often disappointment. The lack of a formal structure to manage this interaction comes through clearly in the data. Responses from LGA are similarly un-strategic, often depending on the tenacity, persistence and influence of the FHC, although some LGAs report inspecting the meeting minutes during PHC supervision. FHCs spend at least as much energy on mobilising local resources than lobbying the LGA for assistance.

> The main achievement of this facility development committee is on forwarding of problem to the LGA for the facility general renovation. Therefore the achievement is that the renovation is part of this budget but we are yet to see it done…The renovation issue was achieved through writing of letter to LGA and we followed it up until when it is included in the budget. They are yet to come to do the renovation as you can see there are lots of leakages in the facility…I am part of the committee and wrote the letter to the LGA. The committee chairman and the ward head went to present the letter to the chairman Soba LGA. The chairman of our committee talked on our behalf and stated our mission, the LGA chairman welcomed us and collected the latter and endorsed it." (OIC) (96)

> "the recent (FHC) meeting discussed on how to expand the facility as you can see yourself how the population is so crowdy…We have decided and plan to carry out some advocacy to the chairman of the Local Government, Emir and even the Governor" (female FHC member) (Kad12) ... "We have not been able to get government to expand the clinic, though we have written them but no response yet" (OIC) (Kad13)

> [The is] no organized feedback from FHCs to LGAs "except when they have problems" (LGA PHC Coord) (36)

> "The FHC report to us through writing or verbally, it is documented in terms of complains but beyond that we do not coordinate their activities." (LGA M and E officer) (66)

There are exceptions however, although not corroborated at least one LGA had at least a theoretical mechanism for interaction with FHC which may serve as a model.

> "In almost all the health facilities, there is a suggestion box and people lay their complaints through that means. We hold monthly meetings with the 13 Ward Focal Persons (WFP) and LGA team and this is a forum where such issues are brought and discussed at the meeting e.g. the immunization days. We have had some cases brought to us and resolved especially issues around health workers treatment of patients. The FHCs are also good at coming straight to the LGA to lay their complaints and we always resolve such issues as much as we can. They also go/channel their challenges through the ward heads who then go to the Health Education unit to lay complain e.g. like when there was an outbreak of cholera, they send letter to the department through the ward head. We plan and we intervene on that issue. Another example is a case when in a particular hospital, where a woman was charged to pay for free drugs; she channelled her complaint to her husband who then came straight to the LGA. We had to investigate the report and when it was found out, a warning was issued to the offender" (LGA health education officer) (68)

LGAs were also asked about the extent which there is public of civil society involvement in budgeting and policy making. With the exception of local councillors who are reportedly involved in the process, the responses were unanimously negative, including from the LHA Health Committee.

> The community can't have access to our budget because it seems to be politicized... The disbursement It's never made public" (LGA M and E officer) (100)

> no one is involved in budgetary matters as such matters were always kept secret and to him, he had no idea how the public can have access to budget issues as disbursement is not made public. Little information might get to the public through the traditional leaders or the media he stated" (LGA health committee member) (29) .

Local Government Area Health Committee

The LGA-HC has clear potential as a body both for civil society oversight of LGAs, and as a mechanism to ensure LGAs respond to FHCs effectively. The exact role of these committees was not clearly reported in the data, indicating their present marginal status and unclear remit.

> "The LGA HC (LGA Health Committee) is made up of the LGA chairman, DPM, Emir and PHC unit, however it is not functioning as it should be. It is only the PHC unit that deals with issues if there is any. The work of this committee is abandoned to it" (LGA M and E officer) (66)

> Membership of the LGA health committee is constituted by the HOD and it comprises of unit head, youth leader and women leaders and the traditional leaders…we operate based on feedback that we receive from the facility and community (Kad19)

Secondary Facilities

There were very few mentions of any links between PHCs and secondary facilities; one can only assume that these links are limited or nonexistent. This would be explained by the differential jurisdictions, State Ministries supporting Secondary facilities and LGAs largely supporting the Primary sector. The data did present references to traditional leader's involvement in some Hospital Management Boards and Committees, presenting a potential conduit for information sharing. One would have hoped to see evidence of issues such as referral, particularly for EoC being discussed.

Interestingly there was virtually no mention of quality of care at secondary facilities in the data, again likely reflecting limited perceptions of entitlement. One Medical Director succinctly describes how committees might be improved at secondary level.

> "The committee should hold regular meetings with regards to health issue, it should manage funds for repairs of the hospital judiciously and leave it doors open for those who are interested in their activities Where there is a complaint, the complainant must be allowed to hear the verdict of the committee. It should address Inadequate staff and no good pay to attract doctors to the village. The government should do something" (Medical Director) (Hospital Management Improvement Committee) (87)

State Government

The data contained few references to the role of, or support from the State Ministry of health beyond training, this despite the fact that under PATHS1, a team from the SMoH was tasked with FHC supervision. Further support to the development of FHCs will have to carefully consider the capacity and potential role of the SMoH. The procedure under PATHS1 of a number of senior SMoH staff conducting extensive state-wide travel for FHC supervision is clearly not sustainable, and is conspicuous by its absence in the data.

The State government support is described predominantly in terms of training, with a central focus on training for SDSS/DRF and (less frequently mentioned) on the formation of FHC. In reality training support is more often described as being provided by 'PATHS', with typically 3 or 4 members of committees reporting receiving such training.

Annexes

Annex 1 Former Kaduna State Demand Side Coordination Forum Membership

S/N	NAME	ORG/LGA	DESIGNATION	PHONE NO.
1	Muh'd Bello F. Hajj.	Kauru LGA	PHC Coordinator	08033145838
2	Salisu Sani	NPHCDA Kaduna	Support Staff	08023436213
3	Binta Moh'd	PHC Dept Zaria	APHCC ESS. Drugs	08024773357
4	Dr. Zainab Mouhammad Idris	UNICEF Kaduna	IMM Specialist	08037850358
5	Dr. N.W. Lolo	M.O.H Kaduna	Dir. PHC Rep. Perm. Sec.	08023550630
6	Dr. Sufiyan M. B	JHU Kusaurara	Prog.Officer	08033175637
7	Shuibu Salisu	SMOH	Assist. State H/Educator	08023801251
8	Maryam I. Kure	SMOH	CHO	08059946185
9	Hadiza F. Dogo	SMOH	BI Coordinator	08035985912
10	Sarah Saleh	SMOH	IMCI Coord.	08023738886
11	Gregory Sheyin	SMOH	S.H.E	08054535481
12	Bethsheba A Halid	SMOH	D.D. PHC	08063219764
13	Jane Gwani	SMOH	Nutritionist	08028332127
14	Yakubu Gorah	KSMC	Graphic Artist	08023736013
15	Dr. Belel. A	NLR Jos	Medical Adviser	08039624149
16	Siako Alhassan	ICAP	Regional Team Leader	08077759700
17	Abdulkadir Yusuf	MOLG	DDPHC	08065768313
18	Dr. Sada Danmusa	PATHFINDER INT'l	SPO	08033001714
19	Lawal Abubakar	MOH, Kaduna	Secretary SACI	08037877797
20	Ibrahim Turundu	KSMC	Executive Director	08033056407
21	Dr. A. M. Baloni	UNICEF Kaduna	IMM Specialist	08037850358

Annex 2: NPHCDA Guidelines on the Ward System

National Primary Health Care Development Agency: Extract from the Training Manual on the Ward Health System for Village And Ward Development Committees

APPENDIX 1

FORMATION OF COMMUNITY VILLAGE DEVELOPMENT COMMITTEE.

The members of the community shall elect persons whom they feel are trustworthy, will respect their feelings and are willing to serve them at no cost to be among the members of their development committee.

The qualities and service term of members of Development Committee shall be decided by the community.

Village Development Committee Members may consist of the following:

Elected representative of associations in the village .

Male representative.

Women' representative.

The voiceless representative.

Youth representative

These representatives will then elect their Chairman, secretary, PRO, etc. The traditional ruler or the village head shall be the patron who would be encouraging the village development committee to carry out their functions.

SUGGESTED RESPONSIBILITIES TO INCLUDE:

Community/Village Level:

The Roles of Community/Development Committee:

Select candidates to be trained as village health workers and traditional birth attendant.

Decide to take the responsibility for the remuneration of the village health workers and traditional birth attendant.

Take the responsibility for ensuring the availability of drug through Drug Revolving Fund(Bamako Initiative).

Review records of the Village Health Worker and Traditional Birth Attendant regularly.

Monitor the health status of the members of the community using the process to educate themselves and the community about incidence of diseases, births and deaths, how to prevent deaths, ensure safe deliveries by pregnant women, etc.

Monitor the immunization and nutritional status of their children.

Ensure that the kits of the village health worker and the traditional birth attendant are always correctly stocked.

Ensure that the environment is well kept, that the villages have portable water supply and VIP latrine are available and well kept.

Ensure maintenance of health centers were applicable, equipment etc.

Support health workers to solve their personal problems.

WARD DEVELOPMENT COMMITTEE COMPOSITION

The members of the committee shall elect persons whom they feel are trustworthy, will respect their feelings and are willing to serve them at no cost to be members of their development committee.

The qualities and service term of members of Development Committee shall be decided by the community.

The Chairmen and Secretaries from all the villages in the Ward.

Any other representative of women, youth or NGOs.

They should elect a Chairman, Secretary, Treasurer, PRO etc. from among them. The traditional leaders are patrons of the development Committee who should encourage the committee to function.

ROLES

Monitor the health and development activities of the Ward.

Manage drugs and finances of the Ward Development Center.

Plan accommodation for staff.

Own the health Center.

Plan and implement the health and development activities of the Ward.

Manage and maintain equipment of their health center.

Take responsibility for ensuring the availability of drugs through the drug revolving fund (Bamako Initiative).

Monitor the health status of the members of the community using the process to educate themselves and the community about the incidence of diseases, births and deaths, how to prevent deaths, ensure safe deliveries by pregnant women, etc.

Monitor the immunization and nutritional status of their children.

Ensure that the environment is well kept, that the villages have portable water supply and VIP latrines are available and well kept.

Ensure maintenance of the Ward Health Centres .

Support health workers to solve their personal problems.

APPENDIX 2

DETAIL PROCESS OF HOW TO ORIENTATE WARD DEVELOPMENT COMMITTEE

ROLES OF THE WDC

Start by requesting the WDC Chairman to ask someone to say the opening prayer;

Chairman welcomes the committee members and guests;

Chairman asks every member to introduce self;

Give the Chairman the topics for discussion;

Chairman to ask secretary to read the last minutes of meeting

Chairman introduces the topic of discussion;

Chairman asks members what it means to be on this committee;

Chairman asks members to discuss their roles as they see it while the secretary records the responses;

In most cases the roles are mixed up with the terms of reference, ask them to sort it out.

If they forget vital issues which the facilitator see as their roles ask whose role is it.

Ask the committee who would be responsible for repairing this building if wind or any destruction happen?

If drug or money is missing what would you do?

How would the committee guard against the missing of their equipment?

If the women are not attending meeting how can they encourage them?

Please do not suggest or force any role on them, it is not theirs and they will say you gave them that role.

At the end remind the Chairman to ask the secretary to read through the list again and see if they agree to all.

Tell them that you are impressed with their roles and that you would show it to other communities to learn from them. Encourage them to revisit the list always and to add new roles as need arises.

MANAGING DRUGS

Ask the LGA B.I. manager with the assistance of the ZTOs to discuss the Accountability Cycle using the B.I. procedure folder.

The B.I. manager should encourage committee members to ask questions in areas they don't understand.

Tell the B.I. manager to find another time to read through the procedure and leave a copy for them.

SELECTION OF VHW

Ask the committee the quality they would want their VHW to have .

Ask questions to remind them of qualities forgotten.

Discuss the roles of Volunteer Health Workers to enlighten the C/VDC.

Tell them to share with their Villages for future selection.