Community Engagement in Public Sector Healthcare

PATHS2 Qualitative Baseline Research Report Jigawa

28 October 2009

Partnership for Transforming Health Systems (PATHS2)

DFID Department for International Development

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
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

Acknowledgements

A substantial number of people contributed a great deal of their professional and personal time in the development and execution of this research exercise. The hard work and dedication of the field data collection teams made this report possible:

In **Kaduna**, supervised by Nkechi Ozumba:
Eng Suleiman Mohammed
Goshi Sherrif
Tonia Inen

In **Kano**, supervised by Maymay Audu:
Aisha Lawa
Aminu Mukhtar
Nagla Bashir

In **Jigawa**, supervised by Asiya Isuwa:
Aisha Zango
Jamila Ginsau
Umar Wada

In **Enugu**, supervised by Effiom Okoi:
Emeka Chukwuwuike
Esther Bialonwu-Sampson
Nneka Ude

Additionally the diligent and dedicated efforts of Ijeoma Nwaloka, Kate Norman and Oko Igado in both overseeing the process, and providing analytical insights greatly improved the final output. The four state team leaders and their respective teams also made significant contributions, particularly supporting the time consuming process of obtaining permissions and organising complex logistics.

Finally, this report builds on substantial work completed during the ‘state scoping’ exercises in early 2009. The contributions of the following consultants, whose text appears in this report, are acknowledged:

Antonia Smithies
Asiya Isuwa
Ben Rolfe
Claire Hughes
Effiom Okoi
Ijeoma Nwaloka
Kate Norman
Mini Soyoola
Nkechi Ozumba
Oko Igado
Rachel Grellier
Susanna Rance

Executive Summary

In general the data presents a relatively positive picture of an active civil society, concerned about health issues and willing to engage with government and service providers, although less so in Jigawa than other PATHS2 northern States. 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.

There is clear evidence of past policy level support for community engagement in Jigawa, with stakeholders at Gunduma level well versed in a variety of mechanisms for consultation and feedback. Whilst some of these have been operationalised, particularly at secondary level, in reality many committees exist in name only, with functionality severely constrained. The lack of past or ongoing implementation support is very evident in the many non-functional committees, the limited understanding among members of the role of these committees and the very significant elite capture in committee membership. The inconsistencies in committee type and structure within and across Gundumas are also a consequence of this lack of support. The issue requires priority attention before these become entrenched.

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. This is particularly acute amongst women in Jigawa, who appear to suffer a particularly significant degree of marginalisation.

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, their role in addressing complaints or holding the supply side to account is extremely limited.

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.

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.

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 affecting 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 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 (see annex). 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 Hospital Management Committees (The FMCH scheme is operational at Secondary Level only in Jigawa). Additionally the level

of community engagement required to operate D+E systems presents opportunities to facilitate engagement with the poor where this is currently lacking.

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 and Gunduma 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.

The operational complexity and large catchment area covering multiple Wards, make support to engagement in Secondary Facilities a very different proposition than support to PHCs. Additionally the primary support base in the secondary sector is the SMoH and high profile political donors, this necessitates a very different membership profile than for primary care.

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. These 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. The table shows the offices that were interviewed.

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.

We may consider a state wise summary table, linked to process indicators, to form an explicit baseline against which to monitor. Pending finalisation of process indicators

	Eg. Supportive and progressive LGA	**Eg. Resources available for ongoing support to FHC**	**Eg. A minimum level to support to the supply side**
Community mobilisation for public health campaigns			
Community mobilisation for quality improvement.			
Monitor facility performance, directly or via community input.			
Management, oversight or monitoring function for essential drugs, including FMCH, DRF etc.			
Advocate or lobby for increased financial, human resource or material support to the facility.			
Help increase access to services, especially by the very poor.			

Jigawa Overview

The baseline data in Jigawa presents an interesting picture, reflecting a good degree of technical capacity for community engagement juxtaposed with the limited capacity for delivering this overall. Government officials and to some extent service providers are well versed in the language of community participation, with a good understanding of how mechanisms might work. The data however provides many less concrete examples than in other States of these structures working on the ground. There are however a number of positive examples upon which to build and the State might be considered relatively 'fertile ground' for these interventions.

In Jigawa the policy environment is positive with 'Community Participation in Governance' a prominent theme in the Jigawa State Strategic Health Plan 2008-2012; and the State Health Sector has set a target of 100% of facilities with functioning Health Committees by 2010. The Gunduma structure presents significant opportunities for work on accountability, although pathways for community engagement are currently hampered by a conflict between Ward and Facility based structures, together with a lack of clarity around the role of the LGA within the system.

Facility Health Committees (FHCs) were to have been supported under PATHS1, however reportedly this support did not materialise, with significant impact on the performance of FHC in the State. This has a particular impact on committee composition. In all PATHS2 supported states, selection of members by traditional rulers presents problems of elite capture. In Jigawa the lack of clear and available operational guidelines has exacerbated the problem. FHC members are often reported to be hand-picked without any reference to membership criteria, making community representation particularly weak.

Jigawa is currently supporting the development of the Ward System under the direction of the NPHCDA. Many of these structures have however only recently been established, with many Gunduma and Wards lacking support and guidance in their establishment and operation. As currently operationalised, they do not constitute an effective mechanism for involving communities in health care delivery. At present, WDCs (and subordinate VDCs) focus disproportionately on immunisation with very limited links to health facilities (primary or secondary). In theory WDCs report to their respective LGA PHC Development Committee on a monthly basis, with reports forwarded to the Gunduma who action relevant issues. In practice this system is not operational, whilst the data do not explicitly identify the reasons for these failures, one might assume a combination of resource constraints together with very limited systems strengthening work in this area to date.

Importantly, the data indicates that some Gunduma do not have constructive working relationships with constitutive LGAs, presenting a significant barrier to systems strengthening. The complex structure and political economy of governance in Jigawa is however little understood, and presents an important area for future research.

> ''The LGA Health Department previously thought that the Gunduma was set up to take over their job and so did not cooperate with the Gunduma. The relationship is now improving. The last radio phone-in programme was done together with the LGA

> HOD Health. They also invite me to some of their meetings now" (Gunduma Director) (8)

Attitudes to government health care provision

As in all PATHS supported states, it is important to remember that public sector facilities are in most cases not the first port of call for those seeking curative care. Taking a systems approach, government services must be understood as one component of a fragmented, mixed economy of healthcare. Whilst popular attitudes to public provision are important, more detailed qualitative investigation is required to better understand the determinants of care seeking. Only in this context can attitudes to public sector services be fully understood. The data contains many examples of alternative pathways of care seeking within the data such as "They go to hospital but if the illness is spiritual or evil spirit they go to Herbalist" (CBO member). These however, do not yet provide us with a clear picture of what implications there are for voice and accountability work in communities where traditional beliefs around ill-health, social change, power and influence remain strong.

What is clear from the data is that, in common with data from other PATHS2 supported states, we see a very limited sense of entitlement amongst community members. Users have justifiably low expectations of services, a fear of reprisals if complaints are made, and in reality limited opportunities to voice complaint. Inevitably these factors impact on reporting around quality of care, resulting in surprisingly little criticism from community members given the supply side constraints. Nevertheless, perceptions are generally negative, with the small number of notable exceptions usually referring to specific areas that happen to be functioning well, rather presenting a competing, positive picture.

> ''We don't complain to anybody. Even if we do, nobody listen to us. If you complain about any staff, you will be maltreated the next you come to the hospital…. Politicians and the traditional leaders have influence. Women in this area are selfish even if they have ability to help they will not. Even if you go their house, they will not give you water ,talk less of helping you. How can they have influence if they are not ready to assist?'' (female community member) (55)

> "If you complain about anything that happens to you during your admission period they will just ask the doctor to discharge you without you getting better" (woman community member)(15)

> If you have a complaint "You don't need to tell anybody because nobody will listen to you. People suffer in silence because they don't know where to lodge complaint" (WDC member) (17)

Complaints commonly focus on staff and drug shortages. Interestingly the data in Jigawa contain many more examples of mistreatment of women by service provider than in other

PATHS2 supported states. It is impossible to conclude whether this is due to a higher propensity to report such abuse, or inferior levels of interpersonal care. It is important to note that numerous complex factors[1] mediate reports around quality of care which is notoriously difficult to compare across data sets. What is clear however is that in all PATHS2 supported states, mistreatment of female clients is common, and that women are often unwilling to openly report such abuse.

> People are saying that there are problems of drugs shortages. Unless if luck shines on you that you get drugs otherwise one will have get it from chemist also there is negligence of patients by facility staff who don't attend promptly to people and always shout at patients. ....Injustice to people in the government Hospital should be stopped. Imagine the case of a sick woman who cannot walk and they facility staff were asked to give a wheel chair to convey her to the doctor's room and they refused. The Father-in-law had to carry her. This is a bad practice in Hausa culture. (community members) (55)

> Hospital staff should be advised on how to behave to patients that are brought to the Hospital and not to be harassed as they are doing now. Both Hospital staff and sub staff of the Hospital should understand their role and responsibility as hospital personnel... (community members) (55)

> Though the situation has changed significantly compared to what it were a couple of years back. People still say that the public facilities are experiencing shortage of drugs and critical services. In the General hospital there is gross inadequacy of Doctors. The relationship between service providers and patients has not improved much. Patients have reported being mistreated, ignored and neglected by medical personnel The FMC services, cost of bed per day have been said to be costly, Consultation fee high. A simple folder is said to be costing N300- 600. (trad leader) (56)

> You know during the raining season, the staff will refuse to come to the facility in time (some will have to go to their farms before they will come and attend to you, so we have to go Kazaure which is an additional burden on us) (women comm members) (91)

> The community members have respect and praises for the facility staff because of their commitment and dedication to work. The staff attend to patients even when officially they facility has closed….Also there are side talks about DRF drugs supplied by the Gunduma. People have complaints about the prices of some of drugs as costly compared to the ones found in the chemist around them. (WDC member) (92)

[1] These may include cultural barriers presenting a normative framework where women are expected not to complain, low expectations and a normalisation of hostile treatment, or, fear of future reprisals from disgruntled staff.

Gender

It is important to consider that particularly at primary level, the majority of service users are women. From the data they reported a very significant degree of marginalisation both as service users and committee members. Even during this research exercise a number of respondents questioned why their opinions were being sought, given the little weight generally attached to their views. Whilst the baseline study cannot be seen as a comprehensive inquiry into social exclusion, the data suggest a particularly significant degree of marginalisation in Jigawa.

> When asked about who the influential people in the community are "I can't list any because I am a woman confined to home" (11)

The data suggest that poor women in particular often receive poor treatment at the hands of facility staff, with examples of women 'dressing up' in order to increase the likelihood of prompt and quality treatment.

> The nurses at the hospital "usually respect the rich people than the poor, they don't have human relation" (female community members) (29)

Women's involvement in the various committee structures is almost universally framed in terms of community mobilisation for public health campaigns. It is also interested to note that they appear rarely involved in the development of these campaigns, but rather 'summoned' to deliver them once male members have met to agree an approach.

> They don't meet often, though they don't invite me always being the only female member in the committee. Women are always segregated. . (Female D and E community Member) (20)

The data present few positive examples of women's influence, despite exceptions such as:

> "If women are in politics, are educated, better employed, and are economically empowered, they will wield influence. The few that are in these areas have changed things to the admiration of the communities where they have lived." (Female WDC member) (33).

The dominant narrative is one of profound disempowerment, with the influence of women being rated below that of 'the poor'.

> In our community none of our women have changed anything remarkable, worthy of reference, not even the wives of politicians (female WDC member) (33)
>
> Women only have influence among other women (16)
>
> [there are] no influential woman in the community because nobody will listen to you (woman community member) (99)

> Poor people do not have influence, but you know when a poor person has an influence is during the election because they want your vote, but no woman has an influence to say anything" (women community members) (29)

It is interesting to note that among professionals working on the supply side, there are often relatively sophisticated understandings of discrimination and exclusion. What is evident however, is a lack of expressed commitment or innovation around ameliorating exclusion from access and participation.

> Those who have influence in this community are title holders (traditional and religious), wealthy people, highly placed in positions authorities. The poor and the excluded people do not have any kind of influence. Women fall within this category due to their educational backwardness. This is further complicated by so called traditions and religious injunctions, which restricts their self esteem and image projection. (WDC member) (92)

With a small number of exceptions

> I was part of the meeting that decided we need a female staff that needs to see clients who come for ante-natal care, through the committee we were able to consults some parents for the release of the female. Their and then two parents volunteer to give there two daughters to study at the school of health technology, jahun. (Senior CHEW) (93)

In the context of Jigawa, with so many barriers to effective participation by women, it is likely that specific measures will be required to facilitate participation, such as women's sub committees with CSO support. Increasing quotas for female participation may not be futile, but will not meaningfully address the entrenched structural barriers o their involvement. In this context, it is important to note that NGOs and CSOs were very rarely mentioned in the data. The SAVI Jigawa CSO mapping presents more insights in this regard.

FHC on the ground

Committees in Jigawa are characterised by a lack of constancy of form or function, with the lack of recent support and clear operational guidance strongly reflected in the narratives. Despite similarities to Kano in terms of fragmentation, the data present a significantly different picture. Whereas in Kano we see a competing multiplicity of structures, in Jigawa these overlapping structures are less entrenched with little evidence of overtly competing models. LHCs, FHCs, WDCs and VDCs exist often in name only and, where this is the case substantial development work will be required. However, where committees are genuinely operational there is little evidence in the data to suggest that harmonisation or re-alignment would be politically challenging, although inharmonious relationships between Gunduma and LGA has the potential to present challenges.

> Before coming to the Gunduma I had worked in a facility, I know of the existence of FHC, HMC and DRF only. However, these committees exist on paper. They do not meet as minutes do not exist! They do not have clearly defined roles or ToR to guide their operations. The LHC functions more only during immunization and DRF scheme. (Gunduma Logistics Officer) (63)

> "Since the chairman died last year no meeting had been conducted up till today" (D and E comm. Member) (20)

> "The formation of the WDC is a directive from the top that each facility must have a committee with community representation. The Gunduma is supporting the adherence to the directive ..The membership of WDC consists of the traditional and religious leaders, most popular businessmen, TBA, local barbers and the Herbalists. The last category is included in the committee because we have instances where they have referred some patients who came to consult them to the hospital for treatment… People are appointed by the traditional leaders in collaboration with the respective facility officers and charge. (M and E officer)(97)

> No, we do not have any FHC here, the only committee known to us at the Gunduma is the WDC. Though the WDC is expected to look into all ward issues and not only health, we found out that they are not facility restricted but covered a wider area of representation".." The WDC are found in all the facilities in the Gunduma. They are responsible for ensuring successful routine immunization and ANC- ante- natal services, and the general wellbeing of the facilities in their respective communities".." The Gunduma helped in selecting the leaders of the Ward committees while the selected leaders chose the members based on the communities in their wards. The Gunduma does not micro- manage the process at that level, but give them free hand to choose the membership" …" The WDC consists of the Ward head, the headmaster, and representatives of women groups, Youth, TBA and Local barbers. It is usually people who have resources or one thing to contribute to the community's wellbeing. Those with any contribution are not included in the WDC membership. Women are always in the minority due to cultural inhibitions coupled with their low education level" (Dep Dir PHC) (96)

> - "Yes, these include: LHC, FMC, WDC, and VDC, however a number of these committees are not functional from our assessment. The reasons are many some of them because the Gunduma no longer pay the any allowances as an incentive….".

Although this report does not attempt to characterise recent history in terms of policy development, from the data a picture emerges of two separate initiatives relating to community committee establishment. In some areas we find LHCs, facility based committees primarily linked to the establishment of DRFs. Elsewhere we see the establishment of WDCs, developed both to support various public heath campaigns, and as a Gunduma initiative to respond to directives from the NPHCDA. WDCs may be more or less facility focused (many Wards having only one facility), and may oversee local DRF, directly or via a subcommittee. Many committees exist in name only and whilst the picture of dysfunctional structures is concerning, it is far from universal with numerous successful examples on which to build.

The absence of allowances, particularly where previously paid, are consistently reported as a barrier to successful operation. Whilst it does not necessarily follow that sitting allowances are a solution, the driving forces for membership and attendance should be considered.

Composition

The lack of clear guidance on LHC composition has had a significant impact on LHCs in Jigawa. Memberships of both WDCs and LHCs are not consistent with templates (WDC provided by NPHCDA and LHC by PATHS1 DRF) frequently misused or ignored. The data indicates significant elite capture and unrepresentative membership. Female membership is regularly described as 'token' with many committees having no female membership at all. Where women are included, they are often related to influential men in the community. A significant number of committees are dominated by facility staff with few 'community' representatives. Interestingly since the LHC guidelines contained in the Jigawa DRF standards make passing reference to 'barbers', we see significant numbers of this group represented on committees. In the majority of cases members are reported to be 'hand-picked' by traditional leaders. There is no standard period of tenure observed in Jigawa.

PATHS 1 LHC Membership Guidelines, as specified in the Jigawa DRF manual.

Local Health Committee

The Local health Committee (LHC) will be constituted by all PHC Facilities operating the DRF scheme

Membership

1. Membership of the LHC will be drawn from the community served by the health facility and complemented with staff of the health facility.
2. The LHC shall have a maximum of 12 members.
3. Membership of the committee will include the following:
   - Officer in Charge (OIC) of the Health Facility (is Secretary to the committee)
   - Assistant OIC (is the treasurer to the committee)
   - Representative of the youths
   - Two reputable religious leaders in the community
   - One respected female community leader who may be the market women leader
   - One respected male community leader
   - The most senior traditional ruler in the community or his Representative
   - Representative of the alternative medical practitioners (VHWs, Traditional Birth Attendants –TBAs and traditional healers)
   - Headmaster of a school located in the community
   - Representative of occupational groups (barbers, drivers, farmers)
4. ***The members of the committee will choose a chairman from among themselves***.

Functionality

With a number of structure types facilitating community engagement in service delivery, no definitive list of FHC functions is in existence[2]. The baseline findings are therefore explored using a 6 domain generic framework, developed from the stated community participation objectives of the National Strategic Health Development Framework and the Kaduna FHC Operational Guidelines, the latter perhaps representing the most coherent unified FHC model for use in PATHS2 supported states.

- Community mobilisation for quality improvement.
- Monitor facility performance, directly or via community input.
- Management, oversight or monitoring function for essential drugs, including FMCH, DRF
- Advocate or lobby for increased financial, human resource or material support to the facility.
- Help increase access to services, especially by the very poor.
- Community mobilisation for public health campaigns

Box 1. Central functions of Facility Health Committees

1. Mobilisation for quality improvement.

There is significant variation in the operational status of FHCs and even those more active FHCs provide no evidence of significant community mobilisation around quality issues. This may not represent a surprising finding since as in other states, where government accountability to the citizenry is limited, the potential impact of such mobilisation is questionable. What is consistent within the data is the use of traditional leaders, Imams and town criers for communication from committee to community, indicating that 'downward' communication, at least to more urban males is possible. Additionally, and peculiarly to Jigawa, there are very occasional references to local radio announcements and call-in shows around committee meetings and health issues. In general, although hard to quantify from these data, community awareness of structures for community participation appears limited, and arguably lower than in other PATHS2 supported States.

> "Community representatives are expected to relay information to the constituents they represent. The committee meets with the community leadership who are expected to inform their subjects accordingly. Special community occasions (naming, marriages etc) are also used to inform community members on decisions taken by the committees. Town criers are used to communicate information to the people. Women CBO rep (52)

[2] A list of functions as defined in the DRF manual may be found in Annex 1

Committees conceptualise their role within relatively narrow boundaries. Whilst responding to complaints is mentioned relatively frequently (although in the absence of any clear accountability mechanism), involving the wider community in advocacy, fundraising or similar is not taking place. A small but significant number of committees are however actively engaging in facility performance monitoring.

2. Monitor facility performance with community participation

There are an impressive number of systems for community feedback on health services, although data indicate that these are rarely used. For example suggestion boxes which are universally reported as rarely used. Occasional references are made to complaint hotlines at both Gunduma and State level. Additionally there are a number of references to SERVICOM at Secondary Level. The data indicates however that whilst senior hospital and Gunduma staff are aware of the existence of these mechanisms, there is no evidence to suggest they are functional. Jigawa presents an interesting picture of a larger number of significant mechanisms in place (Radio, SERVICOM) yet comparatively, an overall situation of fewer functional facilities; a more fragmented system with less opportunities for community engagement. It is likely that this is a function of a more coherent structure at management level provided by the Gunduma system, together with less functional community level structures, given the limited inputs into FHC strengthening and development.

> "There are no defined channels of communication/information flow between community and the committee in place. However, some community members have contacted me and made their comments or suggestions. This is not the best way to go about it. I know we have put up a suggestion box, but this too is for the literate people, what of those who can not write? We need to do something about this. " (OIC) (27)
>
> Government has used media especially the radio, town criers, religious institutions, also during community dialogue and engagements/ sensitization to communicate its intended commitments to the people. The data collected from various facilities especially on: RI, Attendance at facilities and ANC shows that the there is greater awareness and that people are getting to know what their entitlements in the facilities are. It is very possible that all these channels may not be enough to get all the people informed. The challenges of the approach have been the inadequacy of feedback mechanisms that the people can respond to the government on its commitment" (M and E officer) (97).
>
> (Feedback to community is) through announcements. The Committee informs the District Head who uses the town announcers to inform the community. For example, when the problem of lateness and absenteeism of staff was solved, the WDC informed the District Head who announced to the community that the problem have been solved and people should now attend the facility anytime of the day when they are sick. (OIC) (79).
>
> "the committee brought a lot of changes in the community, why because before the committee, I don't care attitude of health workers exist in the facility. Before the

> health facility is just like hen's house but now there are separate wards for children and male" (female FGD participant) (2)
>
> Our committee (LHC) subdivides itself into two sub-committees –one to oversee the activities of the facility (interacts with staff and seeks for their feelings, views and comments about the management of the facility) while the other oversees the general welfare of the community coming for uptake at the facility..(this community sub-committee visits the facility on their own without informing me the OIC and interact with patients asking for their comments on how they have been received and treated, the outcome is feedback to the main meeting" (OIC) (5)
>
> We focus on mobilization and sensitization of the community members during outbreaks".." and supervision of staff. We try to see that staff on duty are at their duty post. You know sometimes when they are on duty some of them don't come and you will see patients waiting" .."renovation of the health facility" has been the main achievement in the last year, "if you look at the facility it is still under renovation and it is the committee that prompt for the renovation..the committee called for a meeting and presented our decision to the local government about the wellbeing of people in the town. When they accepted to do the renovation of the facility, we then made frequent contacts and follow up to ensure implementation"(female LHC member) (4)

Despite the many examples tendered by Gunduma staff in particular, the challenge for PATHS2 will be to bring together rhetoric and reality around complaints and responsiveness. The flowing quote from one Gunduma Director is illustrative. Clearly explicit support for such initiatives is a very positive development. However, developing a responsive health system will require the combination of a sense of entitlement, ability to voice dissatisfaction and institutionalized accountability structures which move beyond unused complaints boxes and add-hoc complaints making their way to senior Gunduma officials. Again the data reinforces the perception that whilst the environment is fertile, research and monitoring will be vital to ground the discussion to grassroots realities.

> People can complain in many ways including the following:
>
> Through the WDC – individual complain to the WDCs in their wards who then present the complaints to the appropriate quarters (either directly to the health facility or to the Gunduma
>
> Suggestion box – There are suggestion boxes in all facilities. Note: Gunduma Director is not very sure of how effective this is in terms of complaints emanating from this channel that have been addressed but merely said that is an official channel of complaints)
>
> SERVICOM has been adopted in Jigawa State and has a Desk Officer in each facility where complaints can be channelled to.
>
> Phone-in Radio programmes – the Gunduma organize radio phone-in programmmes where people call to express their feelings about health care delivery in the area. (The Director however admitted that this channel is not available to some segments of the society especially women and the poor who may not have access to radio and phone.

> Phone calls – The Gunduma Director announced his cell phone number on radio and people have called him personally to make complaints. (This also has some limitations in terms of access to phone by the poor) "During the outbreak of meningitis, people called me directly to report cases of outbreaks in their areas"
>
> Community Reps of the Gunduma Board – The Gunduma Board has Community Representatives who members of the communities make their complaints to. These Community Reps take up the issues with the relevant authorities.

Whilst in theory committees should be involved in PPRHAA/ISS, these initiatives were conspicuous by their absence across the data in Jigawa. With a few exceptions, neither the committees, providers or communities discussed PPRHAA/ISS in the context of quality improvement or any other.

Resource Tracking

In all PATHS2 states there is a marked unwillingness to share budgetary information. Jigawa is no exception; government staff indicate a clear perception that their legitimate authority is not a matter open to public scrutiny. Again the historical evolution of the Nigerian state undoubtedly has significant influence here. A long tradition of powerful traditional, religious and state structures, conceptually inseparable from intensely hierarchical social structures make notions of accountability complex. Whilst we see, for example in terms of patronage, that there are clear roles and expectations of those is positions of power, this does not co-exist with a perceived right to question, voice decent or demand accountability.

> "I remember very well that Paths 1 and PRINN had supported the Gunduma Board in the development of its budget at the state level, during this time CSO/ networks were involved, but at the Gunduma level we did not involve the existing CSOs because we think they should not know the Gunduma budgets since it is still estimates. I still think that budgets are confidential documents of government" (Dep Dir PHC) (96)

Opportunities for resource tracking clearly exist however. The data present important positive examples in two key areas. Firstly the good capacity of structures with CSO and community participation to effectively managing DRF and D+E schemes in some locations. Secondly, the convincing evidence of the ability of FHC/LHCs to conduct 'spot checks' on facilities and engage with staffing issues etc. These combined to illustrate the potential for fairly sophisticated resource tracking exercises in the future. Inevitably a conservative and progressive approach will be required, but there is good reason for optimism about what might be achieved in the medium term within the life of PATHS2.

3. Management, oversight or monitoring of essential drugs.

There is a lack of consistency in management and oversight of the DRFs in Jigawa. In some cases these are overseen by the WDC directly, in other cases there is a DRF committee, either as a subcommittee of the WDC, or of the LHC. One must also consider that in many cases, there is only one PHC per ward, in which case the WDC effectively replaces the need for an LHC. The data presents a mixed picture of both active and dormant committees. In a significant number of cases respondents report that Chairman of the DRFs dominate meetings to the extent that dissent is not tolerated. There is also evidence of DRF capital funds being misused to support payment various allowances.

The lack of training and ongoing support is clearly preventing the effective operation of some committees. Members report not fully understanding proceedings, and being left out of certain meetings. This phenomenon, together with that of meetings being 'hijacked' by personal or political interests is more pronounced in Jigawa than in other states. The data also indicates that in some cases poorly managed D+E processes have rapidly de-capitalised the DRFs, or lead to the charging of above market rates. Further capacity building is clearly urgently required, together with clear guidance on where DRF committees should be structurally located.

> The chairman is the most vocal at the meetings, you must follow his views whether it is right or wrong, he will not allow you to talk. (Just look at what happens about the DRF) He just wants us to continue using the money as a sittings allowance during the meeting." (OIC) (13)
>
> Not all people are knowledgeable on issues at stake. People are different some naturally shy and quiet while others are the talking type. Others will truncate others while they are talking without any apology...in terms of who talks least, the Accountant, CHO and when the only female member is in our midst. The reason is their inability to have a grasp on issues or just shy to share their views, this may require certain level of empowerment and confidence building." (OIC)

The data indicates widespread awareness of the Free MCH programme at secondary level and interestingly, community mobilisation around immunisation appears to have increased publicity around the programme. However there were complaints that common childhood illnesses such as Malaria are often not considered to be routinely covered by the scheme.

4. Advocate financial, human or material support to service delivery

The date presents a small number of examples of facilities selling record cards, or using fees for income generation, these funds being used for minor facility repairs. More common is

facility lobbying for official funding. In most cases committees report being unsuccessful, where they do receive support this is usually achieved by a combination of personal connections, letters and 'advocacy visits' to LGA or Gunduma headquarters.

As in other states, there are examples of successful lobbying, however more frequently respondents describe unfulfilled requests and disappointment. Perhaps has a result of the limited capacity development of FHCs in Jigawa, committees far less frequently report attempts at lobbying for resources. The results of these efforts appear far more modest in Jigawa, with members and staff sometimes financing repairs from their own pocket and less frequently identifying philanthropic individuals in the community to support the facility.

> "Our problem mostly is the renovation of the health facility and we don't have materials for our daily work e.g. brooms. (Sometimes even card, we have to use our money to make them and in turns we use the profit to buy some detergents. Even the water tank I use my money to repair it and nobody is going to pay me back)" (OIC) (13)

> "There was a report from a community member that stray animals often come into the hospital premises and have been eating patients relations food. The committee took a quick action to forestall security of patients relations property in the hospital". (hosp sec) (36)

> "The committee has played key role in responding to the problems in the facility. An example of such was when the facility water source developed a problem; the committee paid a courtesy visit on the LGA chairman for intervention. The visit was fruitful as the LGA chairman provided the needed resources and the water problem was rectified and normal water supply resumed" (OIC)(27)

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

There is evidence that Deferral and Exemption schemes are operational in many facilities. There is strong evidence that where operational, D+E supports the development of links into communities, potentially strengthening accountability functions. Traditional leaders are commonly used to facilitate debt recovery, exploiting their 'powers to get people to pay'. This creates a paradox, with a dominant focus on debt recovery combined with an inevitable exposure to common barriers to access, and opportunities to feed this back to the HMBs who oversee the committee. The potential to utilise D+E structures as consultation and feedback mechanisms should be explored.

> Less privileged people have gained access to health services especially people in the remote area including women…the achievement came as a result of intensive awareness creation on the scheme…Being a community representative in the scheme we reach different groups to take the scheme to door steps of the people..achievements include: Mobilizing people in the rural areas to go health facility. Enlighten public on services available at the facility, debt recovery from deferred patients and leveraging support for the scheme from the community especially philanthropists"

> "People have a variety of places to go when they are sick; others to go the community PHC, while others go the chemist for simple sickness, others due to their financial situation go to the traditional healers because it's cheaper. However, with sensitization and awareness creation, patronizing traditional healers is gradually reducing especially with the introduction of D&E scheme." (woman CBO rep) (52)

The data does not present a clear picture of the level of functionality at PHC level, although clearly with many LHC/FHCs existing in name only, one can reasonably assume that functionality is poor. The PATHS2 quantitative survey will provide a clearer quantitative picture of the distribution of D+E schemes.

5. Community mobilisation for public health campaigns

Community mobilisation is clearly a central feature of LHC and WDC activity, with immunisation campaigns featuring prominently in the data. Whilst it's impossible to assess the effectiveness of these campaigns from the data, there are many examples indicating the positive capacity building effect of such initiatives on committee operation. Women in particular are discussed as taking a lead role in community mobilisation, with committee 'women's representatives' such as TBAs representatives used to provide a link (usually information) to women living in purdah.

Community mobilisation of this kind clearly has the potential to strengthen the capacity and legitimacy of such committees. Unfortunately it also serves to further entrench the dominant one way communication channels from Gunduma to committee to community. Opportunities should be sought to capitalise on new links being made with communities via key gatekeepers such as women, TBAs, occupational groups and traditional leaders.

Support to committees

There is no uniform model of support to Local Health Committees or WDCs. Both may theoretically be supported and supervised by the Gunduma, via the Gunduma council. The council consists of one House of Assembly member and LGA Chairmen from the normally 3 LGAs, a Traditional Leader, the ruling party chairman, 3 community representatives and the chief Imam[3]. The chairmanship of the Council should rotate between the 3 LGA Chairmen. The data present examples of supervision of both LHCs and WDCs from both Gunduma and LGA. The data also suggest that in reality, those committees that are active most commonly

[3] The guidelines also specify that one community representative should be female and provide for the additional inclusion of an NGO representative.

receive support or supervision only during ISS and PPRHAA; when these activates revive specific funding from PATHS.

> I know there were times when we at the Gunduma visit some of these facilities during ISS and PPRHAA activities. At such times technical support was provided to the committee. (Gunduma Logistics Officer) (63)

None of the committee members interviewed reported having received any specific training, with the exception of some members of the DRF and D+E committees.

Hospital Management Boards and committees

There is no one dominant systems at secondary level, whilst DRF guidelines come closest to defining a standard, the picture on the ground lacks consistency. At secondary level hospitals operate a Technical Management Committee and/or a Hospital Management Committee. HMCs were previously known as Hospital Management Boards under the Zonal system, and the terms are now used interchangeably. The DRF guidelines again specify two community representatives on the HMC, but with very limited guidance on selection [4]. In a few cases the Traditional (Emirate) Council appoints 'community representatives' onto the committee, far more commonly, one or two representatives (often 'traditional title holders') are selected by those in charge. Since women do not generally hold traditional titles, and in the absence of more specific guidelines, they are rarely, if at all represented. It is important to note that as with the Primary sector, the committees are variable in functionality.

The DRF committee reports to the HMC in secondary facilities. Some hospitals report a Social Welfare Committee, operating as a feedback mechanism for community concerns. It is unclear if these are in fact sub committees of the DRF committee; either way it suggests an interesting way to extend the D+E component of DRF which necessarily requires routine engagement with poor clients.

> As in other States, HMC/HMBs sit above various other committees) "The HMC casually oversees the activities of the DRF and D&E schemes. The committee ensures that all these schemes meet up with their respective mandates. These two sub committees provides the HMC with the prices and the price list of drugs procured. However, there is no defined procedure in providing its oversight function" (OIC)(27)

The data present anecdotal evidence of a number of feedback mechanisms in place at secondary level, including SERVICOM, suggestion boxes, a Quality Assurance unit, phone

[4] 2 Community members -one from LG in which the facility is situated, one from the larger community.

lines and Radio call-ins and PFQA. There are few consistent examples across the data set to allow triangulation, and, it is likely that these represent relatively limited initiatives. These do however clearly provide very important positive examples of potential structures, although in their present forms do not represent substantive accountability and feedback mechanisms. It is noteworthy that the entire data set presents only three references to PFQA in relation to service quality.

> "In the Gunduma secondary facilities we have put in place a complaint quality control unit, where 2 phone lines have been provided for the public to call and lodge their complaints. Some one has been designated to take such calls, document and forward same to the Gunduma for action. Other dissatisfied persons have walked directly to the Gunduma office and lodged their cases"..." Complaints received are tabled at the Gunduma council monthly meetings. Cases are reviewed, and discussed and recommendations made to the appropriate sections or units or relevant staff to resolve and report back to the council. This process has yielded some results" (M and E officer)(97)
>
> There is also a SERVICOM desk in some facilities with hotlines. The hotlines are announced over the radio for people to call and make their complaints….The different facilities also have suggestion boxes. (Although it was admitted that the suggestion boxes are hardly used) (Dep Dir Hosp Services) (7).
>
> "Though there is no clear procedure for the feedback, however, the HMC has used the Hospital open day forum to engage with the community and make known some of its activities to the community…. none of the HMC members is allowed to provide any feedback to the community, this is the way government works. (hosp sec) (36)
>
> - "The Gunduma has come up with a new innovation of tracking. It has set up a three members committee called Community client view committee (CCVC) for now only in Kazaure general hospital. The committee has been provided with 2 cell phones, while the public was provided with some cell phones numbers to call should they have any complaint or problem in the facility. Suggestion can also be forwarded to the facility management" (Dep Dir, PHC) (96) .

The Jigawa scoping report found evidence of Facility-Community Health Associations (FCHA) with 'one or two Facility staff and as many as 10 – 12 community members selected from various interest groups in the community'. It noted that FCHA lacked overall authority to bring about change at the hospital level. For a number of possible reasons, the Jigawa baseline data contained no reference to these committees. However, the quantitative baseline data will provide a definitive numerical picture of committee activity across the state.

Voice, Accountability and the role of traditional structures

The pivotal role of traditional leaders cannot be overstated. Those with traditional titles provide a central, mediating link between citizen and state in Jigawa. Throughout the data

most narratives relating to complaints or any interface between government and citizenry do so with explicit reference to traditional leaders. Similarly, where women discuss these issues, their husbands form an additional layer of authority between state, traditional leaders and themselves.

Understanding these relationships of authority in detail is beyond the scope of this study, and would require rapid ethnographic approaches to research. What is clear however is that for voice and accountability approaches to be successful, they must account for these structures. Attempts to introduce approaches founded upon individualised constructions of client-provider relationship (eg. suggestion boxes) are unlikely to be successful.

It is interesting to note that in the few instances complaints are made, an individual's status dictates which traditional leader *he* will address, with respondents reporting different points of contact from Village Leader upwards.

> People usually take their complaint to CBOs who take it up to traditional leader and the traditional leader organize dialogue with facility staff to resolve the conflict or problem (Traditional leader) (43)
>
> There is no real procedure for feedback, however, the committee has been providing feedback to the populace through courtesy calls on the community structures (traditional leaders, counsellor and village head) to cascade information to the subject. This has not been so effective as the committee does not monitor to ensure feedback" (OIC) (5)
>
> "The committee expects that community members can reach us through their traditional structures, but this has its shortcomings as not all community members can reach their leaders easily" (OIC) (5)
>
> "Through the traditional leaders and the religious leaders the district head will gather the elders in the community and then pass the information to them, while the religious leaders do same in mosques after prayers." (WDC secretary) (3)

What is not clear from the data however, is the extent to which traditional leaders genuinely facilitate two way communication between community, committee and service providers. Whilst leaders report a role in both communicating complaints and feeding back information to the community, the evidence points for more strongly toward one way 'downward' communication. Within the current FHC structure characterised by a limited focus on community consultation this is no surprise. It is however difficult to assess the extent to which a change in FHC focus would alter the likely deeply embedded norms around communication between traditional leaders and citizens. Achieving successful interventions that mobilise communities to push for quality improvement will be contingent on working effectively with these structures and consequently more research in this area is required.

Whilst traditional title holders do have a pivotal role, the data do not indicate that providers perceive an accountability relationship to be in play. The normative relationship appears to be conceptualised as between 'community' and provider, with little explicit conceptualisation of rights and responsibilities. It is likely that the limited interventions around accountability and community engagement have modified the normative framework (how people talk), without significantly altering the substantive relationship (how people act). Changing the client-provider relationship to include notions of rights and responsibilities requires substantial behaviour change, and indeed, interventions may benefit from conceptualising these issues from within a more sophisticated behaviour change framework.

Conclusion

The more integrated and coherent Gunduma system theoretically presents significant opportunities for work on voice and accountability. The baseline study presents significant evidence for this, in particular the utility of larger bodies at policy level with the potential to ameliorate or bypass barriers caused by chronic under capacity in the numerous LGAs.

The limited number of fully functional committees does however indicate a very significant amount of work required even to establish a significant number of demonstration sites at any scale. A weak supply side together with limited capacity in the NGO/CSO sector has the potential to severely impact the potential pace of change. The many barriers to the involvement of women, together with particularly poor quality of care for female clients present particular challenges. Where D+E schemes exist, however, they present significant potential to link the supply side with the realities of access for poorer populations and women. Additionally, the power of religious and traditional leaders may present both opportunities as well as barriers in developing interventions to promote community voice. As in all states however, the limited sense of *entitlement* within the community is perhaps the biggest barrier to broad based voice interventions. This will require significant communications work to address as a prerequisite to widespread mobilisation around quality issues. Where this is unrealistic, interventions will need to focus on service *access* for the poor in tandem with *voice* for those with existing access to traditional and formal power structures.

Annex 1

PATHS 1 defined LHC Key Functions, as specified in the Jigawa DRF manual.

Roles and Responsibilities in relation to DRF activities

The LHC will

Ensure the development of, and closely supervise the DRF functions of the health facility

Liaise with PHCC (in the LGA) to ensure that appropriate staff are posted to the facility.

Oversee the activities of the Officer in Charge (OIC) and other staff of the health facility and provide them with the necessary supporting environment

Meet once every month to review activities of the health facility.

Ensure that the Drug Revolving Fund for the community does not de-capitalise

by liaising with the OIC to ensure that the cash realised from DRF sales is safeguarded and that the health facility is physically secure.

Make sure that the monthly stocktaking exercise is performed

Endorse the Loss/Expiry forms as may be necessary.

Consider and approve the requisitions submitted for the purchase of drugs and then approve the release of the necessary funds

Ensure that the PHC facility maintains a bank account or metal cabinet, as their local conditions may demand, for the safe keeping of their money.

Use the money realised from other services to improve the health status of the population served by the health facility

as agreed during the LHC meetings. This is after deducting the 20% due to the local government

Report erring staff to the appropriate authorities and ensure the application of sanctions.

Keep the community informed on the financial status of the DRF, the amounts realised from service charges,

as well as on the purpose for which money is expended.

Lobby Policy makers, and undertake extensive community mobilization activities to develop projects that improve the health status of the community

members (including mobilization of community contributions towards such projects).

Ensure that all members of the community have access to health services irrespective of their ability to pay,

by effectively supporting the implementation and monitoring of deferral and exemption system.

The LGA

The LGA is oversight Agency on the operations of DRF at the PHC facilities

The LGA will

Put in place the enabling operating environment for DRF at the PHC facilities.

Monitor supervise and support the PHC facility to ensure sustainability

Execute Motivation and Sanctions of staff 2.4 The Community

Owners of the DRF scheme 2.4.1 Roles and Responsibilities The community will

Assume effective owners of the DRF scheme

Carry out maintenance work on the facility

Actively engage in some activities at the facility as may be required by the LHC

Ensure proper functioning of the LHC

Supervise the activities at the facility through the LHC