

# **PATHS**

Nigeria Partnership for Transforming Health Systems

## **Technical Brief**



## **Strengthening Voice and Accountability in the Health Sector**

**DFID** Department for  
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Development



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*Members of Babban Dodo Facility Health Committee, Zaria Local Government Area, Kaduna State in the new delivery ward for which they had leveraged funds and organised the building.*

## Strengthening Voice and Accountability in the Health Sector

### Summary

Voice and accountability really matter if health services are to be improved. Citizens need to be able to claim improvements in services; providers and policy-makers need to be accountable for their decisions and actions; and services need to respond to the ideas, concerns and suggestions of clients.

When the DFID funded Partnerships for Transforming Health Systems Programme (PATHS) started working in Nigeria in 2002 awareness of rights was almost universally low among the general public. Mechanisms that would allow clients to challenge poor quality health services were largely absent, and health providers and policy-makers lacked incentives to respond appropriately to client needs. The result was very low utilisation of public health facilities and a breakdown in the relationship between health facilities and communities.

Knowing how, when and where to intervene to strengthen citizen voice and accountability within the health sector is challenging in contexts where health systems are very weak and many issues require urgent attention.

Policy commitments to strengthening community participation in the health sector provided an entry point for working on these issues in the states supported by PATHS (Kano, Jigawa, and Kaduna in the North West, Ekiti in the South West and Enugu in the South East).

This *Technical Brief* looks at how seven different systems strengthening and service delivery improvement initiatives helped strengthen citizen participation and voice, and enhanced accountability in the PATHS states over the period 2003 to 2008. The initiatives were:

- Patient Focused Quality Assurance (PFQA)
- Peer Participatory Rapid Health Appraisal for Action (PPRHAA)
- Integrated Supportive Supervision (ISS)
- Facility Health Committees (FHCs)
- Standards of care and Patient Charters
- Safe motherhood demand-side initiative (SMI-D)
- Community Action Cycle (CAC)

A review of these initiatives carried out in late 2007/early 2008 found that involving clients and community representatives in the assessment and monitoring of service delivery (through PFQA, PPRHAA and ISS) not only helped to open up space for citizen voices to be heard in the health sector, but also strengthened provider responsiveness to client needs. Across the PATHS states there were many examples of how changes had been made in provider behaviour, or in the way health services were delivered, in response to expressed client and community concerns about poor quality services. PFQA, PPRHAA and ISS have been tested, refined and 'packaged' over the lifetime of PATHS and could easily be adapted for replication in other Nigerian states.

The review also found that involving members of the community in the governance of health facilities through Facility Health Committees led to communities challenging a variety of accountability failures, either at the health facility or 'higher up the system'. However, in a context where many Facility Health Committees have been inactive for many years, considerable capacity building and on-going mentoring support are required if these Committees are to function effectively.

Although in the PATHS states implementation of systems strengthening and service delivery improvement initiatives resulted in improved accountability of health providers to local communities, for various reasons efforts to strengthen accountability between policy-makers and communities proved more challenging. Initiatives that provided a *formal* mechanism through which citizen voices could reach policy makers (e.g. PPRHAA, ISS and CAC) seemed to offer the most potential from a voice and accountability perspective. These initiatives not only placed an *obligation* on different parts of government to listen to the voice of the people, but also introduced *incentives* to respond. In contrast, where citizens tried to influence policy-makers through informal routes (e.g. SMI-D, FHCs) there was no guarantee that they would get an audience with, or a response from, a policy-maker. These attempts to strengthen voice and accountability were prone to failure in the absence of parallel efforts to strengthen public accountability at local government level.

# Introduction

Voice and accountability (V&A) really matter if health services are to be improved.<sup>1</sup> Citizens need to be able to claim improvements in services; providers and policy-makers need to be accountable for their decisions and actions; and services need to respond to the ideas, concerns and suggestions of clients. Therefore, turning around under-performing health systems in Nigeria requires more than technical know-how. Improved governance, of which voice and accountability are a key part, is also essential.

This Technical Brief looks at how a variety of systems strengthening and service delivery improvement initiatives helped to strengthen citizen participation and voice and to enhance accountability in the health sector in states supported by the DFID funded Partnerships for Transforming Health Systems Programme (PATHS). The states were Kano,

Jigawa, and Kaduna in the North West, Ekiti in the South West and Enugu in the South East. By early 2008, there was evidence to suggest that services in these states were becoming more responsive to community needs as a result of improved accountability relationships between health providers and communities. However, for various reasons efforts to strengthen accountability between policy-makers and citizens proved more challenging.

So that other states can learn from the voice and accountability experiences of the PATHS-supported states, this Technical Brief looks at seven initiatives<sup>2</sup> that resulted in some positive V&A outcomes, and their potential for replication. It also looks at the challenges associated with working on these issues.

## *Drug store rehabilitated by the community, Kuyello PHC, Kaduna*



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1 See DFID, 2007, 'Voice and Accountability Matters for Better Education and Health Services', DFID Practice Paper, London: DFID, December.

2 Other V&A initiatives supported by PATHS, such as the involvement of community representatives in the newly-established district health systems in Enugu and Jigawa, have not yet been reviewed since these reform initiatives are relatively new.

# The Challenge<sup>3</sup>

When PATHS began in 2002 situational analyses highlighted the fact that public health services were of low technical quality, and were often inaccessible and unaffordable to those with the greatest health needs. Awareness of rights was low among the general public, and few people appeared willing to articulate their dissatisfaction with health services. Even if they did decide to complain, there were few effective formal means by which users and potential users of health services could hold providers to account for poor performance, for the outcome of their decision-making, or for corrupt practice. Although informal ways to gain redress could be used, perhaps through the traditional governance systems, or through patronage networks, these routes tended to exclude those who lacked the power and influence to draw down support.

At the level of the health facility, health providers lacked the mechanisms, incentives or authority that would allow them to respond effectively to citizen concerns. The result was weak citizen voice on health issues and poor interaction between health providers, clients and local communities.

Citizens' capacity to influence or hold elected representatives to account for service delivery failures was also weak in a political system characterised by corruption and political patronage. Even if policy-makers were pro-poor in outlook and committed to improving the performance of health providers, their capacity to do so effectively was constrained because of weak incentives and their limited capacity to monitor service delivery.

The outcome of weak voice and accountability relationships between policy makers, providers and citizens were health services that were unresponsive to the needs, views and complaints of users and the wider community. This negatively affected utilisation of public health services and health outcomes.

The factors affecting accountability relationships between citizens, health providers and policy makers in Nigeria are summarised in Table 1.

## Key Definitions

**Voice:** The ways in which citizens place pressure on health providers and policy makers to improve health services. This could be by complaining, seeking redress, protesting, lobbying or participating in decision-making forums.\*

**Accountability:** This involves measures to ensure that the person or organisation with the authority to provide a service actually delivers that service to the best of their ability. Mechanisms need to be in place for providers and policy-makers to be answerable for their actions, in other words, obliged to justify their stance or approach and to be transparent i.e. demonstrate that they have delivered. Also important is the ability to enforce a response and to use sanctions if one is not provided.

**Responsiveness:** The degree to which health providers and policy makers respond to the concerns and suggestions of clients and communities by changing the way business is done in the health sector. This may involve a change in attitude, organisational culture, systems, procedures or policies.

\* From Goetz, A.M., and Gaventa, J., 2003, Bringing Citizen Voice and Client Focus into Service Delivery, IDS Working Paper 138, Brighton: Institute of Development Studies.

3 Based on Green, C., 2003, Concept Paper on Client and Community Accountability in Health, Prepared for the PATHS Strengthening Health Management Roundtable, September, unpublished.

## *Different Types of Accountability\**

**Horizontal accountability** refers to accountability measures introduced internally within an organisation, for example supervisory systems or mechanisms for financial control.

**Vertical accountability** is where external actors hold individuals or organisations to account e.g. community leaders complain about poor service delivery or corrupt practices at their local health facility.

**Short route of accountability:** This is where citizens claim improvements to health services directly from health providers.

**Long route of accountability:** This is where citizens claim improvements to health services from elected officials or policy-makers, who then place pressure on health providers and their managers to improve services.

\* From World Bank, 2004, Making Services Work for Poor People, World Development Report 2004, Washington DC: World Bank.

*Safe motherhood community members, Jigawa*



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**Table 1: Factors Affecting Accountability Relationships in Nigeria**

Actor	Factors Affecting Actors' Accountability Relationship With:		
	Citizens	Providers	Policy Makers
Citizens		<ul style="list-style-type: none"> <li>Widespread distrust by citizens of state institutions</li> <li>Few mechanisms for public monitoring of services</li> <li>Limited performance and other information which would allow citizens to hold providers to account</li> <li>Lack of reliable independent audits</li> <li>Existence of informal payments</li> </ul>	<ul style="list-style-type: none"> <li>Weak civil society and poor track record of citizen engagement with the state</li> <li>Few mechanisms in place for citizens to influence elected representatives</li> <li>Widespread distrust of elected representatives, and assumption that they are pro-rich</li> <li>Few citizen advocacy groups who can link clients with policy-makers</li> <li>Citizen voice channelled to policy makers as part of a patron-client relationship where responsiveness is seen as a 'favour'</li> </ul>
Providers	<ul style="list-style-type: none"> <li>Service delivery not organised around client-centred approach</li> <li>Lack of provider training in rationale and mechanisms for greater community participation</li> <li>Limited provider incentives or resources to perform well or to be responsive to clients</li> <li>Poor supervision and limited overall effectiveness of internal mechanisms for enforcing accountability to clients</li> <li>Weak financial systems for handling facility income</li> </ul>		<ul style="list-style-type: none"> <li>Few incentives for providers to take on whistle-blowing role in context of political patronage</li> <li>Potentially catastrophic consequences if providers challenge policy makers</li> <li>Perceived conflicts between providers' professional associations (whose primary concerns are with protecting their members' interests) and pro-poor policy approach</li> <li>Few mechanisms in place for channelling provider views to elected representatives</li> <li>Weak institutional arrangements that favour a centralised 'political' approach to management (e.g. releases are dependent on politicians and unrelated to budgets)</li> </ul>
Policy Makers	<ul style="list-style-type: none"> <li>Poor representation of constituent views due to rent-seeking, corruption, political patronage</li> <li>Politics organised around ethnic affiliation - affecting responsiveness to selected groups</li> <li>Limited evidence base constrains opportunities to investigate citizen complaints</li> <li>Perception among policy makers that health is a low priority</li> </ul>	<ul style="list-style-type: none"> <li>Limited opportunities for performance monitoring</li> <li>Weak HMIS which would enable policy-makers to track performance</li> <li>Weak incentive systems for enhancing good performance</li> <li>Political patronage undermines attempts at performance monitoring</li> </ul>	

# Designing the Response

## *PATHS Strategy for V&A*

In 2002 when PATHS started work, health services were under-performing in all the states supported by the programme, and many issues required attention. The fragmentation of sector management among three different tiers of government was causing severe inefficiencies, and dilapidated infrastructure, lack of essential drugs and equipment, de-motivated and poorly supervised health staff, absence of clear service standards, unreliable health information, poor quality health planning and budgeting processes, and under-funding of the sector as a whole were all problems. In this challenging context, there was a danger that issues of citizen voice and accountability would be low on the list of priorities. Another challenge was that the language of voice and accountability was not being used locally, and the terms were not well understood by health providers, their managers and policy-makers. It was therefore important to find a way to progress a voice and accountability agenda in ways that made sense locally.

An emphasis on community participation in health provided an entry point. Commitments to strengthening public participation on health issues were reflected in federal and state health policy documents, and the chasm that had opened up between public health facilities and the communities they were supposed to serve was widely recognised. Yet it was difficult to know how to move this agenda forward in a context where state health systems were under-performing on a very significant scale. Within PATHS the expectation was that involving clients and communities in systems strengthening initiatives, for example in the assessment, monitoring and governance of health facilities, would create opportunities to begin to strengthen citizen voices on health and to address accountability failures.

Another part of the PATHS approach was to ensure that, wherever appropriate, health systems strengthening and service delivery improvement strategies incorporated a focus on voice and accountability, and identified effective and timely entry points to intervene.

## *Types of Initiative*

There are three key relationships in achieving accountability: provider-client/citizen; client-policy-maker; and policymaker-provider (World Bank 2004).<sup>4</sup> The focus of PATHS V&A initiatives, and of this Brief, is on the first two. The third type of accountability relationship - that between health providers and policy-makers - is not discussed directly in this paper. However, in the PATHS states, broader systems strengthening efforts with both policy makers and providers provided the backdrop for the efforts to strengthen accountability to citizens. Accountability between health providers and policy-makers should improve as internal accountability systems within the organisations that make up the health sector are strengthened. This could be via improvements in human resource management, strengthening of financial management systems, or improvements in the quality and use of HMIS data.

The seven voice and accountability initiatives reviewed in this Technical Brief can be categorised as follows:

- **Provider-led V&A initiatives:** these were facility-based initiatives that aimed to introduce a strong client focus in service delivery. Mechanisms supported in the PATHS states included patient focused quality assurance (PFQA), Peer Participatory Rapid Health Appraisal for Action (PPRHAA), and integrated supportive supervision (ISS). These were formal, government-sanctioned efforts to improve internal accountability within health facilities and local government health departments.
- **Government V&A Initiatives:** these were interventions that helped to strengthen the government's overall stewardship of the health sector, and which were intended to create a climate within which work on V&A could flourish (e.g. introduction of service standards or patient charters).
- **Joint government-civil society V&A initiatives:** these were government-sponsored mechanisms that involved a high level of community participation. The key mechanism

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4 World Bank, 2004, Making Services Work for Poor People, World Development Report 2004, Washington DC: World Bank.

supported by PATHS was strengthening of facility health committees.

- **Initiatives that established the pre-conditions for voice:** these were awareness-raising or community mobilisation initiatives that aimed to increase understanding among members of the community of their rights and entitlements to quality health services. In the PATHS states examples included an initiative to increase access to safe motherhood services, and a community mobilisation approach called Community Action Cycle.

## Assessing Impact

Assessing the results of these initiatives, in terms of achieving improvements in health service and systems outputs, is challenging. Given the range of reform activities underway in the states supported by PATHS, attribution is difficult. However, in terms of process, the establishment of a number of formal mechanisms through which clients and community members could express their views and claim improvements in health services was a positive step forward considering the near-absence of such mechanisms when PATHS started. In some instances, some communities also began to demand change via informal routes by appealing directly to elected officials and policy-makers.

Several issues are important when assessing the effectiveness of the various initiatives from a voice and accountability perspective:

- Whose voices were heard? Was this only the elites within the community, or did the initiatives capture the voices of 'ordinary people', women, the very poor and other socially excluded groups?
- At what level of the system were citizen voices heard? Was this by health providers or by policy-makers, or both?
- Were the voices responded to? Were providers or policy-makers *obliged* to respond, and did they face *sanctions* if they did not? Or were the responses the outcome of personal initiative?

The section below looks at the approaches taken, results, challenges, and instances where opportunities to increase V&A outcomes were missed. The findings are based on a rapid qualitative review of the various initiatives undertaken in late 2007/early 2008.

# Provider-led V&A Initiatives<sup>5</sup>

## *Peer Participatory Rapid Health Appraisal for Action (PPRHAA)*

### **Approach**

PPRHAA is an annual process of appraisal that involves rapid diagnosis of strengths and problem areas across key areas of health management and service delivery. PPRHAA can be used to assess the performance of health facilities or health departments. Providers and their managers, service users and the wider community all participate in the process. Peers from within the health sector facilitate the process, and health providers and managers are actively involved in the diagnosis of strengths and problems within their own workplace. Emphasis is placed on the process being a supportive, learning exercise.

A rapid diagnostic phase leads to the prioritisation of key problem areas. The results of individual facility or departmental assessment exercises are shared in local government or state summits. This leads to a planning phase where actions that need to be taken to address priority problems are agreed. The summits also provide an opportunity to identify where support from higher levels of government is required in order to tackle challenges that lie outside the capacity of the individual facilities or health departments to address.

In the PATHS states clients and communities participated in PPRHAA through the client and community views (CCV) component. This aimed to:

- Provide an opportunity for citizens to share their views on the accessibility, affordability and acceptability of services;

- To raise awareness among providers and managers of the need to hear and listen to the views of clients and the community;
- To support facility staff to develop action plans that responded to the concerns of clients and the community.

As a rapid appraisal methodology, PPRHAA was designed to provide a 'snap-shot' of citizen's views of health services. For each facility being appraised, the methodology required PPRHAA teams to carry out a small number of client interviews, two focus group discussions (one with men and one with women) within a community in the catchment area of the health facility, and a small number of interviews with key community informants. Views on the quality of services – their ease of access, their affordability and overall acceptability – were sought. Clients and communities were encouraged to suggest solutions to the problems they identified. This information was incorporated into individual facility or departmental appraisal reports.

Key community informants interviewed during the appraisal exercise were also invited to participate in the local government or state PPRHAA summits. These provided an opportunity for community

### **IMPACT**

Improved Management through Participatory Appraisal and Continuing Transformation (IMPACT) provided the framework for all management and systems strengthening work within the PATHS states. The approach aimed to get health facilities at all levels working well by strengthening essential systems, procedures and methods of management. Performance assessment through PPRHAA was the first component of IMPACT. The second component focused on support for essential systems strengthening (e.g. strengthening of drug or financial management systems). The third component focused on provision of on-going supportive supervision. The fourth component was quality assessment and recognition. Health facilities were assessed against pre-defined quality standards, and, if they reached these standards, they were accredited and received public recognition.

See PATHS Technical Brief on IMPACT for more information.

<sup>5</sup> Although the initiatives in this category are described separately, in practice the approaches were closely linked and complementary (see Box on IMPACT).



*Facility staff, PHC Zango Road, Kaduna South LGA, Kaduna*

representatives to reinforce some of the concerns raised by their communities during the appraisal stage and to ensure that these issues were addressed in the PPRHAA action plans. These events provided a mechanism through which the voices of the community could be heard by decision-makers 'higher up the system'.

## **Results**

A large number of health facilities (public, private and mission) and local government health departments were involved in PPRHAA throughout the PATHS states. PPRHAA emphasised the importance of involving citizens in defining and assessing quality of care, and developed a replicable process that both facility and community members accepted. The process helped put clients and communities 'on the map' in the states supported by PATHS, by institutionalising a mechanism for feedback. The process of joint action planning involving health providers and members of the community was new in all the PATHS states. PPRHAA laid the foundations for building other initiatives to strengthen client and community involvement in the health sector.

The qualitative review undertaken in late 2007/ early 2008 documented many positive examples of how client and community voices had been heard and responded to by providers and their managers. PPRHAA successfully developed providers' and managers' capacity to analyse the root causes of problems. It is also credited with having instilled a problem-solving culture, which resulted in the removal of many bottle-necks affecting service delivery. These new skills, combined with the provision of on-going monitoring and supervisory support by state PPRHAA teams, and, later, integrated supervisory teams, both acted as very significant incentives to 'change the way business was done'. There were also a few examples of where sanctions were used to enforce change, for example, via the transfer of under-performing staff. However, the ultimate sanctions – being sacked or prosecuted for malpractice – were rarely used by health managers, primarily because the fragmented nature of the health sector meant that managers' usually lacked full authority to take action.

## ***Community Views Make a Difference***

"We go to the community and find out their views. They say their mind; they say what they need. It is important to hear the opinion of the community. Through hearing community views you will be able to come out with a reliable solution. If you don't hear the community, you may come out with the wrong solution. If you really want to help them, you need to deliver services as per their needs. This positive view of CCV is shared across the state."

*PPRHAA State Focal Person, Jigawa*

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"Before PPRHAA there was no sense of ownership of the facility by the community. It was all the property of the government. It was provider-centred, but now it is client and provider-centred."

*Zonal PPRHAA Team Leader, Enugu*

## Challenges

In practice, with only a half-day allocated to the appraisal process per health facility, compromises in data collection usually had to be made. A further challenge was that PPRHAA teams had little control over who was selected for participation in the appraisal process. Community leaders were requested to invite a cross-section of the community, but this did not guarantee that individuals and groups who were less articulate, very poor, or otherwise socially excluded, would be involved. However, because the PPRHAA teams were briefed to ask about the views of less vocal or visible groups in their interactions with the community, it was hoped that over time this would help stimulate a more representative response. At the facility level,

the random selection of clients for interview helped prevent any biases in feedback.

The quality of community participation in the PPRHAA summits also varied. Since the community members involved in these activities (usually a community leader and a women's representative) were not given any training on how to maximise the benefits from their participation, the outcomes depended very much on what pre-existing skills, confidence and experience the community representatives could draw on. This was a risky strategy in a context where there were often very significant power differentials between providers, civil servants and members of the community. Future efforts should engage members of the community who are involved in other systems strengthening

### ***Facilities and Health Managers Respond to Client and Community Demands***

"In a PPRHAA focus group discussion session in Oyofe-Oghe in Eziegu North Local Health Authority the communities complained that they did not use the facilities because the health workers were not available at all times, especially at nights. The health staff explained that because the area is unsecured they were not confident to stay within the facility premises at night. The communities agreed to extend their local vigilante services to the facility premises. As a result of this staff were available to provide night services."

*PPRHAA Focal Person, Enugu*

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"At Nachi PHC in Udi Local Health Authority, the community complained during the PPRHAA process that the facility was located in an isolated area, and as a result their women were not delivering at the health facility. To address the problem, the community made available a residential apartment not too far from the health facility and agreed that the health workers could use the premises as a maternity home."

*PPRHAA Focal Person, Enugu*

"In Iro community, Gbonya LGA in Ekiti, in one of the PPRHAA quarterly review sessions the community complained about the ambulance not being fuelled, not enough skilled health staff and staff not available to provide night services. The PHC Coordinator redistributed the staff, and the facility management started releasing money for fuelling the ambulance."

*PPRHAA Focal Person, Ekiti*

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"A particular community around Afao Health Centre in Ekiti complained that their facility lacked skilled staff and that the staff who were available were not always around. Local government health managers probed the case further and decided to post resident staff to the facility."

*PPRHAA Focal Person, Ekiti*

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"Another report from the communities was that there were no doctors in the PHCs. Now in three LGAs, National Youth Service Corps doctors are utilised to provide services. One NYSC doctor is employed in an LGA to go round all the facilities in the LGA".

*PPRHAA Focal Person, Ekiti*

initiatives, and who have benefited from the training provided through these initiatives (e.g. for facility health committees). In addition, because women's voices are mediated by gender power relations, particular attention will need to be paid to building the skills and confidence of female community representatives.

Facilitation of the client and community views component was particularly challenging in the early days of PPRHAA since knowledge of social development issues and the skills to engage effectively with communities were not always available within state and local government PPRHAA teams. The quality of data gathered, the way in which it was reported, and the tendency for client and community concerns to evaporate during the facility action planning process were all concerns initially. Targeted capacity building, in the form of formal training and on-going supervisory support, was provided by PATHS in order to increase competencies in this area. As a result, skills to facilitate the CCV component of PPRHAA, among the external consultants<sup>6</sup> and state PPRHAA teams improved significantly over PATHS lifetime. Likewise, the quality of client and community participation in PPRHAA is believed to have improved over time.

Some of the major constraints to effective service delivery, such as shortages of staff, were not always addressed promptly, since these issues required action and solutions that lay outside the immediate control of health providers. Some problems identified through the CCV process - and which required a response from local government - were not addressed, leading to disappointment among community members. Finding out the cause of such inactivity was part of the role of the integrated supervisory teams (see next section). However, in many cases, the inactivity at LGA level occurred because the incentives to respond were not strong enough.

## Quality Assurance

### Approach

Quality Assurance is a continuous process of assessing, monitoring and improving the quality of service provision. In Jigawa state, 23 health facilities were involved in monitoring the quality of service delivery on an on-going basis through implementation of the Patient Focused Quality Assurance (PFQA) approach. One component of PFQA focused on gathering client perspectives of services through client exit interviews. A pre-agreed number of interviews were conducted periodically (depending on the size of the health facility this was between 50-100 interviews every three months) to find out what clients thought about waiting times; the attitude of health providers; the availability and price of drugs; the cleanliness of the facility environment and so on. Facility PFQA teams collated the findings from the interviews, identified priority issues that required attention, and drew up action plans to address these. To ensure transparency and accountability, the results from the PFQA interviews and the facility action plans were displayed in consultation rooms or in other areas where they could be easily seen by clients.

Subsequent rounds of client exit interviews were used to check whether previously identified problems had been dealt with adequately. If not, these issues became priorities to be addressed in the next facility action plan.<sup>7</sup> The idea was that regular consultation with clients would lead to greater responsiveness on the part of health providers to clients' needs and views.

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6 The intention was to gradually fade out use of external consultants as state PPRHAA teams developed their facilitation skills and gained in confidence.

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7 Health facilities that do consistently well in facility performance assessment processes and achieve identified quality standards can have their achievements recognised in a formal process of quality recognition. Because quality recognition was at an early stage of implementation in one PATHS-supported state (Kaduna) in early 2008, it is not reported on here.

## Results

Patient Focused Quality Assurance improved health providers' responsiveness to client needs, and strengthened linkages between facilities and local communities in Jigawa. Although many deficiencies in the quality of health services were identified by clients in the PFQA client exit interviews, facilities visited during the rapid review had taken measures to respond appropriately, where it was within their capacity to do so.

Stakeholders reported that utilisation had increased in some facilities as services became more client-friendly. As relationships between providers and

local communities improved, some PFQA facilities looked for other ways to reach out to the community, for example by holding annual open days. From providers' perspectives it was important to ensure that clients and the wider community were not only aware of the changes that were taking place at the

### **Implementing PFQA: Health Providers' Views**

"Data from the questionnaires is interpreted and plotted on a graph so that we know our deficiencies. We initiate ways to improve our service and decide quality indicators for that month. If there is no improvement over time, we revise our strategies. We display the results in the consulting room so that patients can see."

*Garki PHC, Jigawa*

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"We brief the Hakimi [District Head] and other dignitaries about the PFQA results and also try to get the message out to the community about what we are doing to respond to the problems raised by the survey respondents."

*Dutse General Hospital, Jigawa*

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"We will do our best to comply with clients' views, even if it goes against our views. We will compare and contrast different views and adjust to a compromise. If we do something against the wishes of the community, we know that they won't use the facility."

*Garki PHC, Jigawa*

### **PFQA Facilities Respond to Problems Identified by Clients**

Client exit interviews undertaken as part of the PFQA process revealed several problems that were affecting clients' views of services at Garki PHC. Fortunately, the facility was able to tackle these:

- Clients pointed out that the card issuer left his post at lunchtime, leaving the records office locked. Clients had to wait for him to come back. The facility tackled the problem by posting another member of staff to take over when he was on break.
- Clients were also confused about when they should come back to the health facility for review following an initial consultation. This has now changed. All health providers are being very careful to state when clients need to return to the health facility.
- The pharmacy department was too busy to explain how people needed to take drugs. This was problematic because some clients were given up to four different types of drugs, all with different dosages and application regimes. Many clients were leaving the health facility with no idea of what to take and when. This had to change. The pharmacist is now very careful to explain to clients what they should do.

At Gumel General Hospital the PFQA client exit interviews identified that many clients were concerned about their inability to access drugs at the health facility at certain times of the day. The facility responded by moving two Clinical Assistants to the pharmacy. They now run three shifts and can provide drugs 24 hours a day.

health facility, but also understood the constraints under which staff operated and the various ways in which client actions and behaviour could negatively affect services. For instance, providers complained that because members of the community did not keep to official visiting hours, ward rounds were frequently disrupted. It was hoped that open days would provide an opportunity to explain not only the entitlements of clients and their carers, but also their responsibilities.

Periodic supervisory visits undertaken by the state PFQA team provided an incentive to maintain client-friendly standards of care. In addition, an annual quality of care conference provided an opportunity for health facilities to report on their PFQA-related activity, to highlight what changes were being made in response to client needs, and to discuss challenges that were not easy to resolve. Other systems strengthening and improvement initiatives that were taking place at the same time, such as the annual PPRHAA process, improvements in drugs supplies, and training of health providers in clinical and interpersonal communications skills, all contributed to the momentum for change.

By introducing a formal mechanism through which providers could consult with clients, PFQA enabled clients' voices on the quality of health services to be heard. Since clients were picked randomly for the exit interviews, a variety of voices were heard. The fact that 'client-friendliness' had become a key performance indicator for health facilities in Jigawa introduced a new measure of accountability between health providers and the clients and communities they were expected to serve.

### ***Patronage Increases at Garki PHC***

"There has been a remarkable change in attitudes to clients in this facility. When patients came into town, they used to prefer to go straight to the chemist. Now we are getting a lot more patronage. Patients now ask questions about their diagnosis... even if people don't have an ailment they prefer to come to the facility more... patients are more free with providers."

*Garki PHC, Jigawa*

The PFQA process itself – carrying out a client exit interview, collating and analysing results, prioritising key problems, and devising action plans to address these – was not complex, and a variety of facility staff (e.g. laboratory staff, pharmacy staff, clinicians) quickly got up to speed with what was required. The approach could easily be replicated in other states.

### ***Challenges***

Many of the health facilities in Jigawa were affected by severe staffing shortages, and the PFQA facilities were no exception. This meant that some facilities found it difficult to administer a large number of client questionnaires on a monthly basis (this was originally set at 100 questionnaires per month per health facility).

Although the number of client exit interviews was later reduced to 50 per quarter for primary health care facilities and 100 per quarter for secondary health care facilities, the scale of the human resource problem in Jigawa meant that staffing constraints were likely to remain a problem in the short- to medium-term. Ironically, as PFQA health facilities became busier as a result of their growing responsiveness to client needs, their capacity to effectively carry out PFQA diminished.

### ***Staffing Shortages Affect PFQA***

"We suspended PFQA in January 2007 because the facility PFQA focal person was away on training. We have just resumed. Staff at the facility sometimes do 18 hour shifts. We are very under-staffed."

*Garki PHC, Jigawa*

# Integrated Supportive Supervision

## Approach

In the early days of PPRHAA implementation, quarterly follow-up meetings were held to assess progress with implementation of facility action plans. These meetings were later phased out and replaced by quarterly on-site supervisory visits undertaken by Integrated Supportive Supervision (ISS) Teams. Community representatives participated as core members of the ISS teams.<sup>8</sup>

The ISS teams used a simple but comprehensive checklist to monitor performance in key areas of service delivery and facility management, and to review facility progress in delivering the commitments contained in the PPRHAA action plans. Clients and other key informants, such as community members of facility health committees, were interviewed as part of the ISS process in order to monitor quality from the community perspective. On-site supervisory support was provided to help staff address problem areas. Feedback from each round of ISS visits was provided to the local government health department and senior staff of the SMOH, and policy-makers were advised of any issues that required their attention.

Members of the ISS teams received training on their overall role, how to use the ISS monitoring checklist, how to incentivise providers through the provision of supervisory support, how to write reports on facility performance, and on effective ways to feed back findings to the local government health department.

## Results

Integrated Supportive Supervision teams were established in all the states supported by PATHS. Because this initiative was introduced quite late in the programme's timeframe, as of early 2008 it was too soon to say anything conclusive about the performance of the teams. However, there were some early signs that the initiative held potential from a voice and accountability perspective.

<sup>8</sup> Ekiti State was an exception. ISS teams in this state did not include community representatives.

Community representatives were nominated for inclusion on the ISS teams because they had shown a particular interest in and commitment to improving the health of their communities. These were individuals who had been particularly active and effective on facility health committees, or who had played an important role on behalf of the community in the PPRHAA process. The inclusion of members of the community on the ISS teams put them right at the heart of a process that aimed to increase accountability 'within the system'. The fact that community representatives played an active role in checking and assessing facility performance also meant that ISS helped stimulate greater accountability to the community by health providers.

In a context where few health managers visited health facilities or communities regularly, there were large gaps in their understanding of community needs and concerns. The ISS feedback sessions held with local government health departments gave the community members a direct line to local government, and a rare opportunity to claim improvements in services. Although by early 2008 it was too early to say what demands were being made on local government on behalf of the community, and whether the demands were being responded to, the mechanism itself was promising from a V&A perspective.

Significant efforts were made to ensure co-ordination and integration of different systems

### **Participation of Community Representatives on ISS Teams**

"The community representatives on the ISS teams visit facilities in their area, but not their local facility. They learn about the challenges and strengths of other facilities. This really helps them understand better what constraints the facilities operate under, to learn about good and poor practice, so that they know what to expect from their own facility. The idea behind having community representatives on the ISS team is to let them know that they are the owners of the facilities – whatever is being done, they should see what is going on and get involved."

*Director, Planning, Research and Statistics,  
SMOH, Kaduna*

strengthening initiatives in the PATHS states. The inter-relationships between the integrated supervisory process and the work of the facility health committees are described in the Box below.

### ***ISS Provides Checks and Balances Within the System***

“We went to one facility to provide supervision. The in-charge had gone off to collect his salary. We called him and he promised to be at the health facility within an hour. Now he’ll know to stay in his place of work.”

*Community member of ISS team,  
Tudun Wada, Zaria, Kaduna*

### ***Stimulating a Response from Government***

We appreciate ISS. The ISS teams write a report and discuss this with the authorities. Information on the problems is reaching those who need to know, and there are signs that government is beginning to respond.

*Chairman FHC, Makera PHC, Kaduna*

## **Challenges**

The provision of refresher training and on-going support to the ISS teams will be essential if team members’ knowledge and competencies are to be further developed and maintained. It will be particularly important to ensure that targeted capacity building support is provided to the community representatives on these teams. Since most of these individuals come from outside the health sector, they tend to have less technical knowledge than the other team members, and may also lack experience of effective ways to influence decision-makers. In states where facility health committees are being supported by government, it makes sense to ensure that active members of these committees are invited to participate on ISS teams. This will help maximise the gains from any training (e.g. lobbying and advocacy skills) provided through the FHC initiative.

### ***Links Between ISS Teams and Facility Health Committees***

“When the ISS team visit the health facility they ask questions and compile a report. Since local communities have representatives on the ISS teams, the concerns of the community do inform the monitoring and supervision process. The FHC gets to know the problems of the facility through the ISS process and we as a committee can act on these. As a result of the recent ISS visit the FHC made provision for setting up a suggestion box scheme. We also learned that we needed to publicise the facility services and opening times better and so the FHC put up a signboard. Another issue was that too many injections and antibiotics were being given to clients. This is something that the providers need to act on, but the FHC can watch this. We hope ISS continues because it highlights problems and solutions.”

*Chairman FHC, Makera PHC, Kaduna*

# Government V&A Initiatives

## Standards of care and patient charters

### Approach

Government V&A initiatives are led by government as opposed to health providers. The creation of policies or sets of procedures that clarify what clients can expect from health services are examples of government V&A initiatives. In Enugu, standards

of care, which outlined how services should be delivered, and patient charters, which set out the rights and responsibilities of clients and providers within the health sector, were devised. With an emphasis on entitlements, these initiatives helped create an enabling policy framework for progressing work on voice and accountability.

In 2005 the SMOH in Enugu introduced minimum packages and standards of care which defined how health services should be delivered throughout the state. These protocols set out *where* health care was to be provided, *who* would provide the care, and to *what standard*. While the packages of care defined specific standards for the delivery of priority health conditions such as measles, malaria, and maternal health, the standards of care focused on how patients should be treated. The standards

### Standards of Care in Enugu

The SMOH in Enugu devised 6 overarching standards of care that defined how priority health services should be delivered across the state. The standards were:

1. Every patient is treated with dignity, respect and confidentiality
2. Every patient will have prompt access to appropriately trained health care providers in an emergency or within an hour of arrival in a health facility
3. Every patient is given enough information to make an informed choice
4. Every patient will have a clear and comprehensive medical record
5. Every patient will have easy and quick access to affordable prescribed drugs.
6. Every patient will be cared for by staff using good infection control practices

The standards specified what things needed to be in place in order to achieve the standard (the structure); what action was required to achieve the standard (the process); and the expected end result (the outcome).

For example, in relation to the first standard – every patient is treated with dignity, respect and confidentiality – the prerequisites were:

- Staff with positive attitude and good interpersonal skills
- Staff updated with good communication skills periodically
- Staff are oriented to working in partnership with the patient's family and/or escort

The actions required were:

- Staff will be sensitive to the needs of the patients, demonstrating dignity and respect
- Staff are polite, speak calmly and use appropriate language, recognising the importance of body language
- Staff will seek patient consent and opinion for procedures
- Staff will show respect for religion and culture
- Staff will introduce themselves by name to the patient as well as disclose their status

The expected outcomes were:

- Every patient at the facility feels that they have been treated with dignity and respect
- Every patient will know who has attended to them and in what capacity

were applicable to every patient attending any health facility for any element of care (see Box). Focus group discussions were held with community representatives at an early stage in the development of the protocols to ensure that the standards of care were based on definitions of quality that made sense from client and community perspectives.

## Results

The standards provided the basis for monitoring, assessing and improving the quality of care in health facilities throughout the state. The standards of care were reflected in the quality indicators used during the annual PPRHAA appraisal process and, later, in the checklists used by integrated supervision teams that visited public health facilities every three months for monitoring purposes.

Training in the packages and standards of care was rolled out to health staff in public and faith-based health facilities across the state (over 1,200 staff had been trained by early 2008). Patient charters, based on the content of the standards of care, were developed and displayed in all public health facilities. By articulating what citizens were entitled to in terms of health services, the standards of care and, later, the patient charters, provided an important framework for improved accountability between providers and clients.

**Ministry of Health, Enugu**  
**CLIENT HEALTH SERVICE CHARTER**

This charter refers to your rights and expectations in all public health facilities of Enugu state

1. Right to receive health care on the basis of your clinical need, not on your ability to pay, your life style or any other factor.
2. Right to obtain medical services in any state facility.
3. Right to opt for a second opinion.
4. Expect to receive medical attention within one hour of arrival to the facility.
5. Expect to have access to all prescribed drugs.
6. Right to be treated with dignity, respect and confidentiality.
7. Right to choose whether or not to take part in medical research.
8. Expect all staff to wear appropriate dress with name tags.
9. Expect all staff to respect your privacy dignity, religious and cultural beliefs at all times.
10. Right to have any proposed treatment, including the risks involved and any alternative treatment clearly explained for informed consent.
11. Right to access to your health records.
12. Right to have your complaints investigated and the outcome communicated to you.

Dr. F.S.A. Uzor  
Hon. Commissioner for Health

## Enugu Patient Charter

## Challenges

By early 2008, no specific measures had been taken to promote the standards among the general public, or to raise consumer awareness of what to do if the standards were not met. Although accountability failures came to light through the PPRHAA and integrated supportive supervisory processes, facilities also needed to know how to respond to service failures that were independently brought to their attention by a client or member of the general public. To ensure their full potential as a voice and accountability tool, future attention needs to turn to implementing a public awareness campaign about the standards of care and patient charter. It will also be important to ensure that consumers know where or to whom they should direct their complaints, and that health providers and their managers have the skills and confidence to deal effectively with such complaints.



# Joint Government-Civil Society V&A Initiatives

## Facility Health Committees

### Approach

Facility Health Committees (FHCs), comprising members of the community and representatives of the health facility, were supported in all the PATHS states. In some states, support to these government-sanctioned committees focused on building capacity to oversee implementation of sustainable drug supply systems (e.g. Enugu, Kano and Jigawa) or deferral and exemption (D&E) schemes<sup>9</sup> (e.g. Jigawa). In other states (e.g. Ekiti and Kaduna), where the support was more comprehensive and broad-ranging, FHCs were supported so that they could play a role in:

- Monitoring the work of the health facility on behalf of the community;
- Acting as the interface between the health facility and community for all health systems strengthening activities that required community input;
- Acting as a channel for community voices on health issues;
- Helping to strengthen facility-community linkages;
- Helping to ensure the access of the very poor and socially excluded to health services;
- Jointly managing (with health providers) sustainable drug supply systems and deferral and exemption schemes (where these were operational).

The idea was that FHCs would be an effective means of increasing community participation in health, would create space for community voices to be heard by health providers, and help to address key accountability failures at facility level.

<sup>9</sup> These allow access by the very poor to health care.

### Facility Health Committees in Kaduna

Facility Health Committees in Kaduna support the work of the health facility, act as the link between the facility and the nearby communities, and help build community participation in health. Specifically, the role of the FHC is to:

- *Support* the health facility to deliver against its remit
- *Increase access*, particularly of the very poor and underserved, to health services
- *Monitor* the work of the health facility
- *Advocate* for increased government support for the facility
- *Help build* a good relationship between the facility and its catchment communities
- *Be the first point of contact* for all service delivery and quality improvement activities that require community input
- *Help supervise and support* Community Health Volunteers

The intention is that stronger Facility Health Committees will lead to the following:

- Communities play a more active role in ensuring 'better health for all the community'
- Communities feel that they have a stronger voice on how health services are managed and delivered
- Communities feel that health providers are more accountable to them
- Health services are more responsive to patient needs
- Health services reach the very poor and the underserved
- Women's views and perspectives on health issues are better represented

## ***Building Skills and Competencies of FHC Members in Kaduna***

In Kaduna the training of FHCs focused on building skills and competencies in addition to raising awareness of FHC roles and procedures. The training focused on:

- How to work in a team
- Effective ways to consult with the community
- How to represent the views of the community
- How to identify and reach the poorest
- Understanding the barriers of access to health services
- How to plan for better health with the community
- How to monitor client satisfaction with services
- How to advocate and lobby for improvements in health services

Participatory training techniques were used so that participants could practice what they had learnt during the training. For example, training participants carried out a role-play on what it meant to consult with the community, and practiced their lobbying skills on someone pretending to be a local politician. The SMOH provided follow-up mentoring support to the committees through the core group of state FHC trainers who were drawn from the SMOH, the Ministry of Women's Affairs, the Local Government Service Commission and local NGOs.

## **Results**

As of early 2008, there were many interesting examples of how facility health committees had attempted to address accountability failures at their local health facility. These failures ranged from a lack of information available to clients and communities; poor provider performance; the potential for provider corruption; lack of drugs; or inequitable access to health services (see table below).

In Kaduna and Ekiti, where the support provided to FHCs was more broad-ranging than in the other PATHS states, part of the FHC role was to provide checks and balances against poorly performing health providers (e.g. poor provider attendance or providers being rude to clients), and against provider corruption. In these states, being answerable to a FHC for poor performance, particularly in contexts where the overall supervision of health facilities had improved, meant that it was no longer possible for providers to assume that business could continue as usual.

On the whole, relationships between active FHCs and health providers in Ekiti and Kaduna appeared to be supportive rather than confrontational. Providers recognised that FHCs could make a very significant difference to their capacity to deliver effectively, and many spoke about the effectiveness of FHCs in helping to leverage support for the health facility from traditional authorities, from local communities and to a lesser extent from local government and politicians.<sup>10</sup>

The Box below provides an example of how one FHC in Kaduna managed to challenge local government, and in doing so, made a very significant difference to their local health facility.

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<sup>10</sup> Whether power differentials between provider and community members of the FHCs resulted in the latter being co-opted is not known, although the practice of ensuring that 'community influentials' sat on these committees may have helped guard against this. However, there was also a potential that providers and influential community members of FHCs could combine forces for the purposes of rent-seeking. However, again, there is no evidence to suggest that this happened, although this will need to be monitored in future.

**Table 2: Role of FHCs in Addressing Accountability Failues**

TYPE OF ACCOUNTABILITY FAILURE				
Lack of Information	Poor Provider Performance	Lack of Drugs, Poor Infrastructure	Corruption	Inequitable Health Services
<p>"There are many benefits to having community members involved in the DRF committee. They can explain to the community about the DRF and help manage any problems that arise, including any community misconceptions about the scheme." Members of DRF Committee, Kudai Village, Dutse, Jigawa</p> <p>"There is confusion about the free drugs situation. Many adults think that they should be getting free drugs, which is not the case. The FHC members are doing a lot of work to advise the community to be patient about the situation and to support the free MCH policy while it takes root." FHC Member, Barnawa PHC, Kaduna</p>	<p>"We have to make sure that the workers are here all the time. We take it upon ourselves to come to the health facility to find out what the workers are doing." Member of FHC, Oyotu Odua Health Clinic, Enugu</p> <p>"We do mobilisation every two months. We ask for feedback on how clients have been received at the health facility. . . if there is any way that providers have to adjust we come and tell them." Member of FHC, Makera PHC, Kaduna</p> <p>"Our main job is to see that the facility is progressing by ensuring that the workers are there all the time." FHC member, Iyin Health Centre, Ekiti</p> <p>"I come into the health facility for supervision. I like to see the flow of clients and to see how the providers relate to the community members." Chair, FHC, Barnawa PHC, Kaduna</p> <p>"FHC members have a good perspective of what is going on here since some members are on-site a great deal. We don't think of them as a threat. Them being here makes us more committed to do the right thing and to get things right." Officer in Charge, Barnawa PHC, Kaduna</p> <p>"The committee members have advised staff to arrive at the facility on time." Health provider, Television PHC, Kaduna</p>	<p>"Our job is to shout if the free drugs don't come." FHC Member, Barnawa PHC, Kaduna</p> <p>"We have carefully documented what they need in terms of drugs and what they're getting, and the gaps." Member FHC, Babban Dodo PHC, Kaduna</p> <p>"There is a need for extensive renovation. The Local Government have promised to do so. They have confidence that they will do so. They have incorporated our request into their 2008 budget." Member FHC, Makera FHC, Kaduna</p> <p>"We dug a well for the facility and put up a sign board which explains what services are available and when. We also made a suggestion box." Member FHC, Barnawa PHC, Kaduna</p> <p>"The FHC helped us design and construct a signboard. They bought curtains for the facility and bed slats for the ward. We also had a problem with the electricity supply and they helped with that and we are now getting electricity 12 hours a day." Health provider, Television PHC, Kaduna</p> <p>"We provided 8 new benches, built a new perimeter wall, provided new curtains, and built new partitions to improve privacy for the clients." Secretary, Tudan Wada FHC, Kaduna</p>	<p>"There is less mischief if the community is involved on this [DRF] committee. . . . Because receipts are given and there are good records, it is easy to find out if things are being cooked." Members of DRF Committee, Kudai Village, Dutse, Jigawa</p> <p>"I was called in to receive delivery of the free MCH drugs. I also inspect the ledgers and other records relating to the drugs and check that everything is in order." Chair, FHC, Barnawa PHC, Kaduna</p> <p>"When we need DRF drugs we draw up the list and they [FHC] go through the list. They also go through the records monthly. The Chair goes through the fund valuation forms and signs." Officer in Charge, Aiyede Health Centre, Ekiti</p> <p>"Every day a member of the FHC comes to see what is happening with the free MCH drugs. They see how we give the patients the drugs. It is helpful that they watch the dispensing. We are only getting about 50% of the drugs we need. We therefore need to ask clients to buy outside, and this leads to suspicion of us providers. The FHC is very helpful in explaining the role of free MCH to communities since there is a great deal of confusion among clients." Health provider, Ung Mu'Azu PHC, Kaduna</p>	<p>"If they lack money, we bring the poor person to the health facility and ask the in-charge to organise their treatment." Member FHC, Television PHC, Kaduna</p> <p>"The FHC has introduced an ID referral card for the less privileged. Since we're in the community, we can judge who needs to come. . . those who cannot afford, we can tell who they are." Member FHC, Babban Dodo PHC, Kaduna</p>

## FHCs Challenge Local Government to Improve Health Services



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*New ward (pink building) built by members of Babban Dodo PHC Facility Health Committee, Zaria LGA, Kaduna*

“Our local health facility lost some land when a dual carriageway was constructed. The state government planned to compensate local government for the loss. We lobbied the state government and asked to be paid the compensation directly. We wanted to avoid local government getting the cheque because there would be long bureaucratic delays in moving ahead with the building...The funds were released in September 2007. By early December 2007 we had renovated large parts of the health facility, built a new delivery ward, fenced the facility, installed a new water tank, and dug a pit latrine for patients. The new ward is bigger and better than what was originally in place. It was not easy to make the argument. We had to use impressive people for this... The Local Government PHC Co-ordinator assisted a lot. Everybody knew that if we got the money we could do a lot for the clinic. We submitted an expenditure report to local government in early December 2007 and have arranged for the Local Government Chairman to come and inspect the building work.”

*Babban Dodo PHC Facility Health Committee, Kaduna*

### Challenges

Because of the systematic under-funding of public health facilities since the 1970s, issues of poor facility infrastructure and lack of equipment were high on the list of FHC priorities. However, the FHCs had a tendency to ‘gap-fill’. If funds or offers of labour could be generated at community level in order to carry out repairs or to supply missing equipment, this was usually the preferred way to solve a problem. Local government was commonly only approached as a last resort, when a problem was perceived as too

large or significant for the FHC to act on. Although this demonstrates a willingness on the part of the FHC to take the initiative, the tendency to avoid challenging local government for accountability failures, except where absolutely necessary, indicates either a lack of confidence within the FHCs to present a strong and effective case, or a cynicism about the potential to get a response from local government. Both explanations are probably valid to some extent.

Although there were some positive examples of how communities had successfully drawn down support from state or local governments, many other examples were cited of local government failure to respond to FHC demands.

The absence of local government incentives to respond to community demands, and the absence of sanctions if they chose not to respond, meant that there were systemic constraints to FHCs' capacity to leverage support from this tier of government. Without very significant improvements in public accountability, finding effective ways to challenge local government inertia was likely to remain hit and miss, and likely to remain dependent on FHCs being able to use their influence and draw on patronage relationships. This was not an option for FHCs that lacked members with (the right kind of) power and influence.

In states where support to FHCs focused primarily on their role in jointly managing (with health providers) deferral and exemption schemes or drug revolving schemes (e.g. Jigawa and Enugu) there was less evidence that FHCs played a key role in ensuring community voices reached health providers and managers, or that they were effectively challenging accountability failures. In these states, the role of community members on the committees was in practice defined very narrowly as being a conduit for information about the availability of drugs or safety nets for the very poor, and a means by which communities could be mobilised in support of these initiatives. In most cases capacity building support to these committees had focused on increasing awareness of committee procedures and roles, rather than building members' skills and competencies to carry out these roles. These training gaps had not been filled via the provision of on-going mentoring and supervisory support. This represented a missed opportunity to move beyond token community participation on these committees.

Although in all states FHC membership criteria were drawn up in such a way as to ensure the participation of a cross-section of the community based on gender, age, clan affiliation, and interest groups, including the disabled, in practice nominations were made by community leaders within the traditional authorities, and did not always result in selection of the most effective or committed individuals. In future, introducing some basic performance assessment indicators to measure

## ***Local Governments Fail to Act***

"We once went to the councillor to ask for support for the health facility and he did nothing. He didn't even go to the Local Government Chairman. He's not resident in this community, but lives on the other side of the ward, so he's not interested in the problems in this community. However, this time around we expect change. We have a candidate from this area campaigning for selection."

*Zango Road PHC Facility Health Committee,  
Kaduna*

\* \* \* \* \*

"In 2005 members of the FHC heard an announcement on the radio that a sum of 2 million Naira had been allocated to carry out renovations to the facility. When the money didn't appear we went to see the local councillor about it. He said that he had also heard the announcement, but hadn't seen the money. That was the end of it. The councillor had a responsibility to follow up and find out what had happened to the money. He didn't, so we were all very disappointed. The money was probably misappropriated – it's not possible to make a formal announcement like this unless money has been officially allocated. Because of the lobbying skills we have received through the FHC training we now know the steps to take when we next approach the local government. If we exhaust all avenues to get what we want, we know that we are the people who voted for them. If they seek our votes in future, we will say no. We will put conditions on candidates, and argue that if they make promises, that they must carry out every one of them. After meeting the councillors, if nothing comes of this, we plan to see the House of Assembly representative for this constituency."

*Television PHC Facility Health Committee,  
Kaduna*

the performance of individual committee members could help shift the balance of membership to high performers.

Also common were differences in skills and confidence between the female and male members of the committees, especially in the northern states where women were constrained by purdah from participating in community development processes that took place in the public sphere. In some of the PATHS states the failure to address these gender differences in experience and confidence at the outset was a gap in implementation. In Kaduna, by early 2008 it still remained to be seen whether the emphasis in the FHC training and on-going mentoring support on ensuring high quality participation of the female FHC members had made a difference. In all states, more attention needs to be paid to the quality of women's participation in FHC activities in future.

The role of the FHC as a channel for community voices on health issues is interesting. In the states

where limited capacity building support was provided to the FHCs, there was no evidence to substantiate the claims of the committee members that they were representing the views of the wider community in their committee activities. The tendency was to assume a homogenous community view, and to know what this was without any attempt at consultation. In Kaduna, in contrast, the training of FHCs put significant emphasis on consulting, representing and feeding back to the community. As of early 2008, however, it was too soon to assess whether the training had made a difference and Kaduna committees were effectively representing the voice of the community.

*New signboard erected by Facility Health Committee at Television PHC, Kaduna South LGA, Kaduna*



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# Creating the Preconditions for Voice

Activities that help create the pre-conditions for voice, for example by raising community awareness of their rights and entitlements to quality health services, fall into this category of V&A initiative. In the PATHS states two initiatives designed to increase demand for priority health services proved interesting and important from a V&A perspective: the safe motherhood demand-side initiative and the Community Action Cycle.

## *Safe Motherhood Demand-Side Initiative*

### **Approach**

Comprehensive safe motherhood programmes were implemented with PATHS support in Jigawa and Kano in order to address the extremely high levels of maternal mortality and morbidity.<sup>11</sup> One component of this work focused on addressing the barriers at household and community level that were preventing timely use of emergency maternal health care services. Safe motherhood communities in the two states were involved in an innovative process of behaviour change, which was based on generating community-wide social approval for

*Safe motherhood community members, Kano*



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11 A Kano population-based study undertaken in 2003 identified a maternal mortality ratio (MMR) of 2420 maternal deaths per 100,000 live births. This is three times the national MMR, which is 800. See Y.M. Adamu, H.M. Salihu, N. Sathiakumar and G.R. Alexander, 2003, 'Maternal Mortality in Northern Nigeria: A Population Based Study', *European Journal of Obstetrics and Gynecology and Reproductive Biology*, Vol 109, Issue 2.

new behaviours so that women and their families could deal promptly with pregnancy complications. Community systems were established to tackle the barriers of access to safe motherhood services, including emergency loan funds, emergency safe motherhood transport schemes, and blood donation groups. Significant behaviour change in relation to pregnancy and maternal complications occurred in the intervention communities during the period of implementation, and communities and providers in both states reported that many maternal deaths and morbidities had been averted.

## Results

The original design of the safe motherhood demand-side initiatives in Kano and Jigawa lacked an explicit focus on voice and accountability. However, over time both initiatives evolved to take on a V&A focus, and some interesting V&A outcomes resulted from this work.

In some communities, the safe motherhood work created capacity and willingness among community members to vocalise their demands about the need for general improvements in the quality of health services. As community confidence in their ability to take action and effect change in support of safe motherhood grew, attention turned to addressing other factors that were negatively affecting the health of the community. Recognising that there were issues that lay outside the capacity of the community to act on, communities were aware that they needed the support of local government. However, this awareness was underlain by a tremendous cynicism about the degree to which local government activity was guided by community priorities (see box).

Despite this cynicism, some safe motherhood communities did go ahead and lobby local government for assistance, and some were effective in drawing down support. In Kano where the safe motherhood communities had been trained in simple lobbying and advocacy skills, there appeared to be a greater willingness to challenge local government to take action. However, some of these communities had a history of being involved in other rights-based community mobilisation activities and may therefore have been more attuned to claiming their entitlements.

## Communities Lack Confidence in Local Government

“The relationship with councillors is based on deceit – the councillors aren’t interested in representing us.... when they want our votes, they listen....only when we keep knocking at their door every day will they listen, and we are willing to do this”.

*Yammawan Fulani Village,  
Danbatta LGA, Kano*

\* \* \* \* \*

“Local government people only come to this community when there is an outbreak of disease or when they are electioneering.”

*Sanbauna Village, Minijbir LGA, Kano*

\* \* \* \* \*

“We are not close to the local councillor. There are protocols. You have to make an appointment and they are always very busy doing things. We doubt they can easily listen to us. Most councillors need an easy contract to get a lot of money.... This is what prevents us from approaching them.”

*Makerabu Village, Gumel Emirate, Jigawa*

\* \* \* \* \*

“The problem is how not to become beholden to the Local Government – they are manipulative and can have a hold on you if you ask for something and they supply it. How to retain independence while at the same time holding Local Government to account is a challenge”.

*Kano Safe Motherhood NGO Representative*

\* \* \* \* \*

“As soon as the Local Government elections have passed, they lose interest. Presenting the case isn’t the problem, it’s the action. There is almost no accountability between Local Government and communities.”

*Makerabu Village, Gumel Emirate, Jigawa*



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*Community members, Jigawa*

### ***Safe Motherhood Communities Demand Change from Local Government***

The government in Kano had introduced a policy whereby non-indigenes of the area were to be retrenched from the health service. This included a Senior Nursing Officer based at a secondary health facility in Tudan Wada LGA who had been a major support for women suffering maternal complications. The safe motherhood community volunteers called the provider to a meeting and asked him if he would commit to staying on at the health facility if they lobbied on his behalf. He agreed. The community approached the Local Government Head of Community Development, who had been a great supporter of the safe motherhood demand-side work. He arranged a meeting with the PHC Co-ordinator, who was very receptive to the community's demands, and immediately arranged for the group to meet the Local Government Chairman. The Chairman's response was that "if this is what the people from this community want, they can have it". The Nursing Officer got his job back and has since returned to work.

### **Challenges**

Early opportunities to promote a stronger focus on V&A through the safe motherhood work were missed in both states. For example, more could have been done at an earlier stage to link community-level safe motherhood activities to the work that was being done to strengthen the supply of safe motherhood services. Ensuring that communities had access to basic information on the type of safe motherhood services and treatments that should be available, and the standards of care with which these services should be provided, would have increased community understanding of their entitlements and provided tools with which communities could measure quality.

In order to address the gap between the community- and facility-level safe motherhood work, regular, formal stakeholder meetings between community

### ***Communities Act to Roll Out the Safe Motherhood Work***

The safe motherhood community volunteers in Rogo Ruma Village, Rogo LGA, Kano had received training on simple advocacy and lobbying skills. The villagers rehearsed what they wanted to say to the local government Chairman. The next day a group of 60-70 community members, men and women, accompanied the District Head to the Local Government Secretariat. Their spokesperson, a women's leader, explained the work the community had been doing to raise awareness of safe motherhood and to prepare the community to act appropriately in the event of a complication. She asked the Chairman to support the rollout of the safe motherhood community engagement work to ten new communities; the volunteers were keen to share their knowledge and skills with neighbouring communities. The Chairman agreed to the requests, promising logistical support in the form of a venue, refreshments and budget for transport. As the local government elections approached, however, support for the proposals waned. The community were resolved to begin their lobbying again once the new government had settled in.

safe motherhood representatives and staff of the nearest emergency obstetric care facility were introduced in Jigawa in early 2008. These meetings were intended to increase understanding on both sides of the work that was being done – at household, community and facility level - to increase women’s access to emergency maternal health care. The idea was that as trust between providers and communities increased, the meetings would provide opportunities for joint review of the accountability failures that led to specific cases of maternal death. By early 2008, it remained to be seen whether these meetings would evolve in that direction.

In the Jigawa safe motherhood communities, where there was no long-term history of NGO or donor-supported community level activity, and where lobbying and advocacy skills training had not been provided by PATHS, there appeared to be few recent examples of communities mobilising to challenge local government. Although not enough is known about how the wider political economy in either state creates or hinders voice, and provides incentives (or otherwise) for local government to respond to community demands, a number of factors appeared to be important (see table below). ‘Being influential’ and having connections to the ruling political party were important prerequisites

for gaining support from local government, and respondents were open about the need to ‘play politics’ in order to gain voice. For instance, one community in Kano argued that if they sent a delegation to the local government, they would ensure that this was led by an individual from the same political party as the Local Government Chairman. This suggests that even if communities are equally well placed to voice their concerns, there is no level playing field as far as getting a response is concerned.

Where concepts of public service are weak and few incentives exist for policy-makers to respond to community demands, the promotion of voice through the informal long-route - i.e. where communities appeal directly to policy-makers to improve health – may not be an effective strategy. It may also not be an *appropriate* strategy if the success or failure of community lobbying efforts depends primarily on policy-makers’ interest in dispensing patronage resources rather than on an assessment of community needs and how these fit with wider local government poverty reduction plans. This highlights the importance of timing work on V&A so that it dovetails with other initiatives that aim to increase public accountability at local government level.

**Table 3: Factors Affecting Community Voice and Local Government Responsiveness**

	<b>Enabling Factors</b>	<b>Disabling Factors</b>
<b>Voice</b>	<ul style="list-style-type: none"> <li>Elected representative resident in community</li> <li>Interested District Head</li> <li>NGO or CBO presence</li> <li>Advocacy and lobbying skills</li> <li>Previous involvement of community in community mobilisation process</li> </ul>	<ul style="list-style-type: none"> <li>Distance from local government</li> <li>Lack of influential people in community</li> <li>Weak political ties to ruling party</li> </ul>
<b>Responsiveness</b>	<ul style="list-style-type: none"> <li>Pre-election</li> <li>Demands have minor financial implications</li> <li>Political links to community through party worker</li> </ul>	<ul style="list-style-type: none"> <li>Lack of incentives to be responsive and no sanctions</li> <li>Lack of vote-winning opportunity</li> <li>Lack of personal commitment to the development of the people</li> <li>Rent-seeking</li> </ul>

# Community Action Cycle<sup>12</sup>

## Approach

The Community Action Cycle aimed to create awareness among communities of priority health issues, generate demand for health services, and provide communities with the information and tools to demand improvements in service delivery. Overseen by the State Health Communications Group, community based organisations (CBOs) were trained by NGO implementing partners to facilitate a series of community discussion sessions. These focused on the priority health problems facing the community, and the actions that could be taken to address these problems. One of the sessions, which took place at the health facility, brought together health providers with members of the CBO and the community to discuss community concerns about quality issues such as opening times, provider attitudes and attendance records. In some instances these sessions created an opening for members of the community to press for improvements in service delivery.

Sessions to review progress with the Community Action Cycle were hosted by the local government every two months. These meetings brought together local government departmental heads, a representative of the SMOH, CBO representatives, and representatives of the lead NGO. The meetings provided a formal mechanism via which government policy-makers could listen to and discuss the health-related issues and concerns raised by the community.

## Results

The Community Action Cycle was implemented in Jigawa with PATHS support between 2006 and 2008. Some interesting voice and accountability outcomes were evident from this work. For instance, some CBOs that had been trained to facilitate the CAC process created opportunities for communities to press for improvements in health services, and

## ***CBOs Help to Amplify the Voice of the Community***

In Galadi community, Maigatari Local Government Area, Jigawa, the participants in a community action cycle discussion on quality of health care identified the lack of drugs and poor infrastructure at their local health facility as two of the most pressing health issues facing the community. The participants resolved to present these problems to the head of the LGA Health Department and to ask him to contact the local government policy makers who were responsible for releasing money from the ballot box funds (money for 'local projects' which was distributed by state and local government to each ballot box station in every LGA across the state). The community wanted the ballot box funds to be used to renovate the health facility so that it would qualify for participation in the state drug revolving fund scheme. The CBOs helped the community articulate their needs in writing, and the letter was presented to the LGA policy makers. Elites who belonged to the CBO, and who were indigenes of the town, including the elected councillor of the ward, followed up on the written request. The funds were released and the facility was renovated to a standard which qualified it for participation in the DRF scheme.

A community in Sule Tankarkar LGA, Jigawa, complained about a facility head who smoked in the clinic and behaved in a manner considered unpleasant and unacceptable to the community. The CBO that was facilitating the CAC process in the community, Gumel Emirate Youth Organisation, encouraged the community to complain to the local government health department. The CBO helped the community to write up their complaint and accompanied a couple of community representatives to the LGA health department where the letter was delivered. The case was followed up through networking by community elites and members of the CBO. The member of staff was eventually transferred to another facility.

12 Case study material in this section is from Soyoola, M., 2007, 'Strengthening Citizen Voice and Accountability for Better Service Delivery: Case Study of Community Action Cycle (CAC), DFID Funded PATHS Programme, Jigawa State', Prepared for Options Consultancy Services, UK.

### ***Sanctions are Used by Local Government in Response to a Community Complaint***

During a CAC quality exploration session in Balogo Community in Kafin-Hausa LGA, Jigawa, the community mentioned the poor attitude of the local health provider as one of their most pressing health problems. The CAC participants explained that because of the provider's attitude the community did not like to patronise the health facility, and as a result community interest in participating in the facility's development was very low. The community asked the Balogo Progressive Association, the CBO that was facilitating the CAC process, to help them make a convincing argument for transferring the health provider. The request was put in writing and presented by the CBO at a CAC review meeting which was hosted by the Local Government. One of the members of the CBO was a university lecturer, and he agreed to present the case and help ensure that the complaint was acted on. The CBO was successful and the facility head was later transferred and replaced. This example of responsiveness to community demands raises the dilemma of how human resource managers balance community pressure for removing poorly performing staff with providing with the support and incentives to enhance provider performance.

later used their influence to ensure that community demands were met.

CAC provided a formal mechanism through which communities could share their concerns, and a forum where community voices could be heard by policy-makers. The involvement of NGO and CBO representatives and a state ministry of health official in the CAC review meetings that were held every two months provided an incentive for local government staff to listen and respond to community concerns, where it was within their capacity to do so. In addition, the willingness of the CBOs to pursue complaints and ensure that they were acted on created a new dynamic between communities and local government, reminding policy-makers of their obligation to respond to community concerns. The role of civil society organisations in catalysing changes in accountability relationships is interesting and requires further exploration as new V&A initiatives are designed and implemented in Nigeria.

### ***Challenges***

Women's voices were not articulated at an early stage of CAC. The CBOs that had been selected to facilitate the process at community level were run mainly by and for men. Gender segregation and cultural restrictions on women's mobility meant that opportunities to involve female community members in CAC discussion sessions were missed. Efforts were later made to remedy the situation by co-opting women into the CBOs. However, their late involvement in the process meant that many women missed out on the training that had earlier been provided to the CBO facilitators. This reduced their capacity to participate effectively in the initiative.

# Conclusions and Lessons Learned



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## Safe motherhood community, Jigawa

This *Technical Brief* has attempted to capture some of the voice and accountability characteristics of, and outcomes from, seven different systems strengthening and service delivery improvement initiatives implemented by State Ministries of Health and their partners in states supported by PATHS. The findings and analysis in this Brief are based on the outcome of a rapid review, and therefore cannot claim to be comprehensive. Further work is needed to analyse why different approaches worked (or otherwise) in specific contexts.

Other V&A initiatives have been supported by PATHS, in addition to those reviewed in this brief. One example is the support that has been given to strengthening civil society participation in the governance of the newly-established district health systems in Enugu and Jigawa. Since this work was at an early stage of implementation in early 2008, it is not reported on here. However, these initiatives are

likely to provide interesting case study material in future.

Some general conclusions and lessons learned from implementation of the seven initiatives described in this *Technical Brief* are highlighted below:

1. Involving clients and community representatives in the assessment and monitoring of service delivery opened up space for citizen voices to be heard in the health sector and helped strengthen provider responsiveness to client needs. Approaches such as PPRHAA, integrated supportive supervision and PFQA are promising from a V&A perspective, and could easily be adapted for replication in other Nigerian states.
2. Clients and communities need to be supported so that they can participate in processes such as PPRHAA and ISS in ways that extend beyond token involvement. This requires greater investment in the provision of training and mentoring support than was the case in some of the PATHS states. Finding ways to improve the quality of women's participation in these processes is important. Ignoring gender differences in experience and confidence to participate in public fora will mean that men's voices continue to take precedence in these processes.
3. Involving members of the community in the governance of health facilities through facility health committees proved an effective way to progress a V&A agenda. However, to ensure that these committees functioned effectively, considerable capacity building support, in the form of formal training and on-going mentoring support, was required. The quality of community participation in FHCs was low in the PATHS states that relied on a one-off training, whereas in Kaduna, where the support was more broad-ranging and extensive, early results pointed to some interesting V&A outcomes.
4. Initiatives that provided *formal mechanisms* through which citizen voices could reach health providers and policy makers (see Table 4) appeared to offer the most potential from a voice and accountability perspective. Examples were PPRHAA, ISS and CAC. In the PATHS states these initiatives not only placed an *obligation* on different parts of government to listen to the voice of the people, but also introduced *incentives* to respond.

**Table 4: Reaching Health Providers and Policy Makers Via Formal and Informal Routes**

Initiative	Health Providers		Policy Makers	
	Formal	Informal	Formal	Informal
PPRHAA	*		*	
PFQA	*			
ISS	*		*	
Facility Health Committees	*			*
Safe Motherhood Demand Side	*/-			*
Community Action Cycle	*		*	

5. In contrast, initiatives that relied on citizens trying to influence policy-makers via informal routes (e.g. safe motherhood demand-side initiative and facility health committees) could not guarantee that citizens would get an audience with a policy-maker, while getting a response appeared to depend on a policy-maker's personal initiative or whim. Such initiatives are likely to fail in the absence of parallel efforts to strengthen public accountability at local government level. This highlights the importance of timing work on V&A so that it links in with other initiatives that aim to strengthen performance management and public accountability at local government level.

One implication from the above is that where facility health committees are being supported, V&A outcomes may be better if committee members are encouraged to channel their demands to local government through performance monitoring and supervisory processes such as PPRHAA and ISS. This calls for better integration - on the ground - between different systems strengthening processes.

6. Government-led V&A initiatives, such as defining standards of care and introducing patient charters can help create an enabling environment for voice and accountability. However, it is crucial that these initiatives do not remain a 'paper exercise'. Their provisions need to be widely publicised so that service users and communities are better informed and better able to use the standards as a reference point for claiming their entitlements.
7. Citizens' willingness to challenge policy-makers about poor quality health services in some instances opened up a space for providers to manoeuvre for improved resources or working conditions. A good example was where a FHC in Kaduna documented the arrival of free MCH drugs, calculated the gaps in provision, and then wrote to the State Free MCH Committee to complain about the under-supply of essential drugs. More work is needed to document the extent to which, and how, growing citizen confidence to claim improvements in services catalyses and influences providers' efforts to demand change from policy-makers.
8. Civil society organisations, such as NGOs and CBOs, have a potentially important role to play in creating space for voice and catalysing changes in accountability between providers, policy-makers and communities. This requires further exploration as new V&A initiatives are designed and implemented in Nigeria.





Partnership for Transforming Health Systems (PATHS)



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