



Examining the links between accountability, trust and performance in health service delivery in Orumba South Local Government Area, Nigeria

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This paper is an output of the Consortium for Research on Equitable Health Systems (CREHS). The authors are based at Health Policy Research Group, University of Nigeria (Enugu), Nigeria.

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List of Acronyms

CHEW	Community Health Extension Worker
DRF	Drug Revolving Fund
FCT	Federal Capital Territory
FGD	Focus Group Discussion
HFC	Health Facility Committee
HOD	Head of Department
IDI	In-Depth Interview
IDU	Isulo Development Union
IWC	Isulo Women Congress
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
MDG	Millenium Development Goal
NPHCDA	National Primary Health Care Development Agency
OIC	Officer In-Charge
PHC	Primary Health Care
UDU	Ugwuaro Development Union
UNFPA	United Nations Fund for Population Activities

Executive Summary

Accountability in Primary Health Care (PHC) delivery services is known to be important in delivering health care to the people. However, its impact on healthcare delivery is unknown in Nigeria. This study therefore examined the effects/impacts of health facility committees (HFCs), a specific type of accountability structure, on health service delivery and resource mobilisation. It also investigated the influence of trust over the functioning of HFCs.

The study took place in the Orumba South Local Government Area (LGA) in Nigeria. The first phase of data collection involved a rapid appraisal of 25 HFCs in the LGA to assess their levels of basic functionality and to provide information for the selection of the sites for the detailed case study work. Functionality was judged according to certain criteria: gender composition of the committees; the frequency of the committees' meetings; consistency of member attendance over time; and whether the committees kept minutes of their meetings. This information was obtained by interviewing the health officer in-charge (OIC) of the facility and the HFC chairman. After the rapid appraisal, one more functional and another less functional committee were chosen for detailed investigation of the impact of the committees and the role of trust in the functioning of the committees. The key data collection strategies included in-depth interviews with different stakeholders, focus group discussions with community members and observations of HFC meetings. Data analysis was done using Nvivo 8 software.

The results showed that the more functional HFC improved the availability of health workers in the health facility to which it was attached. Linkage with other local accountability structures, provision of infrastructure and proper information dissemination strengthened the functionality of HFCs. The leadership style of the committee chairman, support by and linkage with other community accountability structures through financial contribution, and provision of manpower for work at the health facility made the committee more functional. On the other hand, the less functional HFC experienced lack of funds for health activities. In addition, lack of remuneration for committee members, power struggles/social conflicts within the community and lack of information about the HFC contributed to its low functionality.

Furthermore, there is evidence of both interpersonal and institutional trust as a factor that underpins the relationships between the health facility committee and other stakeholders, showing that trust relationships are important elements in local accountability structures such as HFC. Efforts should also be made to remunerate the committee members, strengthen health worker motivation and resolve tensions between local authorities.

1. INTRODUCTION

The delivery of quality primary health care (PHC) services can have a large impact on the health of Nigerians. Many of the most cost-effective health interventions to prevent and treat the major causes of mortality and morbidity in the country and progress towards the health Millennium Development Goals (MDGs) can be offered at this level of care. In addition, equity concerns draw attention to PHC as the poor in Nigeria are more likely to seek care in PHC facilities than the rich (FMOH & WB, 2005). Community participation in primary health care service delivery has been institutionalised in Nigeria through the creation of Village Development Committees and District Development Committees and it has been shown that there are striking differences in their functioning in different states of Nigeria (Monica, 2003). This urban-rural study showed that primary health care service delivery in Lagos is influenced by the availability of private facilities and proximity to referral centres, while this is done by the public health facilities with extensive community participation in Kogi states of Nigeria. The extent to which these committees are committed to services at the primary health care centres is not known.

Accountability can be understood as having the obligation to answer questions regarding decisions and actions (Brinkerhoff, 2004). This implies that someone or an organisation should be answerable and sanctions can be applied to restore order. The availability of these sanctions for wrong actions or behavior makes up a defining element for accountability (USAID, 2006). Accountability has also been noted as a key element in implementing health sector reform and strengthening health system performance (Brinkerhoff, 2003). The weakened health systems and lack of due process has necessitated the urge to provide health services effectively, efficiently and equitably. This, in turn, stems from dissatisfaction with health system performance (in terms of transparency and feedback to health service users). Strengthened accountability is therefore widely called for as a remedy for health system weakness around the world. However, there are many challenges to achieving greater accountability in the delivery of PHC services. These include the divergence of public and private interest and incentives meant for its upkeep as well as the motivation of the health workers (Bennett et al 1997, Shaw, 1999), lack of capacity to carry out accountability functions and the strong asymmetries among providers, users and government in terms of information, expertise and access to information (Miller & McKevitt 2000, Shaw 1999).

The framework on service delivery of the World Development Report of 2004 explains service performance through three accountability relationships (World Bank, 2003): “voice” between citizens/clients and politicians/policymakers; “compact” between policymakers and providers; and “client power” between clients and providers. Clients (the patients) in a PHC facility have a relationship with providers, nurses, community health workers and others. Users can hold private providers accountable through the power of their payments. If they are not satisfied with the service, they can look for services somewhere else.

To improve service delivery to the clients at public health facilities, community members have two different routes: a long route of pressurizing their elected officials to ensure that providers offer quality services, and a short route of increasing their power over the provider. Often patients are unaware of their rights or feel disempowered to challenge practises that might seem unfair (Freedman, 2007). The health system has been shown to sometimes block, even quite limited, citizen involvement in low income settings (Zakus and Lysack, 1998).

One mechanism to increase clients’ power is through their direct involvement in co-providing and monitoring health services. In the Nigerian context, this is where health facility committees have a role

to play. These committees are structures attached to PHC facilities and are intended to contribute positively to the development of the facilities (Enugu State Health Sector Reform document 2006). These committees have been in existence but with varying degrees of functionality (FMOH 1994). In principle, they are expected to pursue financial accountability, accountability for service delivery performance and political/democratic accountability.

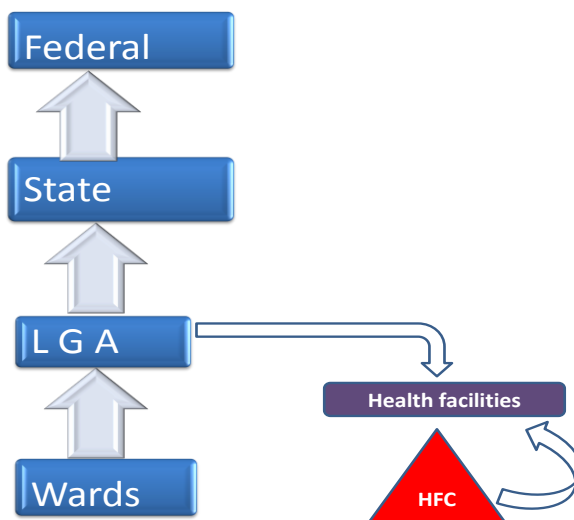
Accountability is also ultimately built on relationships, such as the relationship between patient and provider or citizen and policy-maker. This suggests that it might be useful to specifically explore the influence of trust – a key ingredient in all human relationships – over the functioning of accountability relationships and structures. Trust is relevant both to relationships between people and to those between people and organisations. Interpersonal trust is based on the belief that another person will act in my interest, or at least not harm me. Organisational trust is developed through a combination of inter-personal interactions combined with the existence of institutions (rules, laws, norms and customs (Ben-Ner & Putterman, 1998) that encourage organisational representatives to act in their interests. Theory suggests that performance, accountability and trust are inter-linked.

This study, therefore, sought to investigate the accountability relationships of health facility committees. It assessed why some health facility committees are functional when others are not and also sought to trace the effects/impacts of committees on health service delivery (with a particular focus on human resource issues) and resource mobilisation. While it considered other influences over the functionality and impacts of health facility committees, it also sought specifically to understand the role of trust, both within the health facility committee and in the relationships between the health facility committee and other stakeholders.

2. SPECIFIC STUDY CONTEXT IN NIGERIA

Nigeria operates a federal system of government with three levels: the federal, the state and the local government areas/councils (LGAs). There are 774 LGAs within the 36 states and Federal Capital Territory (FCT) Abuja. The 774 LGAs are further sub-divided into 9,565 wards. This structure is shown in Figure 1 below.

Figure 1: Administrative structure in Nigeria



According to the National Health Policy, the federal government is responsible for policy formulation, strategic guidance, coordination, supervision, monitoring and evaluation at all levels. It also has operational responsibility for disease surveillance, essential drugs supply and vaccine management, as well as for providing specialized health care services at tertiary health institutions (university teaching hospitals and federal medical centres). The federal Ministry of Health and its parastatal agency, the National Primary Health Care Development Agency (NPHCDA), establish policies and guidelines regarding the provision of PHC. States largely operate secondary health facilities (general hospitals and comprehensive health centres), providing mostly secondary care and serving as a referral level for the LGAs. The LGAs have the main responsibility for managing PHC services (with the HFCs attached to these primary care facilities), and in principle, work in collaboration with the state authorities. The states can also generate policies and guidelines that affect basic health services. Communities/towns make up an LGA and villages make up a community/town. The ward is the smallest political structure, consisting of a geographical area with a population range of 10,000 to 30,000 people. On average, there are ten wards per LGA, each represented by an elected councillor. Wards are close to the community and are an operational level in the Nigerian administrative and political system. In some cases, there could be more than one ward in a community/town and in others, a ward could be equivalent to a community/town depending on its population. Each ward is subdivided into sections in urban areas and into groups of villages in rural areas. The ward has been selected as an operational area for delivering a minimum health care package in the country. Thus, according to the ward health system operational guideline (NPHCDA 2004), each section or group of villages should have a health post and each ward should have

a health centre that should serve as the first reference point to the health posts in the same ward. Thus, the PHC facilities are an outgrowth of LGAs and the HFCs are linked to these facilities in the LGAs.

The Nigerian Government has long recognized the importance of community participation in the delivery of basic health care services and has thus tried to involve communities in the development of PHC along the lines of the Bamako Initiative (Uzochukwu et al. 2004) through the formation of health committees. The national guidelines for the development of the PHC system (NPHCDA, 2004) established the following health committees to support activities at village and ward levels: Village Development Committees; Ward Development Committees; and Local Government Development Committees. According to these guidelines, the roles and responsibilities of the Village Development Committees regarding health facilities (also called health facility committees, covering health centres, posts and dispensaries and participate in purely health matters), include:

- (i) determining exemptions of drug payment and deferment;
- (ii) determining the pricing of drugs;
- (iii) supervising and monitoring the quantity of drug supply;
- (iv) supervising all account books;.

The Ward Development Committee is synonymous with the Village Development Committee where there is only one village making up a ward. If one health facility exists in a village or ward then the term Ward Development Committee, Village Development Committee and Health Facility Committee can be used interchangeably. However, regardless of the number of public health facilities in a ward, each facility has a HFC and this only applies for health centres and health posts which are the responsibility of the local government. Hospitals are not included as they fall under either the states or the federal government.

Ward Development Committees are expected to:

- (i) take an active role in supervising and monitoring Ward Drug Revolving Funds/ Bamako Initiative;
- (ii) supervise the activities of Village Health Workers and Community Health Extension workers (CHEWS);
- (iii) monitor activities at both the health facilities and village levels;
- (iv) oversee the functioning of health facilities in the Wards;
- (v) monitor equipment and inventory at monthly intervals; and
- (vi) ensure the proper functioning of the health facilities using a maintenance plan.

The local government development committees have responsibility for liaising with all other health development committees, for leading, planning and managing (including budget management) PHC activities in the local government area, and for monitoring health activities at health facility and community levels. These committees supervise the ward committees and the ward committees supervise the village development committees.

These types of committees have been in existence for some time and are known to have varying degrees of functionality (FMOH, 1994). A study (World Bank & FMOH, 2008) has shown that half of all PHC facilities in the country have or are linked to a health facility committee but these committees are present only in two thirds of public facilities and in less than a third of privately managed ones. The majority of the members of these committees are men and the involvement of these committees in the management of facilities is rather limited, as most decisions are taken by either the officer in-charge of

the facility or by the local government authority. The study noted that this was not surprising as many of these committees were originally created to support health activities in general and did not have a strong mandate to participate in the facility management. However, there has been some policy development to give them this role both in facility management and, more specifically, in oversight of facility health workers and of revenue collection practices associated with the drug revolving funds linked to the Bamako Initiative (Uzochukwu et al. 2004).

Research for this study was conducted in Anambra state. Leadership in rural areas such as this, in addition to what formal government agencies might do, is achieved through the town unions, age grades, and the "Igwe" in council. There are also often youth clubs or women associations. The town union is an agency of the community through which innovations and development purposes are achieved for the community. They consist of organisations of people from the same town or community formed for the purpose of developing their various towns socially, culturally, physically, economically, and politically. The town unions embrace people from all walks of life in the community such as civil servants, businessmen, farmers, academics and politicians. It is made up of an executive body that deliberates, presides over and oversees the activities of the unions (Okeke 1988). They have existed in Nigeria since before the 1940s and came into existence as a response to the failures of indirect rule and warrant chief systems in Igbo land during the colonial days.

Town unions are perceived as instruments and catalysts for community development. While they have been useful in some communities, in other communities they have been under-utilised. In recent times, most town unions have championed rural development in Anambra state. Interestingly enough, every community in Anambra state has a town union. Town unions are also referred to as development unions or progressive unions. Each town union has a written constitution, developed by the members, which contains clearly stated responsibilities and methods of generating funds for financing projects. The constitution also states clearly how elections should be conducted. The relevance of the town unions is further underscored by the fact that the formal tiers of government (the LGA, State and Federal) are all distant with levels of bureaucracy between them for the majority of the people who should ultimately benefit from their service.

The age grades, on the other hand, are people of the same age (usually gender separated) who belong to the same age group. Each age grade normally compiles a list of its potential members that are to be inducted, upgraded or promoted into it during the next upgrading exercise. Entry into an age grade is occasionally marked by an initiation ceremony. These groups are under the guidance of a senior person. Members may be initiated either collectively or individually into a more senior age grade. Activities in the community e.g. manual labour are carried out by age grades starting with the younger age groups.

A last important role player is the Igwe. The Igwe is the traditional ruler/leader of the community and advises the community directly or indirectly through all the local groups under him on matters pertaining to tradition and culture. The Igwe with the council members (members of his cabinet) and the town union represent the informal administrative machinery at the community level. They are often referred to as the grassroots administration which liaises with the formal local and the state government for the welfare of the community. They are not government personnel, but act as a link between the LGA and the community. However, disputes between the traditional rulers and the town unions as well as disputes in the organisation and management of the development unions are common in Anambra state (Nwosu 2008).

3. METHODS

Study Area

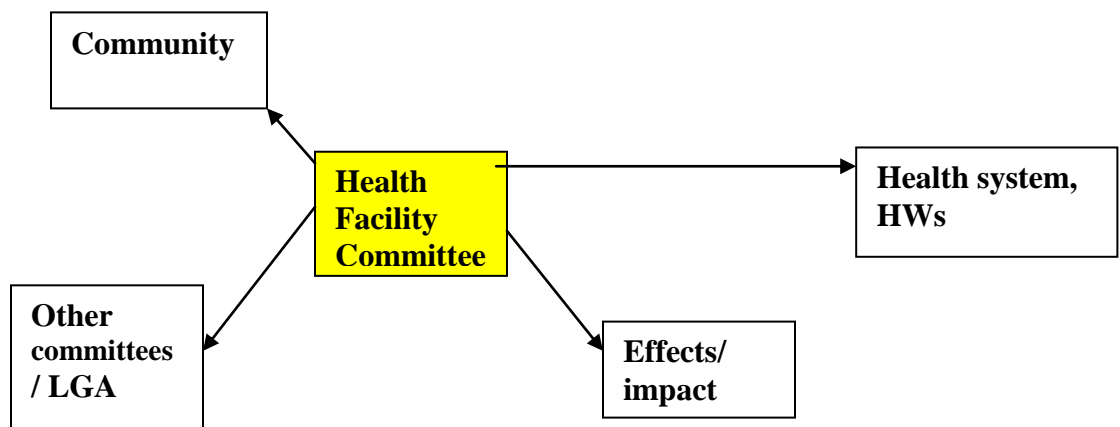
The study was conducted in Anambra state, Nigeria. The state comprises 21 LGAs, 330 wards and 177 communities, with the state capital at Awka. The 2006 census population of the state was 4, 453, 964. There are 33 secondary health facilities, 382 primary health care centres and one tertiary health institution in the state. Private health-care providers also offer services. The HFC system has been operational since 1994.

The case study area was Orumba South, a rural Local Government Area. Orumba South is about 70 kilometres from the state capital and is comparable in general development terms to other rural LGAs in the state. There are 18 wards and 25 health centres in the LGA. At the time of this study, the LGA was benefiting from a European Union Partnership (EU-PRIME) that aimed to improve immunisation coverage.

Study design

This study was an explanatory two-case inquiry (Yin 2003) of HFCs. The use of the case study approach was to allow a detailed examination of the functionality of the committees, their effect/impact on health worker performance and resource mobilisation and use. The role of trust in the functioning of the committees and their linkages with other stakeholders in the community was also explored. The relationships explored in the study are reflected in Figure 2.

Figure 2: Overview of relationships explored



Site selection

Two HFCs in two rural communities from the same LGA were selected to keep the context constant. One more functional (Isulo) and another less functional (Ugwuaro-Umunze) committee were chosen after the rapid appraisal was carried out. Minimal functionality of the committees was measured in terms of a range of core indicators: frequency of meetings; composition of committees, consistency of members' normal attendance; consistency of members' attendance over time; and minute keeping. These indicators were scored on a range of zero to three for each HFC and each indicator had a maximum of three points. These were later added up to give the total scores with a maximum score of 15 points. The

HFCs were then categorized into high, medium and low functionality. From the group of the eight high functionality HFCs, Isulo was chosen by simple random sampling as the more functional case. From a base of 13 medium functionality HFCs Ugwuaro was chosen by simple random sampling as the less functional case. The two HFCs with low levels of functionality were excluded because of the risk of not yielding much relevant information for the purpose of the study. We also explored what committees were trying to do and their impact by means of open-ended questions.

Data collection

The initial preparatory work involved engagement with local health officials to secure understanding of the project and to collate relevant national and state documentation. This document review gave us an insight into the main current trends of policy and experience around local-level committees, and specifically facility health committees, in Nigeria. Secondly, it clarified the specific features of context likely to have influence over the operations of these committees. Contextual information was included in the history of the range of relevant local accountability structures (their responsibilities, authority and inter-linkages and formation) with interest in health and health care issues, and specifically HFC; the current legal standing and basis of all local-level structures of interest; the current allocation of responsibilities and authority between the accountability structures and health management structures; the political and socio-cultural traditions and practices that are likely to influence community involvement in health; the nature and drivers of any current external influences over the operation of local accountability structures, and specifically HFCs.

The first phase of case study data collection involved a rapid appraisal of the existing accountability structures in the LGA to assess their level of functionality. This information was collected through interviewing the officer in charge (OIC) of the health facility and the committee chairman, allowing validation by comparison between respondents. The information collected was also validated by comparing it with minutes of the committee meetings where available. Finally, to assist with the initial assessment of functionality, the researchers asked open-ended questions about the activities and impact of the local-level accountability structures. All 23 HFC currently existing (two facilities had no HFC) in Orumba south LGA were visited as part of the rapid appraisal after which two were selected, as outlined above. During the in-depth phase of work, one month was spent in each selected site. This enabled the researchers to develop a rapport with key stakeholders and capture rich information about the case studies and the underlying contextual factors that affect them.

In collecting the data, we wanted to see what impact the HFC was making in terms of certain health system indicators and resource mobilisation indicators (the presence of health workers and their availability in the facilities, opening and closing times of facilities, addressing negative health worker attitudes to patients, the nature of activities/inputs for which resources were requested, the management of funds, equipment availability within facilities and the state of infrastructure). The idea was then to explore the factors that enabled or constrained these impacts.

Data collection methods:

The following data collection methods were used:

- 1. Document review:** Policy documents relating to local-level accountability structures, their roles and responsibilities were compiled and reviewed. Published and unpublished literature on the role of local-level accountability structures and accountability within the health system were also included in the review.

2. In-depth interviews (IDIs): In-depth interviews were conducted with the members of the selected local-level accountability structures, health workers in the facility attached to the committee, prominent members of the local community, and members of other structures (the head or his/her deputy if unavailable). The interviews covered, among other things, the functioning (including the role of trust) and claimed impact of the structures, awareness of and participation in the activities of the accountability structures, as well as their perceptions about the impact of the accountability structure. All in all, 16 and 11 IDIs were conducted in Isulo and Ugwuaro, respectively. The socio-demographic characteristics of those interviewed are shown in the Annex.

3. Focus Group Discussions (FGDs): Focus group discussions were carried out with community members from each site with the aim of gathering information about issues such as the linkages between the HFCs and the community, the pattern of engagement among different community groups and the accountability structures' perceived impact on health service delivery. Two focus groups with eight to eleven respondents were conducted per case study site, with separate focus groups being held for men and women. The FGDs lasted between 60 to 80 minutes each and were conducted in quiet places like the primary schools and the civic centre to avoid unnecessary background noise. The socio-demographic characteristics of those interviewed are shown in the Annex.

4. Observations: In each site, two meetings of the HFCs were attended. Some time was spent observing health worker practices and the functioning of facilities. This helped build a rich picture of the functioning of the HFCs and also assisted in verifying information about matters such as the claimed impact of accountability structures. Time was spent in communities to better understand the local context and to validate data on responses across the different methods used. Minutes of two earlier HFC meetings (April and May 2009) were obtained in Isulo. The minutes showed the members in attendance for the meetings. It also demonstrated how they set their agendas and how the HFC members follow them through in the next meeting based on the issues identified at the health centre. The minutes also illustrated how money is received and spent. For Ugwuaro, there was no HFC meeting, and therefore, no minutes of the meeting. At the facilities, other observations made included staffing levels, adherence to opening and closing hours, availability of equipment and essential drugs, how the HFC members engage in ensuring that the state of the buildings and its surroundings are kept to standard. The availability of posters and information sheets on the walls were noted. Deliveries were also observed at the health centre to understand health worker performance. By the end of the study period, five deliveries had been observed at Isulo and in Ugwuaro, there was no delivery during this period. The observation also focused on HFC support to the deliveries, especially their effort in ensuring security for the newly confined mothers and making the health centre comfortable. A total of four health facility observations per site were made.

4. RESULTS

Rapid appraisal results

The first phase of the case study data collection involved a rapid appraisal of the existing health facility committees in the Orumba LGA to assess their level of functionality. Functionality was judged according to some basic indicators. Table 2 shows the results of the rapid appraisal of the HFCs against the functionality indicators. All 25 health centres in the LGA were visited as part of the rapid appraisal, but only 23 had a HFC.

The Table below shows the scoring system used to assess functionality:

Table 1: Functionality assessment scoring system

	VARIABLES	RANGE	SCORE
1.	HFC composition (female:male)	1:1 to 1:2	3
		1:3 to 1:4	2
		Above this	1
2.	Meeting frequency	> 1/month	3
		1/month	2
		< 1/ month	1
		None	0
3.	Consistency of attendance (number of members regularly present at meetings)	75% or more	3
		50%-74%	2
		< 50%	1
4.	Consistency of attendance in the last three months (members constantly present at each meeting in the past three months	75% or more	3
		50%-74%	2
		< 50%	1
5.	Availability of minutes	Yes	3
		No	1

Based on the information gathered, the HFCs were placed in the following categories:

- HFCs with high functionality: 11 to 15 points = 8 HFCs
- HFCs with medium functionality: 6 to 10 points = 13 HFCs
- HFCs with low functionality: 1 to 5 points = 2 HFCs

Isulo HFC received the maximum score as they were fully meeting basic expectations. On the whole, of the 23 HFCs that had one form of functionality or the other, eight (34.8%) were highly functional, while 13 (56.5%) were judged to have medium functionality. However, two (8.7%) were placed in the category of low functionality. Two HFCs were not functioning at all. In HFC composition, the committees seemed to have done well in keeping to gender balance as nine (39%) of them were in line with the expectation of having at least 30% females members. Another 39% came close to this expectation, with only five (21.7%) in complete disregard of the standard procedure. In terms of meeting frequency, one of the major factors for distinguishing between functional and non-functional, a majority or 12 (52.2%) of the committees were meeting at least once a month and when they do meet, 75% or more of the members

were usually present in four (17.4%) of the committees, while half of the members were usually present in more than half 12 (52.2%) of the committees. However, only nine (39.1%) of the committees kept their minute books. It is worthy to note that there are some differences among those in the medium category. For example, regarding their meeting frequency, some were meeting at least a few times and some hardly met at all. Also interesting is the fact that Enugu-umuonyia meets irregularly even though it is high scoring. This has implications for functionality as issues are not regularly discussed.

Table 2: Functionality assessment for Orumba South Health Committees

Name of ward	HFC composition (F:M) 1:1 to 1: 2 = 3 1:3 to 1:4 = 2 Above this = 1	Meeting frequency >1/month = 3 1/month = 2 <1/month = 1 No meeting at all = 0	Consistency of attendance/ normal attendance 75% = 3 50% = 2 <50% = 1 None = 0	Consistency of attendance last 3 months 75% = 3 50% = 2 <50% = 1 None = 0	Minutes book Y = 3 N = 1	Functionality
Isulo	9 (4m,5f) 3	Twice Monthly 3	7/9 3	7 / 9 3	Y 3	High 15
Ihite	10 (3f,7m) 2	Once Monthly 2	5/10 2	8 / 10 3	N 1	Medium 10
Ow Ez I	11 (3f, 8m) 2	Twice Monthly 3	8/11 3	8 / 11 3	Y 3	High 14
Ow Ez II (Ihie)	7 (2f, 5m) 2	Once In 2 Months 1	5/7 2	5 / 7 2	N 1	Medium 8
Ogbunka I	6 (2f, 4m) 3	Once In Nov 2008 1	2/6 1	0/6 0	N 1	Medium 6
Ogbunka II	10 (4f,6m) 3	Once In 2 Months 1	7/10 2	7 / 10 2	N 1	Medium 9
Nawfija	10 (2f,8m) 1	Irregular/Emergency Basis 1	3/10 1	0/10 0	Y 3	Medium 6
Ezira	10 (4f,6m) 3	Once Monthly 2	6/10 2	7 / 10 2	N 1	Medium 10
Umuchukwu	8 (3f,5m) 2	Once Monthly 2	3/8 1	3 / 8 1	N 1	Medium 7
Eziagu	10 (2f,8m) 1	Not meeting at all 0	0/10 0	0/10 0	N 1	Low 2
Umunze I						
Ugwuaro	12 (3f,9m) 2	Irregular/Emergency Basis 1	5/12 1	5 / 12 1	N 1	Medium 6
Ndikpa	10 (All Men) 1	Once In 3 Months 1	6/10 2	6 / 10 2	N 1	Medium 7
Umuchioma	10 (2f, 8m) 2	Once Monthly 2	7/10 2	10/ 10 3	N 1	Medium 10

Umunze II						
Lomu	10 (6f, 4m) 3	Once Monthly 2	6/10 2	6 / 10 2	N 1	Medium 10
Nsogwu	10 (2f,8m) 2	Once Monthly 2	6/10 2	6 / 10 2	Y 3	High 11
Amaikpa	6 (2f, 4m) 3	Irregular/ Emergency Basis 1	3/6 1	0/6 0	N 1	Medium 6
Umunze III						
Ururo	10 (4f, 6m) 3	Once Monthly 2	6 /10 2	6 /10 2	Y 3	High 12
Akpu	14 (4f,10m) 2	Once Monthly 2	7 /14 2	7 /14 2	Y 3	High 11
Ogboji	10 (4f,6m) 3	Once Monthly 2	8 /10 3	8 /10 3	N 1	High 12
Onneh	10 (7f, 3m) 3	Once Yearly 1	6 / 10 2	6 / 10 2	Y 3	High 11
Agbudu	6 (All males) 1	Not meeting at all 0	0/6 0	0/6 0	N 1	Low 2
Enugwu- Umuonyia	14 (3f, 11m) 2	Irregular 1	10 / 14 3	10 / 14 3	Y 3	High 12
Umuomaku	8 (All Males) 1	Once Monthly 2	5/8 2	5/8 2	Y 3	Medium 10

Detailed case study findings:

Isulo (more functional)

Historical Context

Isulo town is one of the 15 autonomous communities and also one of the 18 political wards in Orumba South LGA. It is made up of two major sections which are *Akata Akwuosa* and *Isu*. These sections are made up of various villages: *Umudabezim*, *Uhuala*, *Isuebeke*, *Ubaha Akwuosa*, *Ubuluhu* and *Alaohia*. Based on the 2006 national census, the projected population of Isulo for 2009 is 10,955. The ancestral mother of Isulo is said to be the only daughter of Nze, the founder of the present day Umunze who got married and gave birth to the present day Isulo. Isulo town is bounded in the North by Nawfija town, in the south by Ezira town, in the east by Eziagu town and in the west by Ogboji town. All these boundary communities are also in Orumba South LGA. Other towns that maintain a cordial relationship with Isulo town and also share similar traditions are Aroh and Ajalli. 'Isu', as the town was originally called, meant 'to fight'. They engaged in a lot of wars and had many warriors. With the advent of Christianity in 1918, the wars stopped and the name of the town was changed to 'Isulo', which means 'cornerstone of the home'.

The people are highly agrarian and their principal occupation is farming. Staple crops include yam, cassava, rice, cocoyam and vegetables. They are also great hunters, they have a lot of bush meat (especially grass cutters (*nchi*)) and this delicacy is what they fondly call 'Isulo hospitality'. A few people also engage in wine tapping. Like all Igbo tribes, they celebrate the new yam festival in the eighth month of the Igbo calendar, which now falls in September. Another festival is the 'Iheokpara' masquerade festival which is celebrated after harvesting the year's crops, but before the new planting season. The town has a market which operates on a cyclical basis. The market is called *eke* Isulo and takes place every four days. It used to be *Nkwo* until another market now called *Nkwo* market was created in Umunze to distinguish between the two and this has stirred competition between the two markets. The people of Isulo look forward to *eke* market day and keep all their shopping for that day. This is because all forms of items are brought to the market from neighbouring villages and they are actually cheaper. Other villages in Isulo have their market days which also go by the traditional names of the four market days (*Eke*, *Orie*, *Afo* and *Nkwo*).

Isulo has two primary schools, two secondary schools and a school for the handicapped. There is also a modern library built by one of the eminent members of the community. The Basden memorial secondary school was the first secondary school built in the 1960s and this school attracted people from the neighbouring towns of Ajalli and Ufuma. The New Bethel (a boys only school) then was built in memory of one of Isulo's prominent men and was relocated from Onitsha (an urban centre about 60 kilometers from the town) after the Nigerian civil war. Due to the problem of large numbers of people not being enrolled in schools, the New Bethel, that used to be only for males, was converted into a coed school, while the Basden memorial secondary school is now the special vocational school funded by the government. The founder of both schools was a prominent member of the community.

The town has five Christian churches made up of Anglican, Evangelical and Pentecostal types. Traditional religion also thrives here with numerous shrines located in the area. The Anglican Church was first introduced by a community member and 80% of the inhabitants are Anglican. There are other prominent philanthropists that embraced Christianity.

The community has three bore-holes for water supply: one provided by the government; one by the community; and one by a philanthropist from the town. Other sources of water supply include a number of streams, namely Osu (the main stream with tributaries to other locations such as Osu Alaohia, Osu Ikpaja, and Osu Basden, all of which are located around a place called Uzo Okpoeze), Nwoku and Nwogboligbo. The community has a good network of un-tarred rural roads, all of which can be transited by motor vehicle all year round. The only tarred road is the Ekwulobia-Umunze-Ibinta federal highway which traverses the town. Tarred roads in the community were first made by a traditional ruler under the political party of the 1960s called NCNC when His Excellency Chief Nnamdi Azikiwe (the former President of Nigeria) was in government. Recently, due to the rain, the road has not been maintained and it seems like it will take some time before it is repaired. Isulo also has a modern post office which aids communication. Ubuluhu village first installed electric poles with high tension wires through the Olumba bishop, but these were not functional. It was during the political reign of one of the community members that an electric transformer was brought in to supply electricity at phased level in the villages, starting with Alaohia village, while others remained in the dark. The electrical installation was disrupted by a prominent member of the LGA since he felt it was partial. Another transformer was later brought in through community efforts.

Traditional institutions

Traditionally, the community is headed and governed by the *Igwe* who also has a cabinet of red cap chiefs that assist him in critical decision making. To date, three *Igwe*s have occupied the royal throne, with each being replaced due to death or old age. Other institutions that help in the governance of the town include: the Isulo Development Union (IDU) which is the town union government; the age grades (people of the same age group that come together); the Obu Ogu women (also called 'the umu adas'), who are the married daughters of Isulo; the Isulo Women Congress (IWC) a meeting/organisation of all women from the community; the social club (for men only); abroad members (community members not residing in the community but who usually come back during festivity periods) and religious groups.

Facility context

The health centre is situated in a quiet environment in a neatly kept compound with trees and flowers which seemed to be trimmed regularly. The facility is about 120 meters from the tarred road and hence accessible. There was a small farm noticed in the compound and this belonged to the officer in charge (OIC), who also resides in the compound. There is a four-deck double shelf in front of the health centre where baby items and other articles needed by pregnant women for delivery are displayed for sale, as well as other items for convenience such as sanitary towels, Pears baby soap, cabin biscuits, mineral drinks, and liquid milk. The health centre has a lot of space and there are approximately five benches outside the veranda where people can sit. This is used as a reception area. There are 15 beds, but only five beds were in use. The facility environment is very neat and it was noticed that the health workers also help with cutting the bushes and sweeping around the building. It is noteworthy that the community members built the health centre and sunk the bore hole before handing the facility over to the government.

The health centre was initially a large hall with no demarcations, but was later partitioned into nine rooms by the Isulo Women Congress: a consulting room where the OIC attends to patients; a labour room; an injection/treatment room which also doubles as a room for women in the first stage of labour; a laboratory with a few pieces of equipment; two unused rooms with beds and a small cubicle built like an alcove where there is another table and chair; a store; and two other cubicles where items that cannot be put in the store are kept. On the outside are two pit toilets (built by the Millennium Development Goal project in 2005), a placenta pit, a bathroom and a kitchen.

The equipment in the health centre includes: a weighing scale; a sphygmomanometer; a foetal stethoscope; an adult stethoscope; a non-functional oxygen gas cylinder; two non-functional autoclave machines; 2 cold boxes; 2 vaccine carriers; a new piece of equipment for measuring height; an examination couch; a temperature gauge; and some drugs such as barbimox, hydrex, paracetamol, flagyl, and vitamin C syrup. The OIC has a personal office, while the other health workers share a common room. The health centre also admits nursing students from the Anambra state school of nursing for their internship and also provides accommodation for them.

The services offered at the health centre include: antenatal care and deliveries; immunisation services, the treatment of common endemic diseases such as malaria, diarrhoea, cough, and skin infections, and basic first aid services for burns, cuts and bruises. In addition, the health workers and the community members are involved in insecticide-treated net distribution using the free net card, distribution of mectizan for the prevention of onchocerciasis and immunisation services. It was noticed that a chart recording various childhood diseases treated at the health centre daily for each month of the year was posted on the wall and also a chart recording the routine immunisation and dropout rates of the community. The laboratory has acquired HIV test kits and about five HIV tests had been done there since April 2009. A fee of 500 Naira was charged for the test. The kits are supplied by the local government whenever they run out of stock. EU PRIME aided in the water project which failed in April 2009. According to our informants, the pipe was not sunk deep enough and the digging was shallow so the initial water spurt had run dry. The OIC wrote on the wall '4/4/09' as the date when the tap actually stopped running. There is another source of water close to the health centre but there is no generator to help pump the water out, so the staff goes there to fetch water as its only source.

The facility has no stable electricity supply and no generator to provide electricity for the storage of the vaccines. It was noted that the Isulo Development Union (IDU) had levied all the community members N500 to secure electricity. The OIC, through the HFC, has also written to the Local Government requesting a solar fridge so they can store vaccines, especially BCGs for tuberculosis. At the time of the study, nothing had yet come of this. All newly born babies are brought to the health centre on Wednesdays for immunisation. The new OIC has been in the health centre for about two years. She replaced an OIC that was forcefully removed by the HFC. She works hand in hand with the other staff members totalling seven in number:- the lab technician, one CHEW, two JCHEW, the OIC and a cleaner.

The OIC is recognized as the secretary of the HFC and she is said to be hard working in this role. She engages the other health workers in meetings emphasising on moving the health centre forward. Most of the information she gives them (the health workers) are from HFC meetings. This was noted during one of the meetings attended by the researchers to observe what the health workers actually do. In terms of maintaining the environment of the health centre, the OIC in particular, who is a committee member, cuts the bushes around the facility and sweeps it. She sets this example and encourages other health workers to follow. She has a roster for this exercise as well. After one of their meetings, when it was decided in the HFC meeting that some people were coming to offer free eye checks, the HFC members decided it was necessary to keep the health centre clean to receive them. The OIC as the closest link between the health workers and the HFC said she was going to see to that. The OIC has been particularly praised by the community and HFC members as very hard working and fair with a keen interest in her work. The OIC came in just two years before the study was conducted to replace an OIC who was not performing well. Her removal was put into effect by the Health Committee that, through the chairman, wrote to the IDU requesting for a new OIC. This shows the HFC's capacity to take action on human resource issues at the facility. This function was captured by the respondents thus:

“There was a time when the health workers (Nurses) come late to work and the patients complain about it. Then the committee discusses the issue with the OIC and they amend their ways. If the OIC refuses to change, then the IDU will take action on it. For example, the former OIC refused to change, she comes to work late and does what she likes. The committee had to write to the IDU and she was transferred to another place through the committee effort.”(Focus Group Discussion (FGD) Female community member)

“Yes, they look into it, their eyes reach to these areas, because there was a nurse that was sent to us, that was not good but , due to their concern, they were able to know and remove her. There was even a nurse, they brought for us one time, she used our drugs for other personal things... It is this committee that said that what she was doing was bad and they removed her. That’s how I know that the committee looks into these issues.” (FGD male community member)

“The conflict we experienced in the past was before this OIC was posted to this place. There was a lady who was here then, we noticed she didn’t do her work, she would leave it and go about her business, even when we called for meetings here as OIC she did not attend and went for her own thing, so we decided that she should be transferred out and we went to the local government and met the HOD there, which made her be transferred out of here” (In Depth Interviews (IDI) HFC member)

Selection of HFC members: basic procedures, their size and composition

The selection of the HFC members is made by the Isulo Development Union (IDU). Their main objective is to meet the needs of the health centre. The HFC was established since 2005 and the community was mandated by the LGA to select persons to represent them in the affairs of the health centre. The IDU instructed each village to select two persons to be on the committee. However, the chairman of the committee was selected by the IDU and the members were inaugurated in 2006. The committee received materials for work in the facility from the Local Government Area (LGA) as well as from well meaning community members and the town union. The committee members have received some formal training on what their functions are at the LGA. The committee has executives which consist of the Chairman, Secretary, Public Relations Officer, Assistant Secretary, Financial Secretary, the Security Officer and the Treasurer.

It should also be noted that the HFC chairman is an executive member of the IDU as well as a lay reader on the church committee. The agenda for most of the meetings is drawn up by the HFC chairman and this is done twice a month and occasionally on an emergency basis. In some months, this may mean three meetings in a month. The chairman either informs the secretary to notify members or does it by himself. Either the chairman informs members about the meeting through phone calls, by going to members’ homes to notify them, or by a church announcement (since he is also a church committee member). Responses depicting the criteria for selection are reflected in the following excerpts from focus groups with community members and interviews with HFC members.

“IDU will select them through the villages and each village will be fully represented because the village will choose their representative” (Female FGD).

“It is from the IDU that they select members. The way they do it is that when they meet, they do it in the way we used to share things in this community, that is village by village... among all those selected, they pick one leader... They look at what somebody is capable of doing or what one can do before giving the position to him” (IDI HFC member)

“I guess they select on the basis of one who can disseminate information to his/her village” (IDI HFC member)

While ensuring village representation, the IDU also ensures that all the organised groups in the community are represented on the committee by mandating each group to send a representative. It should be noted that the IDU is a political structure and they appoint the chairman. In other words, there are no elections for the post of chairman. However, the rest of the committee members are chosen by the community members who they represent through voting (elections). The community members all agreed that if a person does well in his/her first tenure, then he/she will be voted in for a second tenure. It is also worthy to note that the choice of representatives at the HFC by the communities reflected the fact that these members belonged to other organisations and this particularly helped in the linking between the accountability structures that existed in Isulo since some organisations shared members with the HFC. Other organisations/structures represented at the HFC include: the church group and the Isulo Women Congress. Other groups not represented in the diagram are Leaders of Thought, Obuogu group comprising women born (umuada) at Isulo, Women’s village meeting (Nzuko Ogbe), Works committee, Electricity committee, Education committee, Sports committee, social committee, water committee, and Farmers association.

The committee is made up of nine members: five males and four females. The HFC hold their meetings at a suitable time to ensure that all members attend:

“Sometimes, they hold their meeting once or twice a month but if there is an emergency, the chairman will circulate the news about it and must inform the OIC before the date of that meeting” (IDI HFC male member.)

“Two times in a month we meet, but if an emergency comes up, it makes it three or more meetings in a month”...when we were there we used to have our meetings as planned unless something big like a burial or a village festival happens... then we can postpone the meeting and re-schedule another time. All members do come unless anybody has an excuse; he/she tells the chairman and asks permission before he/she is permitted to be absent” (IDI HFC female member).

Issues raised at the meetings are mainly ones that will help the health centre both in terms of the services rendered and infrastructural development. The quorum for the meeting to commence is six members. All the members are allowed to speak during the meetings, women members are allowed to equally express themselves, and decision making is done unanimously. These are some of the respondent’s views:

“We bring the womens’ and mens’ suggestions together to arrive at a decision. It is before that those women are silenced, not at this present time. It is within us, everyone will say his/her opinion, and we now conclude and decide what to do... Everyone has an equal right to suggest the meeting’s progress, on what is good... If anybody says what you don’t like, you have a right to say No, and say what you feel about the issue. (IDI HFC female member).

“They don’t exclude us; we all have equal right to speak in the decision making...No, everybody will agree together, and if anybody objects, he/she will give her/his reason for their objection” (IDI HFC female member).

Male HFC members expressed similar views showing that no gender disparity exists and this is indicated below:

“Yes we allow everybody to give his/her own opinion, both male and female...If there are too many arguments, then we vote...We vote and the majority carries the vote” (IDI HFC male member).

“There is room for people to give their different opinion concerning such matters in order to promote the functioning of this committee.” (IDI HFC male member).

“All of us gather here, and then we take the decision...Everyone talks in the meeting...They allow us to bring our suggestions in meeting or matters...We don’t exclude the women” (IDI HFC male member).

Some of the HFC members said that the HFC consults the community before it makes any decision concerning the community and also briefs them on governments’ views on issues of concern. This is expressed as follows by a female HFC member:

“Before we take any decision, we tell the community if it is good for the centre, and give them the government’s method. The committee consults the community and vice versa in taking action or approving/supporting issues.” (IDI HFC female member).

The HFC kept a book of minutes which was read out before the start of each meeting. This reminded all the participants where they were in terms of decisions taken and what had been done to follow up on activities.

Responsibilities and roles of the HFCs in the community

In terms of responsibilities, the HFC’s objective is to ensure that the health centre functions effectively in terms of meeting its demands in health service delivery. This includes:

- i. Addressing health issues
- ii. Ensuring that drugs are brought from the Local Government ; disseminating information to community members about availability of drugs and bed nets in the health centre
- iii. Participating in distribution of bed nets
- iv. Ensuring that the health centre is functional, properly maintained, and kept clean; informing the community about problems that need to be addressed.
- v. Monitoring health workers to ensure that they are performing their duties effectively and maintaining a cordial working environment.

This is reflected in the following statements from male and female FGD, IDI, health workers and observations:

“If the building is not in order, the health committee will come and see it and afterwards, they will inform the Isulo Women Congress about it because they are the people who will bring out money for the running of the health centre” (FGD male).

“It is very necessary to consult the IDU on whatever we are going to do in this health centre like its structure or this bore hole... It is very important to consult the IDU so that they can give their approval” (IDI male HFC member)

The HFC ensures that health services reach the community members that they serve. They also participate in the bed net distribution and in the distribution of drugs to ensure that no one is left out in this exercise.

“It is the duty of this committee to make sure that this particular health centre or Isulo gets their own share... They will equally make sure that it gets to the right destination.” (IDI male HFC member).

“The committee helps to convince people in the community to accept drugs for immunisation given to them by the government.” (IDI male HFC member).

Authority of the HFC

In terms of authority, the HFC has a lot of support from the Isulo Women Congress (IWC). In fact, the regular and consistent moral and financial support from the IWC gives the HFC the confidence to carry out its responsibilities. The HFC has the IWC represented in their composition. The IWC is a structure which is one of the organisations or groups in existence and is made up of all women who are married into Isulo irrespective of their original place of origin. They have an offshoot called the ‘Obuogu women,’ comprised of women who are from Isulo and are married in Isulo. Most of the financial needs of the HFC are met by women from the IWC and the resulting financial authority enables the HFC to meet the needs of the health facility. The IWC through the HFC has ensured that the patients and health workers are comfortable by procuring mosquito nets for the health centre and repainting and plastering the health centre. The HFC gets a lot of financial help from the IDU but also, and perhaps more, from the IWC. The traditional ruler (Igwe) and his cabinet also have to be informed of all the actions and deliberations of the HFC so as to obtain the Igwe’s authority in the execution of their activities.

In terms of disciplining erring members of the committee, most of the HFC members said that no sanctions are imposed on non-performing HFC members but that they could be warned or reported to the IDU so that the village the person represents handles the matter. Moreover, the chairman said they could also suspend the person pending whether or not he or she writes a letter of apology. The reason why they do not have any sanction is because they are doing voluntary work and are not being paid for it. A HFC member during IDI said:

“We are not being paid, so you can’t penalize anybody... If somebody does something which we know nobody has done before, we go and report to the IDU (town union). They will know how to remove the person by the village he is representing.” (IDI HFC member)

According to the male HFC, if there are non-performing members, they impose punishments such as suspension. The person disciplined will then write a letter of apology after serving the suspension.

“We give suspension and after the suspension, the person will write an apology that he/she will not do such a thing again” (IDI HFC member).

Other structures in the community

There are various other accountability structures in Isulo. First, there is the town union, which is called the Isulo Development Union (IDU). The IDU has overall responsibility for the local administration of the town and is responsible for the appointment of the members of the HFC, especially the chairman. Second, there is the Isulo Women Congress (IWC), an organisation of all women in the community and which also is given its mandate from the town union. This organisation bears most of the financial burden of the health facility through the HFC. Third, the security committee ensures the safety of the equipment in the facility and of the health workers. Fourth, there is the works committee, which helps in maintaining the environment of the health facility. On one occasion, an electric pole fell down and the works committee had to repair it. It is because of the support from the link between the HFC and the works committee that this was done. Other structures include the Obuogu women (females married

within and outside the community), the age grade and the religious group. In one way or another, all these groups help in the functioning of the HFC.

Health worker performance in the facility

The National Primary Health Care Development Agency (NPHCDA) stipulates that there should be at least ten health workers in every health centre. Isulo has up to six health workers who are all female: the lab technician, 1 CHEW, 2 JCHEW, the OIC and a cleaner, making up to 60% of the required number. Although this number is short of the standard number, the facility still functions well because of the influence of the HFC.

The roles of the HFC which lead to better health workers performance include:

- i. Ensuring that the health workers adhere to the time schedule for coming to work. This they do by paying unannounced visits to the health centre.
- ii. Ensuring that the security guard protects lives and property in the health centre. This makes the health workers feel safe to work and put in their best.

These are reflected in the following quotes from the respondents:

“They make sure that the night guards patrol this place every night for protection of lives and properties here” (FGD male).

“They look into these things, they also check if the staff are punctual to work and they also check if they have problems among themselves or fight during work, because if they do that, they won’t be able to work effectively towards taking care of the patient. So, this committee is trying to look into these aspects, including the things they do/discuss in meeting. After holding the meeting, they come and say it out loud.” (FGD Female)

Others roles of the HFC which support the health facility and services include the following:

- iii. Participating in the distribution of drugs and mosquito nets in the community which enhances the performance of the health workers.
- iv. Maintaining the health centre which motivates the health workers to do more work as they have a conducive environment
- v. Ensuring that the health centre is functioning properly by making sure the patients are attended to. This enables the health workers to always be on their toes.
- vi. In conjunction with the health workers, advocating for pregnant women to deliver at the health centre. This implies an increase in patient turnover which means credit to the health workers as they see more patients and make more money for the facility.

Some of these facts are reflected in the following quotes:

“If the health facility lacks something, for instance, if they lack chairs or beds, they will report to the HFC and they will negotiate and find a solution” (FGD male)

“They put nets in the centre to make sure that women who delivered and their newborns are well protected from mosquito bites” (FGD male).

“The committee told the Obuogu women about this facility and the need for women to come here and deliver their babies” (FGD female).

The HFC ensures that the health workers are always punctual to work and they render a 24 hour-service. This is enhanced by the OIC who resides within the facility premises, guaranteeing availability of a health staff. This was captured by the respondents as follows:

They monitor the nurses and make sure they always come to work and they look into the functioning of things in the health centre and inform us when things are not working” (FGD Female community).

“They also make sure the staff there are in peace, so that they will work well and effectively” (FGD female community).

Negative health worker behavior is occasionally reported to the OIC. She cautions them and encourages them to behave better. In cases where the health worker continues to err, as a member of the Health Committee, she brings up the matter at the committee meeting. Other than this, the HFC members routinely pay regular visits to the health facility as a way of monitoring staff attendance and behavior. One strong health worker impact led to the removal of the OIC. The HFC effected the removal of an erring OIC who was always coming to work late and did as she liked. The HFC did this by writing to the LGA authorities who ended up removing the OIC.

According to health workers, the issues addressed by the HFC include strategies for effective collaboration with health workers and overseeing the general welfare of the health centre through, for example, identifying and handling problems or repairs to ensure the work place is comfortable for the health workers. These are illustrated by the following quotes:

“Oversees the general welfare of the health centre for example, if there is a problem such as conflicts or damages in the health centre” (IDI Health Worker).

Door-to-door immunisation is carried out effectively by the HFC members and the health workers in line with the ‘reaching every ward strategy’ for routine immunisation. During one of our visits, the health workers and some committee members had all participated in immunisation. This synergy enhances health worker performance.

“HFC ensures that whatever government wants regarding health, which we can do, is carried out...Something like immunisation, we do it well; we announce it in churches and use the town crier too” (IDI community leader).

The HFC members usually come to the health centre and join the health workers in issuing the free net cards to community members. This card is usually tendered before one is given a mosquito net, to ensure a family does not receive more than one. This is feasible because the committee members know the community members.

Resource mobilisation and use

A fee of 500 Naira is generated from the HIV test kits for each test. The OIC, after consultation, charges the patients and the money paid at the point of service is used for drug procurement. Returns are made accountable to the LGA as revenue. No charges are placed on drugs, bednets and immunisation

materials used in the health centre; they are given free of charge by the government to people in the community.

The Drug Revolving Fund (DRF) programme is not a function of the HFC in Isulo and is not practiced. Even when explained, they had not heard of it.

The HFC members do not have funds to sponsor their activities and so the major sources of funding are the IDU and the IWC. However, they mobilise these sources effectively whenever the need arises, e.g. when there was a need to repair parts of the health centre or to acquire more chairs.

The HFC helps provide materials which are lacking even when the LGA is not forthcoming. Most of the equipment is functional, except for the gas cylinder and autoclaves. The following quote illustrates this:

“If the health facility lacks something such as chairs or beds, they will report to HFC and they will negotiate and find a solution to it” (FGD male community member).

Equipment availability within the facility and the state of infrastructure are also ensured by the Isulo Women Congress (IWC) and the IDU through the HFC. Most of the equipment is provided by the IWC, including tables, beds and even the construction of the health centre to a modern standard through the advocacy of the HFC.

The committee has also helped achieve some conveniences for the health centre (e.g. the borehole for water provision and three latrines that were built in the health centre). The overhead tank and toilets have the inscription “MDG Project” written on it. This was also written on the pit toilets and the bathroom. All of these items were facilitated by the HFC. The health facility existed without these conveniences but, with the effort of the HFC through the IWC, these additions were made and patients are now more comfortable.

Committee relationships and trust

a) HFC and trust among members

Each of the committee members at Isulo had personal knowledge of each other; they work collectively, treat each other respectfully, and respect each other’s opinion. This most likely stems from the fact that they all come from the same community. A cordial relationship was noted to exist between them. For example, during one of their meetings it was observed that absent members had HFC members give reasons for their absence. This meant that they trusted others to cover for them should anything happen. During his IDI, one of the HFC members confirmed that they trust each other and their motivation came from the desire to volunteer community service. All the members of the committee are given a chance to express their opinions on all issues to ensure there is no partiality and that all sides and groups are considered. Decisions are also made in unison during the meetings. There has never been a conflict between the OIC and the HFC members. The interconnections of these relationships demonstrate the inclusivity with which they handle all groups represented in the committee to ensure no group dominates or shouts at the other. This also stems from the respect they have for each other which is based on the fairness involved in past dealings. The chairman carries everyone along and gives room for questions during meetings so that areas that are not understood by the members can be cleared.

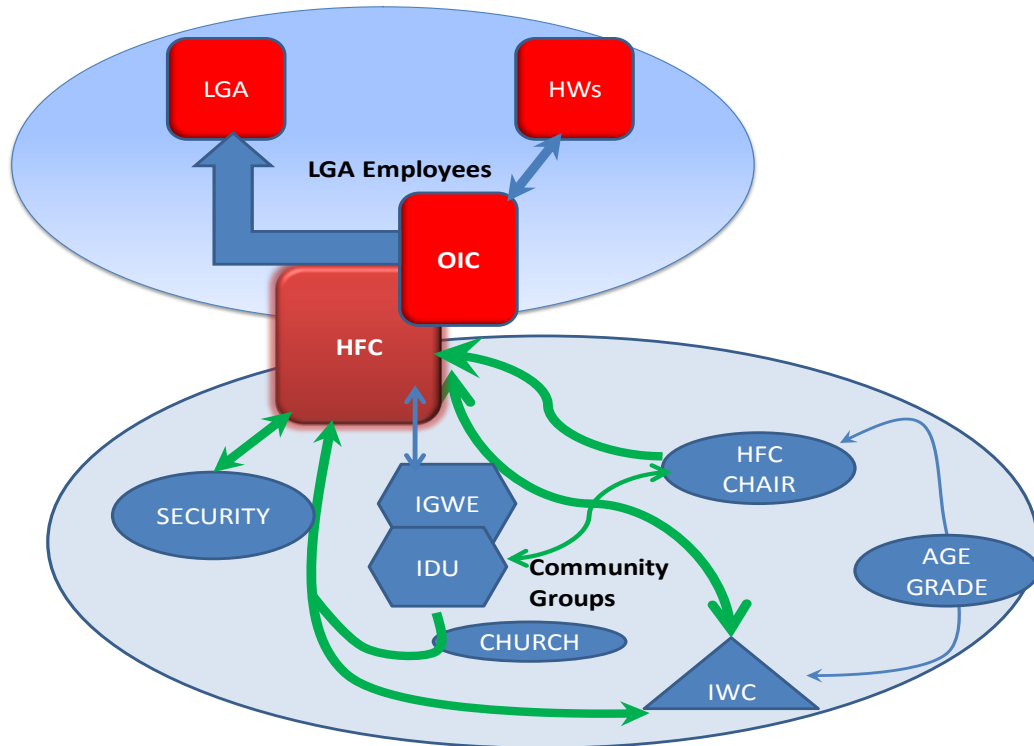
b) Links of HFC to IDU, IWC and community and basis of trust in that relationship

The diagram below shows the relationships among the various structures in Isulo and the different ways in which they interlink with each other. The management of these relationships around the HFC contributes to placing Isulo as a highly functional committee because of the support they derive from each other. Also, there are more active accountability structures available at this site and which are also more involved in the activities of the HFC, indicating a more dynamic relationship. For example, the HFC members are composed of representatives from all these structures, namely the security group, the church group and the IWC. This means that various groups are represented on the HFC. Thus, there will invariably be a good balance in terms of representation of different voice groups and whatever decisions that are taken are carried back to their parent organisations. As a result, Isulo has an active community life with many structures and the good functioning of the HFC is a result of the relationships among these structures. This was stated by an HFC member thus:

“I represent the IWC, so I personally report to them” (IDI female HFC member).

The chairman of the HFC is an executive member of the IDU. He was actually appointed by the IDU, conferring on him the extra power to act effectively in the HFC, as opposed to other members who were elected by their various groups. This singular position enabled the removal of an erring OIC by the IDU probably because of the synergy and extra weight his voice carried on the issue due to his dual membership in both structures. This shows the level of authority that the HFC has and this derives from these interrelationships. The chair is also a member of the church committee, where he functions as a lay reader, and also belongs to the social club. This means that information can be communicated from the HFC by the HFC chairman to the church members and other community members represented in the social club. Thus, the presence of a member of the IWC and IDU in the HFC enhanced resource mobilisation and moral support for the HFC. The Igwe has a cordial relationship with the IDU as shown by the overlap in the diagram. This has a positive contribution to the functioning of the HFC as each group knows what the other is doing in terms of transparency, a situation that enhances institutional trust. Furthermore, when solicited, the Igwe’s support is easy to access because of the good relationship between the HFC and Igwe. In addition, the Igwe is accessible because he is a retired civil servant, he lives within the community and he visits the health facility from time to time. He also offers financial and moral support to the committee. This support from the Igwe acts as a motivation for the HFC.

Figure 3: Relationships and linkages in Isulo



Sits on HFC and has strong influence on HFC



Influential relationship; Very strong



2 way membership (executive)



2 way membership



Group with bilateral relationships



A good working relationship was recognised between the HFC and the community. The community responds to the requests made by the HFC quickly. This trust is based on the good decisions made by HFC as reflected in this quote:

“We usually agree with their decisions because they are always good ones” (FGD female community member).

One of the health workers also indicated that the community trusts HFC members. In fact, she indicated that HFC members are selected because of the trust the community has in them. Responses from HFC members also show that they believe that the community trusts them because on one occasion the community agreed with HFC’s decision to honour a nurse who was providing good services at the centre.

In addition, the community always gets feedback from the HFC through the HFC members representing other community structures e.g. from church announcements, IWC meetings, IDU meetings etc., and the community through the IDU or IWC gets feedback on the HFC needs. It was the community members who reported to the HFC about the negative attitude of a former OIC, which they followed up on from cautioning her to effecting her removal. Projects embarked upon by the HFC members are followed through because both the IDU and IWC are ready to support progress at the health facility financially. The basis of this trust element is that several structures are represented in the HFC and they give regular feedback to their parent bodies.

c) Role of OIC as link to staff and then to LGA, and basis of trust in both relationships

The OIC informs the health workers on the deliberations at the HFC meetings and urges them to continue their hard work, thus establishing that trust element. The health workers are confident that their interests will be represented by the OIC. The HFC, through the OIC, gets to quickly know the needs of the health facility and the needs of the health workers. Whatever concerns raised in the HFC meetings are readily fed back to health workers e.g. after one of the HFC meetings that we observed, the OIC told the health workers that it was decided that they will be part of the environmental cleaning exercise for health facility. The OIC and health workers, in turn, have respect for the HFC members, know where they live and they visit each other. A response from a health worker during IDI indicated that the health workers trust the HFC because they always provide assistance to them and HFC members, in turn, do not hesitate to correct them when they (health workers) make mistakes.

Conflict between the OIC and the HFC is rare and, in fact, there is a good relationship between the HFC and the OIC, as depicted in the diagram. As the secretary of HFC, the OIC ensures that members understand what is said at the meetings by repeating the questions to them. This was noted during one of the observations made during a meeting session.

There is also a good relationship between the OIC and the health workers, as shown in the diagram. She communicates with the health workers about the deliberations of the HFC meetings and urges them to continue their hard work. This makes it possible for the health workers to trust both the OIC and the HFC.

The OIC also has a strong link with the LGA and gives a feedback on HFC functioning to the LGA. On one occasion, for example, the OIC through the mandate of the HFC wrote to the LGA requesting for a solar refrigerator so they can store vaccines, especially the BCGs for tuberculosis. She also followed this up and mentioned it at the last meeting, which we observed. The minutes book also showed that it had been mentioned in the previous meeting.

The community also has a lot of respect for the LGA and trusts that the LGA will always protect their interests by providing the drugs and materials for their health needs through the HFC and OIC, who seem to have a strong rapport with the LGA officials.

d) Conclusions on how relationships and trust underpin impact of HFC on HW performance and resource mobilisation

The health workers, HFC members and the OIC all live in the same community which allows time for relationships to be built based on trust. These groups all meet in different places at one time or another e.g. in the church, market, village gatherings, festival times, etc., and so have more time to spend with each other and understand one another better. The interconnections of the relationships here demonstrate the inclusivity with which they handle all groups represented on the committee to ensure

that no group dominates another group. The chairman carries everyone along and gives room for questions during meetings. This synergy and trust among the various structures underpin the impact of HFC on health worker performance and resource mobilisation. Trust in this community has elevated levels of commitment and there is sustained effort and performance by both the HFC and health workers. Thus, good relationships and trust in relationships have helped the HFC to function well.

Ugwuaro (less functional)

Historical Context

Ugwuaro, with a population size of 5 212, is the largest clan in Ugwunano village, Umunze, Orumba South LGA. Ugwunano is made up of four clans, namely Ugwuaro, Ugwuikpa, Ugwuagbada and Ndikpa. Umunze town is made up of seven villages, namely (in order of ancestral seniority) Nsogwu, Ugwunano, Lomu, Ubaha, Ururo, Ozalla and Amuda. The founder of Umunze, a man called Nze, was originally from Ohafia, in the present Abia state of Nigeria, which is about 150 kilometres from the present day Umunze. Nze was both a warrior and a hunter. Umunze has three political wards. Ward one is made up of Ugwunano alone and the remaining six villages share the other two wards. Traditionally, Ugwuaro is the oldest son of Ugwunano and so everything comes first to this clan before the others. The traditional ruler of the Umunze town comes from this clan. The people of Ugwuaro are mainly Anglicans and the first Anglican Church in Umunze was built here in 1910. They do not have their own post office, but have a general post office in Umunze town. They are mainly subsistence farmers and are also well known for their hunting skills. They are known for their hospitality as they accommodated many refugees during the Nigerian civil war since they were not affected by the war.

The people of Ugwuaro are of the Ibo tribe of Nigeria, hence Igbo is the local language spoken. They celebrate their new yam festival in the eight month of the traditional Igbo calendar which falls in September. They have a market day (“Eke”) every four days. However, the activities of this market are overshadowed by the central larger market called *Nkwo Umunze*, which is also located in Ugwunano village. Other markets in Umunze are *Afo Ururo* and *Orie Lomu*, both of which are still functional but are dominated too by the *Nkwo* market. More people attend the *Nkwo* market day to sell their wares and other market days are usually not as populated as the *Nkwo* day. Ugwuaro has four primary schools (two public and two private) and two secondary schools (one public and one private). They obtain their drinking water from a bore hole which the traditional ruler supplies free of charge. Alternative sources of drinking water are from two springs, namely *Iyi-Ohuru* and *Oji-mbia*. The water corporation installed pipes for a water supply about 15 years ago, but these have never been functional.

Traditional institution

The traditional leader of Umunze (the *Igwe* of Umunze) is also known as the *Ablikete* of Umunze. He was interviewed for this research and is from Ugwunano village. The *Igweship* is rotational and must pass through all the seven sons of Umunze. This title is held until the *Igwe* dies or is impeached. The first son of Umunze (Nsogwu) produced the first *Igwe* who ruled until he died. The current *Igwe* is a business man and resides in far away Lagos (about 800 kilometers from Umunze). He has been on the throne since 1989. The *Igwe* has his own traditional governing council which is called the *Ablikete* traditional council and they judge all matters in the town. Most problems brought before the *Igwe* are tabled before this council where a decision is made before action is taken. The *Igwe* also has his own traditional task force and security that sees to the day-to-day running of activities in the town and also maintains law and order. However, for some time now, the *Igwe* has been at loggerheads with the town union, which is called the Umunze Progressive Union (UPU), as a result of conflicts on issues regarding the jurisdiction and functions of each institution. The relationship between the two institutions has been

anything but cordial and this has affected activities in the town and villages, including the HFC that naturally needs to function with support from both institutions. Apart from the Igwe, the clans are governed traditionally by the Ichies, who are also members of the Igwe's cabinet. The village union, called the Ugwuaro Development union (UDU), is one of the structures in Ugwuaro and operates as the village government with a chairman and other members. It is responsible to and is an offshoot of the UPU and has a strong political power. They see to the welfare of village members.

Facility context

Ugwuaro health facility was opened in 2006 and housed in a temporary accommodation. According to the information received from the community members, the facility was always open by 9:00am. The official closing hour is 4pm. However, in emergency cases, the OIC, who is a trained nurse and appointed by the LGA, can always be contacted because she lives very close to the facility. The health facility was supposed to serve all the clans in Ugwuaro village, but because of political wrangling, two more health posts were established for two other clans of Ugwuaro, but these problems are said not to affect the functioning of the Ugwuaro health facility. This facility still serves all the clans in the village. The health facility building is an old, unpainted, shoddy-looking rented one-storey building. The health facility occupies three rooms on the ground floor of the building (one for consultation and treatment, one for emergency deliveries, and the other for inpatients), while the top floor is occupied by other tenants. The environment is not very neat and is a bit noisy because of the other occupants of the building. The facility has six beds in total, but only two are being used because of a lack of space. The other four are in the HFC chairman's house. The facility contains one water system flush toilet and no placenta pit.

Most of the equipment needed to work is being stored in the house of the HFC chairman because of a lack of space. However, a few basic drugs and first aid treatment materials were available. No new drug stocks were seen during the period of the study. The most common illnesses handled at the facility include malaria, cough, diarrhoea, and minor injuries and ailments. The more serious cases are referred to a secondary facility called Umunze cottage hospital which is less than one kilometre away. The facility also conducts routine immunisations and distribution of insecticide-treated bed nets. There are immunisation charts on the wall and charts showing the target population for routine immunisation and catchment areas.

The health centre used to deal with antenatal cases and deliveries as part of their functions, but about two years ago they were stopped by some aggrieved members of the community. The community members went to the extent of getting policemen to close the facility, but the members of the health committee and head of the health department at the local government intervened and resolved the matter. Since then, they rarely take deliveries unless under emergency situations.

The health facility has five workers: a nurse midwife who is the OIC; one staff nurse; and three community health extension workers (CHEWs). In the absence of the OIC, the staff nurse takes care of all administrative duties and together with the CHEWs, takes care of the patients, including dispensing drugs, dressing of wounds and injections (which is mostly done by the OIC). The OIC has been in the post for about five years.

Selection of members: basic procedures, their size and composition

Information obtained from HFC members showed that the idea of establishing the HFC came up in response to the community's request for the establishment of a health post. The community was mandated by the LGA to select capable persons to oversee the affairs of the health post. Two persons were selected from each of the villages by their villagers. The members were inaugurated in 2007 and

the committee was given some equipment for the health post by the state government through United Nations Fund for Population Activities (UNFPA). A doctor also came and provided some guidelines on how to run a health post. The executives of the committee include the Chairman, Secretary, Public Relations Officer, Assistant Secretary, Financial Secretary and Treasurer. As captured by a respondent:

“Our community demanded a health post and they agreed to nominate... the educated ones; those who will be able to understand what is happening there...they selected me and one other person to represent our village. Also, one doctor called us for inauguration at the local government on October, 2007. We went for that inauguration and after that, he gave us the go ahead order. They gave us some equipment and we checked all of them” (IDI HFC member).

The criteria for selection are based on one’s capability to do the work effectively, including education, the ability to communicate effectively, integrity and gender. In addition, one’s ability to attract financial contributions from one’s village is also considered in the selection. Excerpts supporting these ideas follow:

“When they started the meeting, they told each village to select two or three people that will represent them. You cannot become a member of the committee without being selected by your village” (FGD female).

“By merely looking at a person you can discover what the person can do. They will select the person who will be capable to inform the village or community about what is happening. So, the selection was based on the person who has knowledge and understanding” (FGD female).

“They told us to select two people, a man and a woman, from each village. So each village has two representatives... They select those who will do the work effectively” (IDI HFC female).

However, the committee chairman was said to be specifically appointed by the Ugwuaro Development Union (UDU) because of his track record of being hardworking and honest, while the OIC is an employee of the LGA. The committee consists of 12 members: nine men and three women, thus confirming the rapid appraisal findings. There was no attempt to have representation from various groups in the community.

The HFC meetings are usually conducted only on an emergency basis, as shown in the rapid appraisal result, i.e. only when there is something happening or when they are planning for an immunisation program. They have no specific times for holding their meetings and thus, in a three month period, they might not have any meeting, while the next month, they might have two meetings a month depending on what is happening. This has made their meeting times a bit erratic and disorganised:

“Mostly all our meetings are on an emergency basis because we don’t have a fixed date for holding meetings. When any thing comes up, we hold a meeting for it” (IDI HFC male).

... if there’s a need for it, we call the members for a meeting...The Chairman passes the information to the people he sees, and we have the PRO who does that. It is his duty to circulate the information to members and we have some people’s phone numbers, we call them” (IDI HFC female).

Even when the emergency meeting is fixed, some members still do not attend for one reason or the other. The members of the HFC are very inconsistent in their attendance and only about five of them

were a bit more consistent than the others, confirming the appraisal findings. But according to a HFC member, the only truly consistent member of the HFC is the chairman and this was captured thus:

'There are a times when all of us come, but the most regular attendant of the meeting is only the Chairman. The others don't come regularly.... It's just like that.'

Responsibilities, authorities and Roles of the HFC

In terms of responsibilities, the HFC does not have autonomy to act on its own and usually the LGA and UDU have the final say on HFC issues, e.g. funds required. The UDU appointed the HFC chairman and therefore, most deliberations made in the HFC filter to the UDU. The UDU still does not meet all the requirements of the HFC and this is not complemented by the other structures represented on the HFC. The HFC is expected to ensure that the health centre functions effectively in terms of meeting their demands in health service delivery by:

- i. Sourcing funds for maintenance of the health post.
- ii. Monitoring health workers.
- iii. Ensuring that the health post is functional and that the welfare of the health workers is ensured.

However, in practice, these functions are not carried out as none of the HFC members come to the health facility except the chairman. When the chairman is not around, things are in disarray and the health workers do what they like.

This probably explains why the committee is not strong, since the UDU has not been meeting up with the HFCs demands as pertains to the upkeep and general maintenance of the health facility, e.g. no progress has been made in the past six months towards repainting the building, putting up nets for the patients, ensuring that drugs are always available. The general maintenance of the health centre environs is a function of the HFC, as well as making sure that drugs are available due to its link with the LGA through the OIC. The HFC cannot act on its own but must go through the Igwe in order to notify him and to get his support (otherwise it would mean undermining his authority). However, in most cases he is not there because he resides in Lagos which is over 700 kilometers away and only comes home once in a while. These findings are all based on our observations and from comments made by most of the patients that we saw at the health post. One of the HFC members had this to say:

We are called by the government and the community selected us, so we are accountable to the community and we are equally accountable to the government on the other hand. They are the people that give us go ahead'. 'We don't have any authority to decide on our own, rather we can decide to do something but before we decide the thing, we will first of all approach our Chief' (IDI HFC member).

The fact that the HFC had to wait for the consent of the Igwe was corroborated by him during the interview with him. It was also observed that some decisions taken by the HFC were tentatively awaiting the approval of the Igwe. One of the roles of the HFC is to disseminate information about any activities taking place in the health centre which can help improve health. They are also supposed to be involved in mobilising people during the immunisation exercises and also in helping the health workers reach members of the community. In addition, they are expected to collect and ensure proper distribution of all the items, such as drugs and bednets given to their community by the LGA. However, funds are not readily available for these activities and hence, are rarely achieved. On some occasions, these functions are also not carried out due to lack of collective involvement by HFC members.

They also pay attention to how the health workers conduct themselves at work, their relationship to the patients, punctuality, and closing times and how well they keep to the time and the quality of care given

to patients. The HFC also resolves conflicts among the health workers. However, one of the health workers claims that it is mainly the HFC chairman who does this and not the HFC members in general. This goes to show that the HFC chairman can be trusted to carry out the duties expected of him. This is reflected in the following statement: *'They have not taken care of all these things except for the health committee chairman who always come here to ask me how we are doing things here. He equally asks me about the performance of the health workers in regard to absenteeism, punctuality, lateness to duty and other things'* (Health worker).

It is the general belief of some members of the community that the HFC can and should do more than what it is doing now and that they have not achieved much. The community seems to expect so much from the HFC and still trusts the committee, especially the HFC chairman when it comes to mobilisation for immunisation activities, as noted in the following quotes:

'They have not achieved anything recently unless in the area of mobilisation. They help to create awareness of this health post and they try to convince people to come and receive treatment in this health post for things like immunisation and others' (Female FGD).

The HFC claimed to have engaged in fundraising activities from both community members and the government for the proposed new health centre and also helps in maintaining the present one by raising the money for paying the rent. They also claimed that they provided security for the health facility and the health workers. However, from observations made and the interview, this is not so. For example, the building is an old unpainted house with barely enough space and the landlord is owed more than three months' rent and is threatening to close the facility. The HFC has not been able to mobilise the community to erect a permanent structure for the health centre and this is captured by some HFC member as follow:

"Some of the things we have on the ground for discussion is how to develop our permanent site because this place we are now is a rented house, it is on hire" (IDI HFC male member).

"The difficult thing now in all we were told to do is finding a land where we will build the structure; they said it's our duty to do so. The possibility of seeing the site or constructing the building is a little hard for the community. That's why we have not really achieved it" (IDI HFC male member).

Also, some HFC members who spent their personal money for some of these activities have not been reimbursed. Most of this lack of interest in HFC matters was blamed on a lack of financial incentives. For example, during meetings, no refreshments are provided. Despite this, the chairman is always available and tries in his best to encourage other members.

Whenever the HFC holds their meetings, decisions are usually arrived at by taking a vote from the few members that attend. It was also a glaring omission that the health committee had no minutes book for the meeting they had last, which was six months ago, in August 2009. This is linked to two factors. First, for some time, the OIC was not recognised as the secretary of the committee, with the committee instead electing their own secretary (the members simply did not like the OIC), much to the displeasure of the OIC. Secondly, the committee meeting arrangements were haphazard, found to be based mainly on immunisation activities and distribution of bednets. They seemed to have no agenda except relocating to a new site. Every other item was dealt with according to the prevailing need. Considering the fact that they hardly meet and when they do meet, minutes of meetings are not kept, it is very difficult for this committee to achieve anything meaningful.

The HFC hardly obtains money for their activities and when it does, it comes from the UDU and the abroad group (members who live outside the community) and this only happens when the committee makes an active request. However, even when the funds are provided, they are never enough to carry out HFC activities.

Other structures in the community

Ugwuaro has slightly fewer other local structures than Isulo, as shown in Diagram 4. These structures include the Igwe and the village union government (UDU) that was responsible for the appointment of members of the HFC. Other structures are the security, youth, abroad and religious groups. The HFC members are not composed of representatives from all these structures and hence, there is less voice in this site. The abroad members, people who reside outside the community, also attend to the HFC needs when they get to know about it, especially during their meetings which are held once a year.

Health worker Performance

According to the National Primary Health Care Development Agency (NPHCDA), there should be at least ten health workers in every health centre. However, Ugwuaro health centre has only five health workers (one OIC, one staff nurse/midwife and three community health extension workers). This shows that they fulfil 50% of the requirement, but a closer look at the various categories of health workers shows that other areas of health service delivery requiring the expertise of a staff are not covered, unlike in Isulo, e.g. laboratory services, cleaner. Compared to the official level, Ugwuaro is short-staffed. Issues on the HFC addressing health worker performance in the community are based on their focus on immunisation in this health facility. This is high and seems to be one of their major activities that they carry out effectively. The HFC is involved in immunisation and members ensure that they obtain a good coverage in their community. They help mobilise the people join in this exercise, thus enhancing health worker performance.

The HFC chairman closely monitors the activities of the health care workers to make sure that they provide good quality of care to the patients and checks on them to make sure they keep to the normal working hours (punctuality), i.e. opening by 9am and closing by 4pm. He has been noted as the only HFC member that does this and probably cannot do much on his own in terms of monitoring the health workers. The OIC lives very close to the health facility and is usually available in cases of emergency. None of the health workers live on the premises. Some of the health workers are usually punctual to work, but a majority of them are not. When this was reported to the HFC by the community members, no action was taken regarding the situation. The chairman only cautioned the erring staff and did not take any disciplinary measures. Thus, the committee has no powers to punish erring staff as they hardly meet to decide on issues. In any event, it should be noted that some community members feel the HFC should not take matters into their own hands but instead should report any such unruly behaviour to the LGA.

You know everything has its own jurisdiction.... the nurses are different from the HFC members, so if the HFC members finds anything wrong with the staff behavior, I think the best thing is to go to the LGA headquarters and report the case (FGD Male community member).

Resource mobilisation and use

The focus of the HFC whenever they meet is geared towards building and moving into a permanent and more comfortable structure. However, this plan is yet to materialize because of the lack of funds. An avenue they have tried to use for generating resources is through village levies and contributions, particularly from community members living outside the community. However, this has not yielded much funds to tackle needs. Our interviews highlighted this finding thus:

'... members which recently concluded their meeting ... they are the ones who did the launching for the fund of the permanent site and the women too, they contribute and fight for our progress, that's why we have women represented in the committee'. (IDI HFC member).

"We don't have any other source of raising funds rather if there is need for that then the committee will inform the community through the town crier. Then both men and women will contribute money to solve that problem. So, we don't have any other means of raising funds, no purse" (FGD female community member).

However, it should be noted that these funds generated are not managed solely by the HFC because the UDU is very involved and before any funds can be disbursed for any activity the UDU must know about it. No money comes from the LGA, making things more difficult for the HFC as noted by members:

'Nothing comes from the LGA but we have been making appeals, but the little we get from the community is what we are using and trying to use to build permanent a site. We will also plan to table that to the LGA for assistance, money is one the obstacles that hinder our work here' (IDI HFC member).

From our interviews, we observed that the Drug Revolving Fund (DRF) is not practiced in this health facility. Most of the HFC members did not even know about this, even when it was explained to them. It was also observed that the members of the HFC sometimes contribute or use their own personal funds to run the affairs of the committee and unfortunately, do not get reimbursed. This disillusions the members of the committee and makes them quite uncommitted to the success of this committee. It affects the trust the members have in the government (local government). This issue was raised by a majority of the HFC respondents and a community respondent captured it thus:

'You know this is a voluntary assignment, if the government were able to be giving the committee something for encouragement, they would not be reluctant when they are called, but sometimes, when you call a member, he goes for his personal needs rather, but when you give one something it makes the person more dedicated' (FGD Female).

Members of the HFC stressed the importance of funds in running the HFC and some were of the opinion that some remuneration should be given to the HFC members as an incentive to commit them to the job.

'Money is the issue; I don't think one can achieve anything without money. Money remains the most important; it is the factor that influences the functioning of HFC' (HFC member).

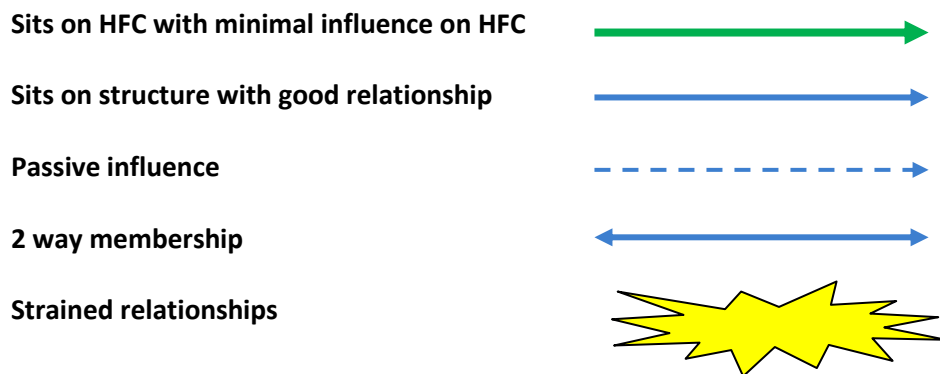
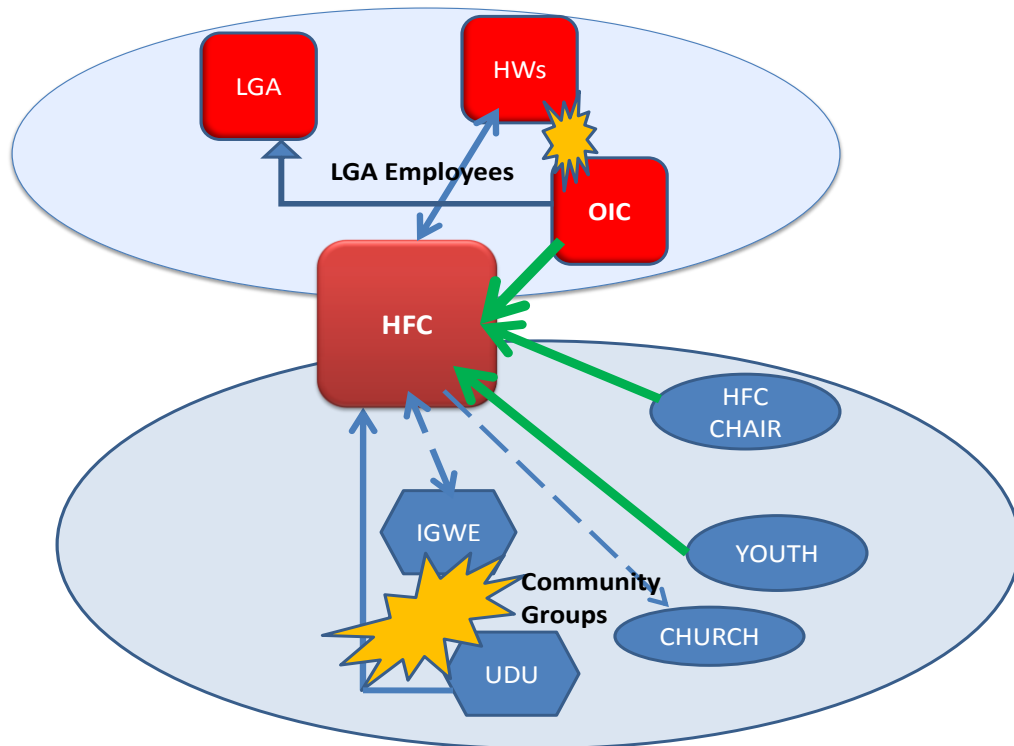
The state of the health centre is deplorable. There is no infrastructure for the health centre and so the facility is housed in three rooms in a rented building. This situation has made it difficult to even equip the place because there is no space and so most of the equipment is kept in the HFC chairman's house. There is no doubt that this situation will discourage the government from equipping the place because

the equipment already supplied cannot even be put to use. This has also hampered service delivery in the facility because it makes it difficult for them to take deliveries of babies or keep inpatients.

Committee relationships and trusts

The HFC has links with fewer other local community structures than Iguro in an effort to improve the health service delivery to the people of Ugwaro. Diagram four shows this interlinkage below. Foremost in this equation is the UDU. They occasionally assist the HFC financially and they are the ones who usually have a final say in anything pertaining to the HFC, as depicted in the diagram. The church group has a passive role to play as they only respond to HFC demands if brought to their notice. The only specific group involved in the HFC is the youth group, otherwise the rest are members of the community (not representing any group in particular) and the OIC.

Figure 4: Relationships and linkages in Ugwuaro



a) HFC and trust among members

The relationship among the members is not cordial. Some members were of the opinion that some members are not happy because HFC has not refunded money owed them despite the promise by the committee to do so. This is likely to give room to mistrust since the committee did not keep to its word. In addition, some people felt aggrieved that they were not selected to participate in some HFC activities. The chairman was accused of preferential treatment in assigning people to participate in distribution of bednets or similar activities of HFC. This creates a lot of mistrust among members. Excerpts illustrating these responses follow:

“We get along except for the people owed money who have not been refunded, the person won’t be happy of course. Another thing is that whenever we do some things in the community, and maybe a few of us are selected to do that thing, one person usually gets angry because he was not among the few selected and asks why he was left out, while he’s a committee member. Such things are problems we usually have” (IDI HFC male member).

Although the members of the HFC know each other personally and due respect is accorded to all members of the HFC, this does not guarantee trust because they do not meet frequently in order to know what is happening in the facility. The chairman most of the time calls the people he likes to attend meetings which are not scheduled. This means other members will not know what the chairman has told them. There is a lot of inconsistency in attendance to meetings and the HFC members do not seem committed to their jobs. From the interviews, it was gathered that some members of the HFC only came to meetings when they felt there was something to be gained and if there was something to motivate them. This is illustrated in a quote from the interview:

‘...Most of them don’t care about this health post unless there is something they will receive free’ (IDI Health worker).

There are no sanctions placed on absenteeism because the job is seen as a volunteer job with no financial benefits. It is believed that if sanctions are placed, the already poor attendance will worsen. However, any erring member is reported to the clan and they either caution the individual or replace him/her.

b) Links of HFC to UDU and community and basis of trust in that relationship

A majority of the HFC reported that there is a cordial relationship between the UDU and HFC and that the community is happy with their services such as immunisation and distribution of bednets. HFC also notifies the community before embarking on activities concerning the community, and the UDU will in turn make financial contributions for approved activities. In fact, the chairman of HFC mentioned that it is because of the trust the UDU has in the HFC that members’ tenure in office has continued.

A supporting quote reflecting these responses follows:

“The community is very happy because they can easily get their own share from the government. For example, they see the outcome of it just like these nets we distributed last time. They collected their own nets and they don’t need to travel far for immunisation, rather it is very close to them” (IDI HFC female member).

“If you are doing what the community expects you to do they will trust you, but if you are not performing well they have the right to remove you and put another person” (IDI HFC female member).

However, this trust relationship has not transformed into a reasonable commitment by the UDU and the community to the HFC. For example, the UDU have not been able to raise funds to pay the landlord of the building occupied by the health facility. And when funds are raised, the HFC is not allowed to manage such funds, rather the UDU does so. This might be as a result of the UDU’s mistrust in the HFC resulting from its lack of seriousness. It was obvious from the information gathered that the chairman of the committee was probably the only true functioning and dedicated member of the committee and the other committee members were not as dedicated. The absence of proper representation of the other structures in the committee might be responsible for this as members are not accountable to any

specific groups in the community. This might affect the community trust in the other committee members' integrity.

Furthermore, the HFC chairman was noted to be an ordinary member of the UDU. This position does not confer on him any additional influence in the UDU. If he were to be an executive member of the UDU, he would have been in a vantage position to influence and convince the UDU to facilitate the functions of the HFC and become an effective link between the HFC and the UDU, as was found in site 1. The women's group here is not active in supporting the HFC and is not represented in the committee, and for this reason, they are not shown on the Diagram.

As shown in the Diagram, the Igwe has a strained relationship with the UDU. These two institutions are traditionally regarded as the power block of the town with their various functions; therefore, they are expected to work in harmony to achieve results. While the town union is perceived as an instrument and catalyst for community development, the Igwe is the traditional ruler/leader of the community and advises the community directly or indirectly through all the local groups under him on matters pertaining to tradition and culture. This friction therefore is a de-motivating factor for the HFC and is likely to undermine trust as things never get done. This is because most deliberations of the HFC do not reach the Igwe, so there is no impact from him on the HFC's actions. In addition, the Igwe who is a business man (with less time for HFC activities) lives in far away Lagos, is not readily available and does not support the HFC effectively. The Igwe's support was expected to come in the form of provision of material needs, by offering moral support to the HFC and even assisting in the issue of re-locating the facility to a better place. In addition, he is expected to receive feedback on the HFC's deliberations. However, because he is so far away, these expectations are never achieved and his impact is not felt. Also, the community members hardly get feedback on activities undertaken by the HFC and information about anything that concerns health and this is likely to undermine trust.

c) Role of OIC as link to staff and then to LGA, and basis of trust in both relationships

The OIC is linked to the HFC by being a member (functioning as a secretary) and is also a staff member of the LGA and an eye of the government in the HFC. However, her linkage with the LGA is not strong as she hardly attracts any resources from the LGA for the committee. In addition, she does not report the proceedings of committee meetings to the LGA. The OIC is also not very active in the committee and has a strained relationship with her fellow health workers. This affects the functionality of the HFC because the OIC will not provide the committee with the needs of the facility from the health workers and this makes the HFC look inept. Although the health workers work with the OIC, they feel their needs are not carried by the OIC to the HFC members and hence, the relationship between the OIC and the health workers is strained, leading to mistrust. This is likely to affect the functioning of the committee and health worker performance.

d) Conclusions on how relationships and trust underpin impact of HFC on HW performance and resource mobilisation

The HFC members and the OIC all live in the same community and this was expected to build relationships based on trust. The relationship of the various community structures to the HFC is very weak and at times strained (as between the Igwe and the village union) and these weak relationships demonstrate the difficulties in harnessing the potential of the community. The chairman of the HFC does not carry all the members along and does not seem to wield the power to discipline health workers. The OIC, in turn, does not link up properly with both the health workers and the LGA, all of which leads to

mistrust. Thus, this lack of synergy and trust among the various structures underpin the impact of the HFC on health worker performance and resource mobilisation as the level of commitment by the HFC and health workers is low and does not sustain effort and performance. Thus, poor relationships and mistrust in relationships have resulted in a poorly functioning HFC.

5. EXPLANATIONS OF HFC IMPACT ACROSS SITES

In general, the high functioning HFC exhibited more impact on resource mobilisation and health worker issues than the less functional HFC. For example, the functional HFC was able to raise funds for its activities through the assistance of both the IDU and IWC. In addition, they were able to discipline an erring OIC and are involved in regular supervision and monitoring. On the other hand, in the less functioning HFC, these attributes were lacking: the HFC is unable to raise funds and could not do anything about an erring health worker. What could have been responsible for these in both sites? A range of reasons could be responsible for these outcomes, as shown below:

Selection of HFC members and link with other community-based structures

Isulo has an active community life with many structures and the high functioning of the HFC is a result of the relationships among these structures. One element of this is that various groups are represented on the HFC. In Isulo, the more balanced gender composition (four females and five males) of the HFC may have contributed to better cohesion of the committee. Even though the female members are from different villages, they all belong to the powerful IWC that contributed so much to the functioning of the HFC. In Ugwuaro, there are nine males and three females who do not each represent a structure (three may come from one structure), hence some structures go unrepresented at the HFC level. In addition, the female members of the HFC in Ugwuaro are mainly health workers in the facility. This explains why they do not have support and links from other accountability structures. The problem here stems from the choice of members that compose the HFC. This is one of the reasons why their voices are not heard. Their composition and the non-representation of other structures mainly affect feedback of information from the HFC to the other community structures. Selection of HFC members in Ugwuaro was not done as in Isulo where various groups are fully represented.

As shown in Figure 3, Isulo with the more functional HFC contains many community-based structures that are interlinked and have interest in the HFC. These rich relationships that exist among them made it possible for better and more contributions to the HFC. There is representation from different community groups in HFC and this was the decision of the IDU. For example, IWC represents links to a women's group for resource mobilisation and in fact they bear most of the financial burden of the health facility which they do through the HFC. In addition, the HFC chairman's role in IDU as an executive member allowed for back up, for example, in the removal of the OIC at a specific point. The security committee ensures the safety of lives and property within the facility and the works committee helps in maintaining the environment of the health facility. The HFC has support of the community/good relationships in general which sustains its work. In addition, the OIC member in the HFC monitors health workers in the facility and the chairman of the HFC and OIC have good working relationships in which provider issues are brought to the committee for action.

In contrast, as shown in Figure 4, Ugwuaro has very few community-based structures that are not properly linked and they did not provide as much financial support as those of Isulo. The link between Ugwuaro HFC and the UDU is not as strong as in Isulo since the HFC chair is not an executive member of UDU so that the HFC could not do anything about an erring health worker, as opposed to in Isulo where

the OIC was removed by the HFC through the village union. Also in Ugwuaro, there has once been police harassment at the health facility occasioned by some members of the community who were aggrieved by the deplorable state of the facility. This contributed to scaring patients away. Although this was resolved by the HFC, it shows that there is a poor link between the HFC and the community, as well as weak security and, hence, no strong support. There is also limited financial support from the Igwe who did not assist in contributing money to meet most of the HFC's needs. The only group that seems to be interested in the affairs of the health facility is the village union that gives little support when called upon. The church group is also only passively involved.

Formal training in HFC functions

In Isulo, the OIC and most of the health workers have attended one training and workshop session on the functions of HFC members while in Ugwuaro, there is no evidence of such trainings. The only information that they received was just before the formation of the committee when a doctor from the LGA came and briefed for a few minutes on the functions of the committee. An attempt to train them in the past failed. These are captured by these quotes:

"A doctor came and addressed us on how to run the health post, we were called and they formed a committee that will help the health post to achieve things (IDI HFC Ugwuaro).

"...We went for a seminar at local government; firstly...for inauguration and we also went for seminar with other towns. We waited but the seminar was not held and they did not inform us when to come next time" (IDI HFC Ugwuaro).

This shows that the HFC members at Isulo are more equipped with information on their functions while this is not so in Ugwuaro. For example, the Isulo HFC members know what their composition should be, why the different voices in the community should be represented on the committee, why they should meet regularly, why they should keep minutes, the authority of the HFC executives, the position of the OIC as the secretary and the link to the health workers, etc.

Meeting frequency and timing

Regular meetings in the well functioning HFC allow for decision-making and action, leading to impact. Responses from male and female FGD participants as well as HFC members in Isulo indicated that the HFC holds meetings about twice a month or as the need arises. Attendance at meetings is mandatory, but sometimes people have acceptable reasons for being absent. These include bereavement, festivity or workplace obligations. Attendance has been regular and nobody has stopped attending meetings except a teacher who is not able to get permission to attend regularly when meetings are scheduled during working hours. Meetings are held at a time when people can attend and at any of the meetings, there is usually up to 75% attendance of members. In addition, the HFC keeps minutes and reads these minutes at subsequent meetings, allowing for consistent actions. Thus, the regularity of the Isulo meeting gives it more chance to make an impact and a stronger base from which to work.

But Ugwuaro holds meetings on a very irregular basis and most of their meetings occur on an emergency basis. The chairman undermines the HFC by holding meetings at odd hours like 6 a.m (so the HFC members can go to their farms and other businesses) and most of the members say the timing is too early for them. As a result, the members who cannot attend are often given second hand information on the decisions reached. Secondly, the health workers are rarely part of the HFC meetings too because of the timing. This is captured by respondents from Ugwuaro thus:

They don't normally have meetings regularly to know what's happening in the health post, some feel less concern about the whole issue, and they always think that this place is a growing health post and therefore take it for granted. The committee doesn't take this issue seriously and has not looked into the staff's punctuality or so forth, but I caution the health workers when they come late" (Female HFC member Ugwuaro).

Mostly all of our meetings are by an emergency basis because we don't have a fixed date for holding meetings... when any thing comes up, we hold a meeting for it "(HFC member Ugwuaro).

In addition, not many members are called and there is a complaint by HFC members that the chairman favours some members over others as some are called for the meetings and some are not called. And most of the HFC members are nonchalant and demotivated about doing their work unless there is something to be gained. A member of the committee also categorically stated that he had no idea regarding the events of the last emergency meeting because he was not informed. Thus, this leadership style of the chairman undermines functionality and trust because all the members are not carried along. Finally, there are no minutes of meetings held for continuity of actions.

Monitoring of health workers and health worker attitude

Responses from HFC members in Isulo revealed that the HFC conducts unscheduled monitoring visits to the health centre. They correct weaknesses that they observe about health workers and improve anything that is not being properly done. Those that persist with negative attitudes are reported to the OIC for warning and subsequently, if they do not improve, their removal could be requested. The health workers are keenly aware of this and it makes them very active in performing their tasks. There is also support from the Igwe cabinet. In some cases, the Igwe's cabinet had cautioned health workers who have shown negative work habits. This may have made health workers in Isulo be more effective because of lessons learnt from the removal of a nurse who had a negative attitude to the patients. However, this is not the case in Ugwuaro where this function is performed only by the chairman and the Igwe is miles away from the community. Secondly, no action is taken in Ugwuaro against erring health workers. This difference may stem from the fact that the HFC chairman in Isulo is an executive of the IDU and can influence them to support him in bringing up such matters to the LGA level where action can be taken. This is not the case in Ugwuaro where the HFC chairman is a floor member of the UDU. Also in Isulo more support for the HFC chairman apart from the UDU influence can come from the cordial relationship he has with the Igwe, whereas in Ugwuaro, the Igwe and the town union (UDU) have a strain in their relationship.

Relationships and trust

The well functioning HFC has a historical tradition of collective action, especially for undertaking joint projects for community development. The members, for example, built the health facility and handed it over to the Government. They also sunk many boreholes for both the community and the health facility to use. It is also the same community members that chose their representatives at the HFC and these are people they know and have access to. This shows that the community has a good relationship in health facility matters, from building the centre to choosing its HFC members.

They also have a tradition of having prominent members of the community who establish projects for the community. For example, the two secondary schools in the community were developed by a community member. This was also the case for one of the bore holes for water supply.

In contrast, in the less functional HFC, there were no such communal efforts especially in the health centre. Although a permanent site for the health centre has been secured, the building of the facility has not commenced due to both a lack of funds and commitment from the community.

Trust plays an essential role in health care where care is delivered through interactions among individuals and organisations. And relationships and trust can affect the impact of HFC on resource mobilisation and health worker performance. For example, committee practices and procedures influence trust within the committee. The regular meetings in Isulo allowed some trust to be built within the committee which underpinned joint action by the HFC, while in Ugwuaro, the role of the HFC chairman in organising meetings at odd hours and calling only his favourites undermined trust within the committee. This is reflected thus:

“Why trust is not exactly there is because may be for example, if there are mosquito nets to be shared or so on, and the Chairman sees me on the way and tells me to help and distribute the nets, other members will start feeling the Chairman purposely selected the ones/ persons he prefers, or that the Chairman picked the members related to him by village, such things cause misunderstanding and might look suspicious to other members” (HFC member Ugwuaro).

Also, the role of the OIC in Ugwuaro in not putting forward health workers’ problems to the HFC caused distrust between the OIC and health workers. However, in Ugwuaro, the little trust that existed between the members is based on the fact that they come from the same community.

In addition, trust in the relationships with other community structures contributes to impact. For example, local relations are important in the well functioning HFC, like the relationship between the HFC and the IWC and the fact that the HFC chairman sits on the executive committee of the IDU, leading to impact. In the less functioning HFC, this simply does not exist and may have led to mistrust.

Furthermore, the local context in which the committee works can influence the trust relationships within and around the committee. For example, in the less performing HFC, local tension between the traditional ruler and the town union undermined the trust relationship and may have contributed to less impact. On the other hand, in the well performing HFC, the cordial relationship among these local structures may explain the high impact. In addition, the state of repair of the facility had an influence over committee motivation, because the HFC and health workers were highly motivated in the well functioning HFC and demotivated in the less functioning HFC.

6. CONCLUSIONS AND RECOMMENDATIONS

The motivation for this study was primarily to explore the accountability relationships of health facility committees, and why some health facility committees are functional and others are not. In addition, the aim was to trace the effects/impacts of committees on health service delivery (with a particular focus on human resource issues) and resource mobilisation. Hence, the main conclusions and lessons emerging from this study inform our understanding of the accountability structures in existence and the extent to which they are effective (or not) in influencing the health facility committees. In addition to the general lessons, this study has generated rich evidence on the role of trust as a factor that underpins the relationships between the health facility committee and other stakeholders. Below the main conclusions of the study are summarised for each of these areas.

In Orumba south LGA, few or very few HFC are functioning at a 'high' level according to the rapid appraisal criteria. Experience from the Isulo HFC provides some idea of factors that may explain high levels of functionality. For example, in terms of frequency of meetings, the high performing HFC meets regularly and there is consistency of attendance over time. And apart from one of the higher performers, all the rest have kept minutes of their meetings. It is believed that if other HFCs were to do this, their functionality might improve, although by itself, this is not enough to ensure high functionality. On the other hand, a majority of the HFCs are not functioning optimally and the findings in Ugwuaro generate ideas that should be considered and dealt with in order to ensure high functionality, for example social conflicts and leadership favoritism.

Initial and appropriate training and supervision is essential to enhance functionality of HFC. A wider application of these findings could be in the new concept of Ward development committee (WDC) within the new Ward health system. Thus, in rolling out the WDC there is a need to understand how the HFCs are fairing and the way WDC is introduced should be streamlined. The WDC thus provides an opportunity to apply a training style that facilitates relationships.

There should be stimulus and incentives to work, especially when members are committed to work. Committees can be given minimal financial incentives at least to manage their meetings. But the committee at the long run should be able to mobilise its own funds.

There is also need to document good practices of HFCs and government can sponsor study tours from the more functional HFCs to other less functional HFCs to share their experiences and good practices.

In general, local committees with a health focus have an impact on health facility performance where the committees are functional. The practices and procedures of the HFC influence their impact on health facility performance and trust within the committee contributes to these impacts. Mistrust as was found in Ugwuaro to be an issue and leads to low functionality. The dense network of relationships between HFC and other local accountability structures, the provision of infrastructure and proper information dissemination are likely to strengthen the functionality of HFC. The presence of an OIC on the committee, though necessary, is not enough to ensure functionality unless the OIC is proactive. HFC functionality is also undermined by local tension and a poor state of repair of the facility which influences committee motivation.

What do we need to do to strengthen HFC? In the first place, knowing that various accountability models exist in a community, there is a need to revisit the guidelines to note what is missing. For

example, the guidelines on membership do not say anything about other accountability structures in the community and the need to have them on the committee for wider representation, yet our findings suggest that they are important. Representation of other accountability structures on the HFC enables these groups to participate in the health decisions that will ultimately affect them. Thus, they are empowered to voice their opinion on the one hand, and, on the other hand, build the capacity of the communities to participate in strengthening and building functioning HFCs. These HFCs need to be accountable to the communities they serve. There is also a need to ensure that a good working relationship exists between and among the HFC members and that they especially trust each other as this will facilitate progress. Strong links among the other accountability structures was also found to be an important element as this creates synergies towards achieving better service as seen in the removal of the erring OIC in Isulo. This can be attributed to the dual representation of the HFC chairman in this capacity and as an executive in the town union. Thus, relationships are important elements in local accountability structures such as HFCs.

The guidelines also do not say anything about the necessary style of leadership and how to manage meetings, yet these are important aspects to ensure the functionality of the HFC. The democratic pattern of leadership as seen demonstrated by the Isulo HFC chairman seems to be accepted by the committee members. His transparency in handling affairs of the committee helped engender trust while, in contrast, this was not so in Ugwuaro. This open style allows each member a voice in decision making. Meeting management should encompass all steps from meeting schedules, agenda setting, adequate notification of all members, adequate timing of meetings, to regular meetings and keeping of minutes as this strengthens the committee by ensuring a continuity of actions. Specifically, regular meetings have been noted to be an important factor as this also implies high functionality.

There is a need to manage tension between local authorities for optimal functionality of the HFC. The state government through the Ministry of Local government and Chieftaincy matters can do well to attend to these issues in collaboration with the LGAs. Tension between these local authorities has been known to impede development in the communities (Nwosu 2008). There is also a broader debate in Nigeria and especially Anambra state on the establishment of the fourth tier of government under which these local authorities will fall. This was based on the fact that Nigeria is made up of Federal, State and Local Government, and, therefore, there is a dire need for the creation of the fourth tier of government which will be the village government that will be able to reach directly to the people. The village head is expected to be made the automatic head of that government where allocation is also made to execute some minor projects within the limit of the village government law. If this is done, it might provide solutions as the government can now effectively manage the tension.

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8. ANNEXES

Annex 1: Socio-demographic characteristics of in-depth interview of Isulo respondents

S/N	IDNO	GRADE	Structure	Years Worked	Gender	Community
1	IDIHFC20MO1	Chairman HFC	HFC	6	Male	Isulo
2	IDIVIG20MO1	Chairman Vigilante	Vigilante	2	Male	Isulo
3	IDILR20MO1	Lay Reader	Lay Readers' committee	2	Male	Isulo
4	IDIHW20FO1	Health worker	Health Centre	0.12	Female	Isulo
5	IDIHW20FO2	Health worker	Health Centre	3	Female	Isulo
6	IDIHFC20MO2	HFC member	HFC	Unknown	Male	Isulo
7	IDIIWC20FO1	IWC rep	IWC	Unknown	Female	Isulo
8	IDICL20MO1	President General	IDU	1	Male	Isulo
9	IDIHFC20MO3	HFC member	HFC	Unknown	Male	Isulo
10	IDITR20MO1	Traditional ruler	Igwe's Cabinet	Unknown	Male	Isulo
11	IDIHFC20MO4	HFC member	HFC	4	Male	Isulo
12	IDIHFC20FO1	HFC member	HFC	3	Female	Isulo
13	IDICHEW20FO1	CHEW	Health Centre	2	Female	Isulo
14	IDIML20FO1	Med laboratory Technician	Health Centre	0.5	Female	Isulo
15	IDIIDU20MO1	IDU Sec General	IDU	Unknown	Male	Isulo
16	IDIWKS20MO1	Chairman Works	Works Department	1	Male	Isulo

Annex 2: Quantitative summary data for FGD Isulo

S/N	IDNO	No of Participants	Mean Age of Participants	Sex	Education most common	Occupation most common
1	FGDAD20F01	9	37	Female	Primary	Trader
2	FGDAD20M01	8	62.2	Male	Primary	Trader/Farmer

Annex 3: Demographic characteristics of male FGD participants in Isulo

Participants IDNO	Marital	Age	Age range	Sex	Occupation	Education
P1	Married	83	80+	Male	Farmer	Primary
P2	Married	42	40-49	Male	Trader	Primary
P3	Married	70	70-79	Male	Farmer	Primary
P4	Married	70	70-79	Male	Photographer	Primary
P5	Married	76	70-79	Male	Trader	Primary
P6	Married	60	60-69	Male	Tailor	Primary
P7	Married	50	50-59	Male	Driver	Primary
P8	Married	50	50-59	Male	Driver	Primary

Annex 4: Demographic characteristics of female FGD participants in Isulo

Participants IDNO	Marital	Age	Age range	Sex	Occupation	Education
P1	Married	45	40-49	Female	Trader	Secondary
P2	Married	32	30-39	Female	Trader/Tailor	Secondary
P3	Married	35	30-39	Female	CHEW	TTC
P4	Married	32	30-39	Female	Trader	TTC
P5	Married	50	50-59	Female	Farmer	Primary
P6	Married	24	20-29	Female	Trader	Secondary
P7	Married	50	50-59	Female	Trader/Farmer	Primary
P8	Married	30	30-39	Female	Trader	Primary
P9	Married	35	30-39	Female	Trader/Farmer	Primary

Annex 5: Socio-demographic characteristics of in-depth interview respondents in Ugwuaro

S/N	IDNO	GRADE	Structure	Years Worked	Gender	Community
1	IDIHW30FO1	Health worker	Health Post	3	Female	Ugwuaro
2	IDIHFC30FO1	HFC member	HFC	3	Female	Ugwuaro
3	IDIHFC30FO2	HFC member	Health Post	1	Female	Ugwuaro
4	IDYUL30MO1	Youth leader	Youth Organisation	Unknown	Male	Ugwuaro
5	IDIHW30FO2	CHEW	Health Post	1	Female	Ugwuaro
6	IDIHW30FO3	Senior CHEW	Health Post	3	Female	Ugwuaro
7	IDIHW30FO4	Health attendant	Health Post	1	Female	Ugwuaro
8	IDIHFC30MO1	Chairman HFC	HFC	1	Male	Ugwuaro
9	IDITR30MO1	Traditional Ruler	Igwe's Cabinet	Unknown	Male	Ugwuaro
10	IDIHFC30MO2	Executive member	HFC	3	Male	Ugwuaro
11	IDIHFC30FO1	Secretary HFC	HFC	3	Male	Ugwuaro

Annex 6: Quantitative summary data for FGD Ugwuaro

S/N	IDNO	No of Participants	Mean Age of Participants	Age Range	Sex	Education most common	Occupation most common
1	FGDAD30MO1	11	47.3	26-72	Male	Primary	Farmer
2	FGDAD30FO1	9	49.3	35-63	Female	Secondary	Trader/Farmer

Annex 7: Socio-demographic characteristics of male FGD participants in Ugwuaro

Participants IDNO	Marital status	Age	Age range	Sex	Occupation	Education
P1	Married	69	60-69	Male	Retired civil servant	Unknown
P2	Married	34	30-39	Male	Furniture maker	Unknown
P3	Married	72	70-79	Male	Farmer	Primary
P4	Married	57	50-59	Male	Trader	Primary
P5	Single	43	40-49	Male	Pastor	Primary
P6	Married	30	30-39	Male	Farmer	Primary
P7	Single	30	39-39	Male	Business	Primary
P8	Married	46	40-49	Male	Farmer	Primary
P9	Married	68	60-69	Male	Security officer	Primary
P10	Married	45	40-49	Male	Farmer	Primary
P11	Single	26	20-29	Male	Student	B.Sc

Annex 8: socio-demographic characteristics of female FGD participants in Ugwuaro

Participants IDNO	Marital Status	Age	Age range	Sex	Occupation	Education
P1	Married	35	30-39	Female	Trader	Secondary
P2	Married	43	40-49	Female	Farmer	Primary
P3	Married	40	40-49	Female	Trader	Primary
P4	Married	48	40-49	Female	Trader	Secondary
P5	Married	50	50-59	Female	Farmer	No Formal education
P6	Married	55	50-59	Female	Trader	Secondary
P7	Married	60	60-69	Female	Farmer	No Formal education
P8	Married	50	50-59	Female	Nursing	Secondary
P9	Unknown	63	60-69	Female	Farmer	No Formal education