March 2024

Nigeria HPN Multi-Activity Evaluation

FGD and KII Results: Ebonyi, Kebbi, and Zamfara states

Introduction

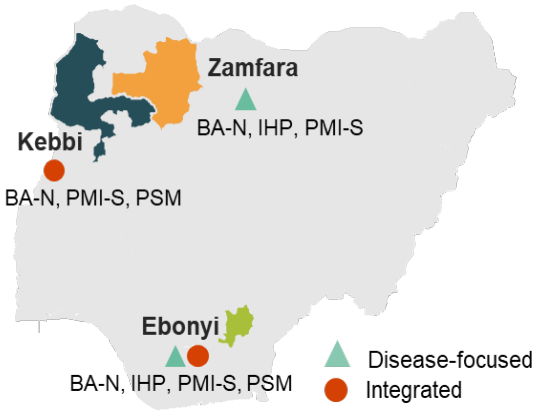
Data for Impact (D4I) is conducting a prospective mixed-methods portfolio evaluation of four USAID/Nigeria Health, Population, and Nutrition (HPN) Activities. The primary focus of this evaluation is to compare an integrated health programming approach with a disease-focused malaria approach. The evaluation results will inform adaptive program implementation and support USAID/Nigeria's investment strategy prioritization to improve health outcomes.

D4I partnered with the Nigerian research firm, Data Research and Mapping Consult Ltd. (DRMC), to conduct a qualitative assessment in Ebonyi, Kebbi, and Zamfara states to monitor the implementation progress and effectiveness of the HPN Activities. The research also aimed to gain a deeper understanding of several key aspects of healthcare and health service provision, including demand generation, quality of care, provider attitudes toward respectful care, affordability of healthcare, perceptions of Drug Revolving Funds (DRFs), monitoring of health service performance and data use, and perceived capacity of Facility Management Committees (FMCs) and Ward Development Committees (WDCs).

Evaluation Questions

The qualitative component of the evaluation was designed to address the evaluation context and specific aspects of selected evaluation questions:

1. *Did malaria and other health and service delivery outcomes improve more from baseline to endline in LGAs/states where an integrated approach (IHP) was implemented, a disease-focused approach (PMI-S) was implemented, or a combination of the two?*
2. *Did relevant commitment/engagement and capacity outcomes improve more from baseline to endline in LGAs/states where an integrated approach (IHP) was implemented, a disease-focused approach (PMI-S) was implemented, or a combination of the two?*
3. *Which implementation strategies are associated with improvements in service delivery, and system strengthening in different contexts?*



- **Integrated approach**: The Integrated Health Project (IHP) implements a fully integrated set of reproductive, maternal, newborn, and child health plus nutrition and malaria (RMNCH+NM) and health system strengthening interventions.
- **Disease-focused approach**: PMI-S focuses on malaria health programming and health system strengthening.
- Both models include **demand creation** (led by Breakthrough ACTION – Nigeria [BA-N]) and **commodity procurement and distribution** (led by Global Health Supply Chain Program – Procurement and Supply Management [GHSC-PSM]) interventions.

Methods

Assessment design

The assessment included key informant interviews (KIIs) with health facility officers in-charge (OICs) and focus group discussions (FGDs) with FMC and WDC members, as well as with men and women who are primary caregivers of children under five years in communities. Interview guides for each participant group, focusing on a range of topics. These topics included coordination and collaboration between health facilities and WDCs, FMCs, and HPN Activities, availability of essential drugs, diagnostics, and supplies (EDDS), perceptions of DRFs, monitoring of health services' performance, affordability of healthcare services, and current attitudes among health care providers in facilities. All these fall within the scope of interventions supported by USAID through the four Activities involved in the evaluation. The guides were informed by the HPN Activities' Monitoring, Evaluation, and Learning plans, the portfolio-level Theory of Change (TOC), and the evaluation questions.

Sampling and data collection

In July and August 2022, D4I conducted FGDs and KIIs across the three case-study states. Collaboration with HPN Activities facilitated the identification and approach of potential participants. For each state, D4I selected the OIC from each of the six site facilities for KIIs. Furthermore, FGDs were conducted in three of the six site facilities per state, involving members of the FMC and WDC that corresponded to the selected facility sites. Additionally, D4I held three FGDs with both men and women who were primary caregivers for children under five in each state. Table 1 summarizes the sampling methodology.

Interviews lasted an average of 60 minutes and were conducted primarily in English, with the exception of the FGDs with men and women, which were also held in Hausa (Kebbi and Zamfara states) and Ibo (Ebonyi state). D4I audio recorded and took notes on FGDs and KIIs. The research team obtained verbal informed consent at the beginning of each interview.

Table 1. FGD and KII participants, by group and state

Participant	Ebonyi	Kebbi	Zamfara	Total
Key informant interview				
Health facility in-charge	6	6	6	18
Focus group discussion *(6-8 participants per group)*				
FMC members	3	3	3	9
WDC members	3	3	3	9
Men with children under 5	3	3	3	9
Women with children under 5 (ages 15–24)	3	3	3	9
Women with children under 5 (ages 25–49)	3	3	3	9
Total	6 KIIs + 15 FGDs	6 KIIs + 15 FGDs	6 KIIs + 15 FGDs	**18 KIIs + 45 FGDs**

Analyses

The research team transcribed and translated recorded interviews into English. The research team collaboratively developed three codebooks for three participant groups, including FMC and WDC members, health facility OICs, and men and women. Initially, a set of deductive codes was developed and aligned to discussion themes and evaluation questions. D4I then refined and supplemented these codes through an inductive process while reviewing the initial set of interviews. The research team analyzed FGD and KII data using Dedoose software. After all interviews were coded, the team conducted a thematic content analysis to identify patterns in the data as key themes and developed memos to summarize the themes. D4I analyzed data from men's and women's FGDs separately to identify potential

gender-related themes. D4I then synthesized the memo content into reports for each State along with an overarching report. The team included illustrative quotes as evidence to support the identified themes.

Results

Health planning, management, and coordination at the state level

Roles of FMC and WDC

FMCs primarily consisted of health facility staff (HFS) (e.g., OICs and department/unit heads) and members of the WDC, typically the chairman. The committees convened monthly and, when necessary, on an ad-hoc or emergency basis, to outline work plans and address issues like facility maintenance and the application of the Basic Health Care Provision Fund (BHCPF). On the other hands, WDCs, which play an essential role in planning community health activities, were largely comprised of community representatives (e.g., village heads, civil servants, business leaders, women leaders, and imams) and FMC members (often the OICs). When discussing the gender breakdown of WDC membership in FGDs, men outnumbered women. One OIC in Zamfara, expressed concern that some WDC members were too “advance in age,” and as a result, movement around the ward to conduct activities is difficult. Like FMCs, WDCs also held both regular and ad-hoc meetings. Their funding primarily came from NGOs and contributions from membership dues (Ebonyi), “well-to-do” community members, solicited donations from store owners (e.g., for drugs or construction supplies), or other non-government funding sources.

FMC and WDC coordination and collaboration

Together, FMCs and WDCs were reported to share the joint goal of advancing health facility development and improving community health standards. As such, the two committees met together monthly to share information and discuss issues. FMCs shared information related to the facility (e.g., low turnout for services, renovation, or maintenance needs) that WDCs could assist with addressing. In turn, WDCs shared any feedback they received from community members about services received at the facility (e.g., attitudes of healthcare workers, stockouts) and worked jointly with the FMC to plan for a way to address the feedback.

Community mobilization and sensitization

FMC and WDC respondents indicated that both committees actively engaged in community mobilization and sensitization. WDCs rallied community members to utilize primary health services (e.g., antenatal care [ANC], labor and delivery, and immunization), and often assisted with or provided free transportation to the health facility for these services. They also disseminated health messages, including warnings against harmful practice of female genital mutilation, and advice for malaria prevention and treatment through house visits and collaboration with religious and civil groups. FMCs, frequently working jointly with WDCs, directly engaged with communities through outreaches in markets, villages, and home visits. In Ebonyi and Zamfara, there were reports of certain FMCs assigning individual members targets for mobilizing specific numbers of people monthly for ANC and immunization. WDC FGDs in Kebbi reported they helped enroll community members in a contributory healthcare insurance scheme administered by Kebbi Contributory Healthcare Management Agency (KECHEMA).

Data use

FMCs and WDCs met monthly to share and analyze health data, highlighting areas with low service uptake like ANC or immunizations, and areas with concerning trends, such as rising malnourishment, or an increase in malaria. The two committees coordinated efforts to mobilize people for these healthcare services and focus sensitization activities accordingly. One WDC FGD in Zamfara reported that they proactively reviewed the health facility registers to

determine if cases, for example malaria, had increased or decreased from month to month, to guide their sensitization activities. From the registers, FMCs also disaggregated data by sex and age to target efforts and participate in monthly data validation meetings to address issues with the goal of improving data quality. In addition, if the registers indicate that community members had missed ANC or immunization visits, WDC members, and sometimes FMC members, tracked these individuals and encouraged them to return to the health facility to complete their full schedule of appointments.

Management of health facility funds

To ensure accountability and transparency, WDCs collaborated with FMCs to oversee the spending of funds from the BHCPF. Typically, the facility OIC and WDC chairmen usually served as joint signatories.

WDC members were reported to review, approve, and verify spending plans. In Kebbi, some WDCs had taken further measures by visiting health facilities to confirm the presence of drugs and exploring chemists and marketplaces to identify where drugs could be procured at the most affordable cost.

Other joint collaborations

In addition to partnering on community mobilization, sensitization, and use of funds, WDCs and FMCs were reported to collaborate in various other ways. Joint efforts between the two committees had led to initiatives, such as identifying land where medical facilities could build a pit for placenta disposal, and creating food banks for families with nutritional issues (Ebonyi); as well as raising funds for ice blocks and fuel generator to maintain cool temperatures for certain medicines (Kebbi). Meanwhile, in Zamfara, an OIC explained that following advice from the WDC, the facility constructed separate male and female wards and a temporary structure for admitting clients.

Challenges

Most FMC and WDC FGD respondents expressed positivity about their collaboration and joint achievements, indicating minimal challenges in working together. However, some specific issues were noted. In an FMC discussion in Ebonyi, a respondent mentioned that fellow FMC members sometimes failed to attend community sensitization activities due to lack of transportation or short notice. In Kebbi, FGD participants observed that WDCs might misinform community members by stating that drugs are free, but this only applied to those registered with KECHEMA. In Zamfara, an OIC acknowledged occasional disagreements between FMC and WDC members regarding issue handling but noted that they typically resolved differences or “agree to disagree.”

Drug Revolving Fund (DRF) scheme

In a DRF, donors provide a seed stock of drugs and commodities that are then sold to patients/clients at affordable rates, and the revenue is used to restock supplies. The primary objective is to ensure consistent availability and affordability of drugs. FMC and WDC FGD respondents from Ebonyi and Kebbi were able to provide detailed insights into the operation of a DRF and enumerated their perspectives on observed or potential benefits, which included:

- Access to affordable drugs, offering a more economical option than purchasing from markets or pharmacies.
- Availability of medications at local health facilities, minimizing or even eliminating the need to travel extensively or visit multiple locations for prescribed drugs.
- Assurance that the provided drugs are neither expired nor without National Agency for Food and Drug Administration and Control (NAFDAC) approval.
- Improved drug adherence because of paying for the medications rather than receiving them for free.
- Increased sustainability of health facilities since they are not dependent on the state funding or donations

for their drug supplies.

In Ebonyi, the majority of FMC and WDC respondents revealed that they either lacked a DRF, or its role had been diminished. They proposed that the state must either furnish the drugs or revive the DRF, as facilities were financially incapable of acquiring them. Additionally, among the OICs interviewed, three reported that the DRF had ceased operations, one indicated a diminished role in their facility, and two stated that it was still functional. For the non-functional DRFs, respondents explained that the funds were not operating as "true" DRFs because they received drugs that they neither needed nor requested, leading to medication expiring, while they were required to pay for drugs before using them. The OICs also noted that the drugs they received from the state could be bought at a lower price in the market. These issues resulted in the discontinuation of the DRFs. In one of the facilities where the DRF had become defunct, the OIC reported a lack of funds to purchase drugs. They explained that when community members learned about the unavailability of drugs at the facility, they ceased visiting and instead obtained medications from private chemists. In another facility without a DRF, the OIC revealed that they used a portion of their capitation payment from the National Health Insurance Scheme (NHIS) to purchase drugs. Contrastingly, in facilities where the DRF remained functional, the OIC reported that FMC members manage supplies and monitor when stocks of a particular drug reached minimal levels and needed to be restocked. To maintain accountability, WDC members were kept informed about the types of drugs procured and how they are used.

In Kebbi, most FMC, WDC, and OIC respondents reported encountering no issues with their DRFs. They explained that the DRFs at their facilities were functional, ensuring a steady supply of drugs and commodities. Out of six Kebbi OICs interviewed, four reported no challenges with the DRFs while one emphasized that some community members were unable to afford drugs at any price. Another OIC pointed out a unique issue arising from lack of trained pharmacy staff, leading to some "fill-in" staff inadvertently overcharging or undercharging for medications. Much like Ebonyi, FMC members in Kebbi were responsible for monitoring stocks. WDCs also play an essential role in accountability within the state, such as ensuring that drugs were sold at the predetermined prices, verifying that drugs were available at the facilities, and confirming that funds generated from drug sales were appropriately deposited.

In Zamfara, DRFs were reported to be functional across all facilities. Interviews with OICs revealed that both FMCs and WDCs played essential roles in managing the funds. FMCs were tasked with overseeing the sale of drugs and depositing funds and ensuring that the funds were used judiciously. Additionally, they ensured that drugs were available and managed in a manner that the expiration of drugs was either minimized or eliminated. Some FMCs even had authority to approve expenditures for restocking. One OIC explained that their FMC had a specialized subcommittee dedicated to drugs and commodities that regularly monitored stocks to ensure a two-month supply was maintained and determine if restocking was needed. WDCs were similarly involved in drug monitoring to ascertain that drugs and commodities were available and aligned with community needs. They ensured that the revenue generated from drug sales was allocated toward restocking drugs and commodities.

Coordination and collaboration with HPN Activities

Across the three states, FMCs and WDCs reportedly received significant support from HPN Activities, which encompassed various aspects such as community mobilization, specialized trainings for health care workers and WDC members, and the supply of necessary drugs and commodities.

FMC members expressed appreciation to and detailed the support they received from the HPN Activities, including:

- **Community mobilization, sensitization, and outreach**
  - *All three states:* Community mobilizations on attending health facilities for essential healthcare services.
  - *Ebonyi:* Sensitizations on malaria testing, receiving proper medications from health facilities, and malaria management (e.g., malaria testing, accepting test results, and medication).
  - *Kebbi:* Specialized community mobilizations that employed various methods (e.g., community meetings, home visits, and specific social behavior communication campaigns, namely "Albishirin Ku" [Glad Tidings]) focusing on RMNCH+MN, malaria management (e.g., malaria testing, accepting test results, and medication), and seasonal malaria chemoprevention campaigns.
  - *Zamfara:* Mobilizing mothers of malnourished children to seek assistance at health facilities.
- **Health trainings for HFS, including FMC members**
  - *All three states*: Trainings on topics related to management of uncomplicated malaria.
  - *Ebonyi*: Specialized trainings on family planning (FP) and MNCH
  - *Kebbi*: Capacity building activities focusing on ANC, FP, childhood illnesses, FP, childhood illnesses, managing postpartum hemorrhage, new labor and delivery techniques, immunizations, and other specialized skills related to malaria management (e.g., proper response to malaria testing results and identifying other potential causes of fever, and administering Sulfadoxine-Pyrimethamine [SP]).
- **Supply of drugs and commodities**
  - *All three states:* Provision of essential drugs and commodities, including malaria medications and supplies, which are free of charge to women, children, individuals with disabilities, the elderly, and those unable to afford payment.
- **Data quality and reporting**
  - *Ebonyi and Kebbi*: Providing training related to data quality and reporting standards.
- **Other**
  - *Ebonyi*: Assisting community members with enrollment in the BHCPF.

Additionally, WDC members highlighted HPN Activities' effort in areas such as:

- **Community mobilization, sensitization, and outreach:**
  - *All three states:* Community mobilizations on various health-related issues, including the importance of attending ANC during pregnancy, delivering at health facilities, the importance of exclusive breastfeeding, taking sick children for medical care, sleeping under mosquito nets, maintaining clean surroundings free of standing water, and ensuring child immunization.
  - *Kebbi:* Sensitization on gender issues.
- **Health trainings for WDC members**
  - *Zamfara*: Training WDC members on Rapid Diagnostic Tests (RDTs) and treatment of malaria, as well as public speaking techniques for more effective community sensitization.
- **Supply of drugs and commodities**
  - *Kebbi and Zamfara*: Providing essential drugs and commodities, including antimalaria and mosquito nets.
- **Other**
  - *Kebbi*: Assisting with maintenance of health facilities.

Demand generation for healthcare in community

An increased demand for quality health services was anticipated to contribute to increased sustainability of health systems and improved health outcomes by changing social norms and expectations around health services in the community. Across the three states, outreach and health messages were reported as common strategies generating demand for health services in the community. KIIs with OICs and FGDs with men and women in communities highlighted these demand generation strategies, indicating positive impacts as well as challenges affecting the implementation of these initiatives.

Outreach activities

The OICs interviewed across three states confirmed that outreaches have become an essential element of the states' healthcare infrastructure. The activities offered a broad spectrum of services including routine immunization, treatment for minor ailments, essential medications for children, childhood diseases, growth monitoring, ANC, FP, malaria prevention and treatment, and COVID-19 prevention, and health education or community sensitizations on general health issues (e.g., hygiene practice, food demonstration, nutrition, and breastfeeding practice).

In Ebonyi, respondents confirmed that regular outreach activities typically occurred every one to two months. The primary targets of these included communities with limited access to health facilities or difficulty accessing medical services. The activities were mainly conducted by OICs and other healthcare providers and were announced in advance to ensure community awareness and participation. There were mixed responses about support for conducting the outreaches. Some OICs confirmed support from organizations like IHP. Others noted that previous support from organizations such as World Health Organization (WHO), United Nation Children's Fund (UNICEF), USAID, and local health authorities had ceased. However, some key informants reported that they never received support for conducting outreaches.

In Kebbi, participants confirmed that health facilities had implemented various outreach strategies to increase awareness and provide essential health services in the communities. Decisions on the focus areas for the outreaches were often based on the specific needs of the community, allowing for targeted interventions. The healthcare providers conducted these outreach programs in collaboration with WDCs, with the support the State Primary Health Care Development Agency (SPHCDA), BA-N, and IHP. Community leaders, traditional birth attendants, and local people were informed in advance, fostering a sense of collaboration and community engagement. Additionally, town announcers, posters, and songs played a crucial role in publicizing these outreach events and disseminating health messages.

In Zamfara, outreach activities were reportedly designed to generate demand and ensure accessible healthcare for those communities hindered by distance and security issues. The program was strategically planned with monitoring charts and guidelines and carried out by health professionals with the help of community volunteers. The outreaches were conducted three to four times a month, and these services were also flexible, allowing for adjustments depending on prevailing diseases and health conditions in the communities. Support in carrying out the outreaches came from a variety of organizations, such as Global Alliance for Vaccine and Immunization (GAVI), United Nation Children's Fund UNICEF, the State Government, PMI-S, WDCs, and local representatives like the Senator for Zamfara North. OICs noted that support ranged from financial incentives to transportation assistance and mobilizing communities.

OICs discussed both successes and challenges of their outreach programs:

State	Successes	Challenges
All three states	▲ Enhanced public awareness of general health issues, such as benefits of immunization, personal hygiene practices, and environmental sanitation. ▲ Increased access to and use of healthcare services at hospitals and local facilities, reflected in health registry records, including ANC, FP, and routine immunization. ▲ Improved vaccine coverage for childhood diseases like measles, yellow fever, TB, and whooping cough. ▲ Positive acceptance of and participation in services offered during outreaches within communities, even from neighboring villages.	▼ Shortage of staff to conduct the outreaches due to perceived lack of funding.
Kebbi and Zamfara	▲	▼ Non-availability of various drugs, medical supplies, and commodities, resulting in decreases in health service attendance (e.g., shortage of FP commodities, low health service attendance among mothers due to lack of specific supplements like peanuts). ▼ Non- or low acceptance of certain healthcare procedures (e.g., non-acceptance of HIV tests among women, low acceptance rate of FP methods). ▼ Poverty or economic constraints.
Ebonyi	▲ Increased commitment by healthcare providers and the FMCs had also contributed to sustain the ongoing successes ▲ Collaboration with the WDCs and town announcers had contributed to sustaining the achieved successes	▼ Withdrawal of support from some organizations, resulting in some services no longer being provided during outreaches. ▼ Transportation difficulties to the outreach communities. ▼ Weather-related disruptions such as rainfall.
Kebbi	▲ Encouraged community contributions to health facility renovations and the acquisition of land for the construction of new health facility	▼ Inconsistency in attending a same hospital/facility for both ANC and delivery services, posing challenges to reconcile records of women reached with ANC

		intervention in outreaches with overall Health Management Information System (HMIS), thus hindering accurate assessment of the effectiveness of the outreach programs.
Zamfara	▲ Decrease in under-five mortality rates	▼ Lack of consistent support from traditional and religious leaders ▼ Inadequate incentives for health personnel and WDCs have hindered further success to the outreaches ▼ Lack of dedication by some health workers in conducting outreach activities. ▼ Insecurity in the state

Health messages

Health messages play a vital role in elevating awareness, encouraging preventive and health-promotion behaviors, and driving the demand for essential health services, therefore enabling community members to be well-informed and make informed health decisions. Generally disseminated through various communication channels such as radio, television, gatherings, religious and traditional leaders, and health providers, these messages reportedly address different health-related topics tailored to the community's needs (Figure 1).

Figure 1. Common channels for community health messages across states

Malaria messages

Across the states, both men's and women's FGDs indicated that they had heard or seen messages related to malaria through various channels within the past six months. There were common sources of information through which both groups received these messages, including radio, hospitals/healthcare facilities, healthcare providers, television, newspapers, churches, mosques, and town criers. In Ebonyi, some women also reported hearing or seeing the malaria messages from the National Youth Service Corps, village meetings, seminar, pamphlets, and the 321 hotline, which were not mentioned by the men's group. In Kebbi, the men's FGDs reported an additional range of channels for receiving malaria messages, including bullhorn-mounted vehicles, mosques, signboards, social media, neighbors, friends, and WDCs. In Zamfara, the men's FGDs mentioned additional sources of malaria messages like the World Health Organization (WHO), the internet, and community traditional and religious leaders, while the women's FGDs respondents mentioned mobile phones, and wedding ceremonies.

The content of malaria messages disseminated in Ebonyi, Kebbi, and Zamfara states shared an emphasis on general awareness, preventive measures, and treatment options across both men and women groups. The common points across all three states included the dangers of malaria, its signs and symptoms, and the importance of implementing preventive measures. Messages also stressed the "need to sleep under mosquito nets," "maintain environmental sanitation," "avoid self-medication," and "conduct tests to confirm malaria before initiating treatment." However,

there were notable differences in the focus of messages targeted towards men and women in these states. In Ebonyi and Zamfara, men generally received messages that concentrated on broader awareness and general prevention. These included topics such as the seriousness of malaria as a life-threatening disease and the role of environmental sanitation. Women, on the other hand, received more targeted information that focused on specific demographics, such as "the danger of malaria to under-five children" and "malaria and pregnant women." In Kebbi, while the information was generally uniform across both genders, the messages tended to revolve around broad topics such as the "danger of malaria," its general "signs and symptoms," and the need to "maintain personal hygiene."

Across all three states, men's and women's FGDs found them to be "clear," "understandable," and valuable in emphasizing the "importance of prevention and treatment of malaria." The participants largely appreciated the malaria messages, and many even reported making behavioral changes based on the messages received. However, there were distinct gender-specific concerns and reactions to the messages. In Ebonyi, a women's FGD expressed dissatisfaction about the inconsistency between messages promoting free malaria drugs and the actual availability of these drugs, a critique that was not reflected in the men's group. In Kebbi, men in FGDs further acknowledged the clarity of the messages; they specifically noted dramatized versions of the messages on television helped clarify any ambiguities from radio content. In Zamfara, both men and women reported that the messages led to improvements in their personal and child health. Yet, women's reflections focused more broadly on community-wide benefits like overall health status, acceptance of preventive measures, and uptake of drugs. Men, on the other hand, spoke primarily about their personal commitments to follow precautionary measures.

Both men and women FGDs across three states were aware of various malaria projects implementing in their communities. Projects, such as net distribution at healthcare facilities, community sensitization about malaria, and access to free drugs and supplies, seemed to be well-received and benefited community members. In Ebonyi, men were more specific in naming community sensitization initiatives by organizations like BA-N and New Life, which were not mentioned in the women's FGDs. In Kebbi, men paid particular attention to projects related to the distribution of free malaria drugs and noted a subsequent reduction in malaria cases. In Zamfara, both men and women recognized and reported benefiting from various projects like WDC sensitization campaigns and house-to-house distribution of malaria drugs to children.

FP messages

In Ebonyi, Kebbi, and Zamfara states, men and women FGDs reported having encountering FP messages within their communities over the past six months through various channels, including healthcare centers, radio, television, and in some cases, religious institutions and educational facilities. In Ebonyi, men cited a broader array of sources for FP messages, including newspapers, friends, neighbors, and village and market squares, which were not mentioned by the women's FGDs. In Kebbi, while both genders accessed messages through common channels, women also received information via mobile phones and during special ceremonies such as naming ceremonies. Men, on the other hand, cited neighbors, friends, workplaces, and gatherings as additional sources of information. In Zamfara, although both groups identified similar primary channels, women emphasized receiving the information from friends, neighbors, relatives, spouses and hospitals. Additionally, they were aware of specific FP programs like the free distribution and insertion of implants, whereas men focused more on broader sensitization campaigns by organizations, such as WDCs, the government, schools, and mosques.

In all three states, FP messages generally centered around the importance and benefits of FP, especially with regard to child spacing and women's health. However, the focus of these messages varied between men and women. In Ebonyi, women's messages incorporated the benefits of FP for a healthier life and the idea of giving birth to the

number of children one can manage. Men's messages, on the other hand, emphasized spousal communication before adoption of FP, and various types of contraceptives. In Kebbi, women received more comprehensive details about FP, including the various methods, places to get services, the timing of FP use after delivery, and the information that the services are free. Men's messages focused more on how FP reduces burdens on people and when it should be taken. Zamfara showed a similar pattern; FP messages to women were tailored towards family well-being and children's quality of life, whereas men received more general information on the importance of FP and the availability of various FP methods.

Across all states, most men and women responded positively to the FP messages they received. They expressed an understanding and appreciation for these messages, largely acknowledging the life-saving implications of FP and its role in preventing unwanted pregnancies. However, some disparities were also noted. In Ebonyi, some women expressed confusion about the side effects of FP, a sentiment not shared by men. In Kebbi and Zamfara, the participants claimed that the FP messages had educated and encouraged them and other community members to use FP services.

When it comes to awareness of FP-related projects, there were some differences between men and women. In Ebonyi, men were aware of community sensitization and the establishment of women's committees for FP mobilization, while women did not report any such project. Similarly, in Kebbi, men mentioned outreach programs involving home visits and distribution of free FP commodities, which women did not report. In Zamfara, both men and women were aware of similar FP projects like sensitization campaigns and house visits by health workers for FP commodity distribution.

ANC messages

In all three states, both men and women FGDs reported having heard or seen messages about ANC within the past six months. Common channels for these messages included radio, television, hospital/healthcare facilities, outreaches, churches, mothers, and neighbors. In Ebonyi, men also cited unique channels such as town criers, wedding ceremonies, market square, and the internet, whereas women in Kebbi mentioned more diverse sources, including mobile phones, drama *Albishirin Ku!* on radio, bullhorns-mounted motor vehicles, newspapers, and mosques. Zamfara also saw a similar trend, with men mentioning traditional leaders as sources, while women frequently noted health workers.

There was a significant overlap across genders in all states regarding the essential content of ANC messages. These typically covered core aspects, such as benefits of ANC, the importance of regular ANC check-ups, the timing for starting ANC, dietary guidelines, and the importance of hospital delivery. However, women generally received more detailed ANC information compared to men. For instance, women in Ebonyi were informed about specific

Table 2: Reflections of men and women on health messages

Reflections	Ebonyi	Kebbi	Zamfara
Malaria			
I like the messages.	•	•	
The messages are easy to understand.	•	•	•
The message are helpful.	•	•	•
Family planning			
I like the messages.		•	•
The messages are easy to understand.	•	•	•
The message are helpful.	•	•	•
ANC			
I like the messages.	•	•	•
The messages are easy to understand.	•	•	•
The message are helpful.	•	•	•

aspects of pregnancy care, such as the period at which women should start attending ANC, the way pregnant women should sleep, the food that pregnant women should eat, the kinds of clothes that pregnant women should wear and the necessity of exercise during pregnancy, which were not mentioned by the men's FGDs. Kebbi and Zamfara reportedly follow a similar pattern, where messages for men specifically aimed at encouraging them to accompany their wives for ANC, while women received comprehensive information on pregnancy care and maternal health topics, such as the dangers of not attending ANC, period of start of ANC visits, health of pregnant mothers, availability of free ANC drugs and supplies, different ways of pregnancy care, and protection against malaria.

The ANC messages were overwhelmingly well-received across genders and states (Table 2). Both men and women expressed that they "understood" and "liked" the messages. They claimed that the messages "were not confusing," and they "found the messages helpful" and had put them into practice. The positive reception had reportedly resulted in perceived improvement in the health of pregnant women, increasing use of ANC services, and reducing pregnancy-related complications and mortality during delivery.

Regarding awareness of ANC projects, men and women in all states claimed to have seen or heard about ANC initiatives within the past six months, although there were some differences in level of detail. In Ebonyi, a small number of men and women said they had never encountered any ANC projects. In Kebbi and Zamfara, men were aware of specific projects like IHP and BA-N, and UNICEF's monetary incentives for ANC service users, whereas Kebbi women cited programs like "Lafiya Jari" (Health is Wealth) (primarily funded by the Government of Nigeria with support from World Health Organization [WHO], and United Nations Children's Fund [UNICEF]) and ActionAid that focused on educating people about ANC. In Zamfara, women were reportedly less familiar with specific ANC projects in their community.

Impact of COVID-19 on demand for health services

The COVID-19 pandemic brought unique challenges to each of the three states, but reflections from OICs suggested that the pandemic generally led to an initial decline in demand for health services.

In Ebonyi, the majority of the OICs observed that the pandemic did not substantially affect patient demand and service use, with some specifically noting an increase in demand for COVID-19 vaccines. In Kebbi, initial fears surrounding the virus led to a decline in healthcare service usage, especially during the initial stage of the pandemic. However, interventions by WDCs have since helped restore normalcy, encouraging community members to resume use of healthcare services. In Zamfara, key informants revealed that fears of contracting the virus led to a sharp decline in healthcare demand and disrupted the positive gains made by previous healthcare outreach programs. Added challenges in the state also included insecurity and unavailability of FP commodities, which further contributed to the decline in healthcare demand.

Health facility readiness to provide services

The readiness of health facilities to provide services is considered an essential factor contributing to influence the public demand for and use of healthcare services within the community. FGDs with FMCs and WDCs and KIIs with OICs identified and discussed various key components integral to health facility readiness for effective service provision.

Availability of essential health services

In-facility services

In Ebonyi, Kebbi, and Zamfara states, essential health services were generally available at primary health care

centers (PHCs), according to responses from OICs, FMC, WDC, and community members. These services cut across a broad range of healthcare needs, including treatment of minor illnesses, ANC and postnatal care, FP, labor and delivery, nutritional guidance for pregnant mothers, growth monitoring for children under five, and immunization. All three states offered referral services for severe or complicated cases that required special medical attention or surgical interventions.

However, there were differences in service delivery across these states. In Ebonyi, labor and delivery services for pregnant women were reportedly often not available, primarily due to lack of HFS to provide 24/7 health care, which was attributed to their not being accommodated near the health facilities. In contrast, Kebbi's PHCs were reported to offer routine childbirth services. A unique feature in the state was that the essential services were delivered through specialized units within the same facility, even if the services were administered by the same HFS. Meanwhile, in Zamfara, health services were organized into separate preventive and curative sections, including dedicated areas for childbirth. Additionally, the state's health facilities incorporated pre-consultation rapid diagnostic tests (RDTs) for malaria as a standard procedure for all fever cases.

Outreach services

Outreach health services in Ebonyi, Kebbi, and Zamfara states played a crucial role in extending essential healthcare access to remote and hard-to-reach areas. These outreaches, often collaborative efforts between health facilities and WDCs, aimed to enhance supply and coverage of essential health services within the catchment areas of each facility. The principal goals of the outreaches were consistent across all three states: To raise awareness about health issues, mobilize communities to use healthcare services, and provide specific essential services directly. These essential services commonly included immunization, ANC, and FP.

Despite these commonalities, each state had its unique set of circumstances that affect the implementation of these outreach programs. In Ebonyi, the outreach activities were supported by organizations like WHO, UNICEF, and IHP, but they faced limitations in distributing of contraceptives for FP due to approval constraints. Kebbi's outreach activities received minimal funding from multilateral organizations, which limited the scope of services like FP. However, these programs were strategically focused on areas with identified service gaps and also addressed broader community development issues that are relevant to health services. In Zamfara, support for outreaches activities primarily came from UNICEF, GAVI, and PMI-S. Like its in-facility services, the state's outreaches offered RDTs for malaria for all fever cases. However, FP services had been discontinued due to the end of a project that previously funded this component.

Availability of EDDS

The availability of EDDS across healthcare facilities in Ebonyi, Kebbi, and Zamfara states presented a complex picture, characterized by both improvements and lingering challenges in resource allocation, community engagement, and funding sources.

All three states reported some level of "significant improvement" with "a lot of positive changes" in the availability of EDDS in recent years, offering a wide range of EDDS (e.g., routine essential drugs for general care, malaria drugs and diagnostic tests, ANC supplies, and FP commodities). OICs from the three states noted that enhanced resources had not only filled the shelves with medications and

> *"It [the SP] is out of stock completely… Sometimes, we try to purchase them and keep them in the pharmacy. But some of the patients do not feel they should buy since treatment is free. While some will buy and others would rather take prescription; however, when they go home, since it is given in dots, there is no guaranty they will take."* – OIC, Zamfara Central

diagnostic tools, but also resulted in better quality services and encouraged more community members to use local healthcare services. This development had led to increased patient volume and was credited with improving health outcomes in these communities. For instance, one OIC from Kebbi Central reported that about 781 people had received services in their facility over the past year, thanks to external support used for buying drugs and other services. Funding for EDDS in all three states came from a variety of sources, including state government allocations, DRFs, capitation funds from national and state health insurance schemes, community-raised funds, and contributions from other HPN activities, such as PMI-S in Ebonyi and PSM in Kebbi. Despite these shared improvements, all three states faced a common challenge regarding either inconsistent availability or frequent stockout of malaria drug Fansidar/SP (sulfadoxine/pyrimethamine) for pregnant women.

Additionally, each state had it unique progresses and challenges. In Ebonyi, government support was primarily focused on malaria drugs and FP supplies, while there were inconsistencies in the availability of certain medications like antibiotics (e.g., Amoxil and Ciprofloxacin). In addition to popular EDDS, Kebbi facilities also offered more advanced diagnostic tools like microscopes and hearing-test machines; however, the state was reportedly challenged by the inconsistency in the availability of certain drugs, such as antibiotics, for general care due to either high demand or delays in restocking. In Zamfara, while some OICs acknowledged an increase in the availability of essential drugs like folic acid, antibiotics, and anti-diarrheal medications, the majority indicate "no changes" or "little improvement" in overall EDDS availability. The gap was reportedly in the stock of key diagnostics for conditions like hepatitis B and syphilis.

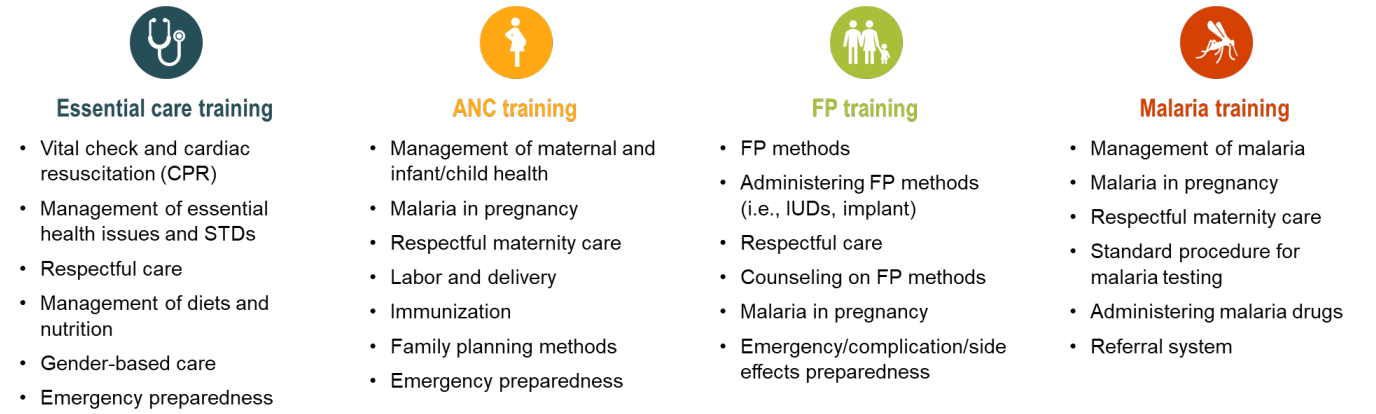
Staffing at health facilities

The OICs interviewed in Ebonyi, Kebbi, and Zamfara states emphasized the importance of staffing in health facilities' capacity to deliver essential health services. Across all three states, well-trained staff were cited as essential for not only "effective diagnoses," "accurate treatment," and quality patient care, but also enhancing the overall patient experience and ensuring "patients are treated with respect." There was also a shared acknowledgement among OICs that healthcare facilities had generally seen improvements in service delivery as results of various training programs on health service provision provided to staff.

> *"Because we were taught how to take care of a patient, we don't humiliate the patient. Now, if the patient comes here, we will examine him properly. Welcome patient, give him a place to sit and ask him relevant questions with respect, to the best of our ability."* – OIC, Kebbi South

The training programs, often funded by organizations, such as USAID, focused on several critical areas, from essential care (e.g., vital checks, gender-based care, and emergency preparedness), malaria treatment (e.g., standard testing procedure, administering malaria drugs), ANC (e.g., management of malaria during pregnancy, respectful maternal care), and FP (e.g., administering FP methods, and preparedness for complications) (Figure 2).

Figure 2. Reported training types and topics for health facility staff.



Successes of health staff training

The OICs interviewed in Ebonyi, Kebbi, and Zamfara states discussed the successes and ongoing challenges of health training programs to HFS:

Successes	*Challenges*
▲ ***Strengthening capacity****:* The training modules had proven successful in strengthening the capacity of HFS through diverse training content and the "stepdown training" approach, where skills and knowledge were cascaded down through the organizational hierarchy.	▼ ***Mismatch of content and needs***: There is a gap between the content of the training and the actual needs on the ground, as some skills acquired during the training sessions are not directly applicable or used in daily practice.
▲ ***Quality of care***: Trainings had positively transformed the way HFS provide healthcare services, which used to be "out of rule," into improved "team spirit," increased adherence to standard treatment algorithms, ensuring a more uniform and "improved quality of care."	▼ ***Logistical constraints***: The concentration of numerous training programs within a limited timeframe had led to staff stress, leaving inadequate time for the practice and mastery of the new skills.
▲ ***Increased patient flow***: The "improved quality of care" had also contributed to "increasing the patients flow" seeking treatment at the facilities.	▼ ***Pandemic-related issues***: The COVID-19 pandemic had presented logistical challenges, particularly in having enough HFS available for training, given social distancing norms and other safety protocols.

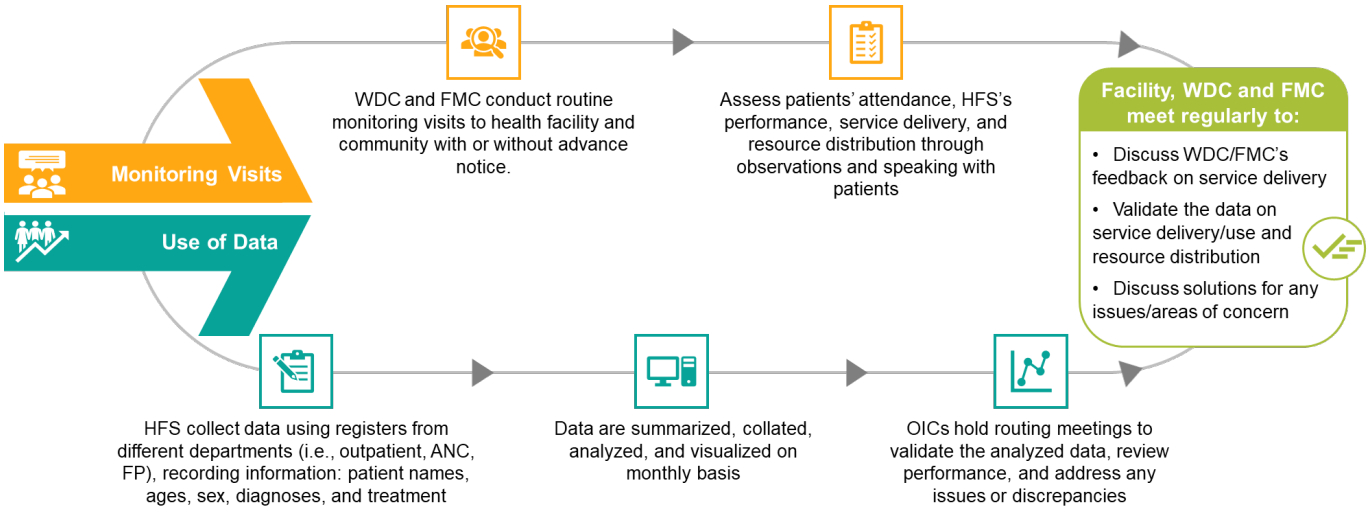
Monitoring health service performance

Monitoring health performance is essential to ensure quality care, patient safety, resource allocation, and accountability. In all three states, KIIs with OICs and FGDs with WDC and FMC members reported that all health facilities are actively engaged in the continuous monitoring of their health service performance, so that the HFS can "assess impact of their services," "track where the progress is lacking behind," identify the gaps and solutions, and "decide where the services should focus."

Approaches for service performance monitoring

In Ebonyi, Kebbi, and Zamfara states, monitoring health service performance is a collaborative and systematic effort among various stakeholders such as HFS, FMCs, and WDCs. There were two core multi-layered approaches employed to ensure effective monitoring of health service performance across various facilities in all three states. These involve using data to validate performance metrics and conducting monitoring visits to different units within health facilities (Figure 3).

Figure 3. Approaches implemented to monitor health service performance.



All the OICs interviewed across the three states confirmed that performance monitoring was an integral part of their facilities' routine operations. The HFS used a data-driven approach to assess and improve their services. As one OIC in Zamfara put it, "each [health] service needs to be monitored to assess its impact. So that you can plan ahead."

In all three states, health facilities employed monitoring charts to track key indicators such as immunization rates, outpatient registrations, and trends in community access to specific health services (e.g., ANC, FP, and malaria testing and treatment). This data-driven approach was reported to enable HFS to timely "identify service gaps," direct their efforts toward "areas that require attention," and contribute to informed decision-making process and promoting continual improvement in health service delivery.

Additionally, in each state, FGD and KII respondents indicated that both FMCs and WDCs were actively involved in supervising and supporting health service performance at the facility level. WDC members frequently conducted site visits to conduct real-time assessment of health service provision through observations of in-facility services, interactions with patient, and HFS/OIC consultations. These visits reportedly aimed to not only ensure quality assurance but also to foster community engagement and trust. For instance, WDCs in Ebonyi and Kebbi engaged in monthly dialogues and supervision visits with health facilities, while in Zamfara, the committees conducted home visits to facilitate healthcare attendance in community. Similarly, FMCs in each state closely observed daily health services, focusing on both service delivery and financial components. Their strategies spanned reviewing patient registers, endorsing community health service usage, and ensuring that facilities comply with their set workplans.

> *"We use all the registers, general attendance, outpatient department register, antenatal, lab register, and the rest of them... So that at the end of the month we will be able to analyze it and say we are doing well, or we are not doing well, we are going forward or we are going backward."* – OIC, Ebonyi Central

While the overall monitoring approaches were similar across Ebonyi, Kebbi, and Zamfara, there were also differences in the depth and specialization of their monitoring practices. In Ebonyi, FMCs had a particular focus on financial aspects, such as budgetary compliance and workplan implementation. The committees reviewed patient registers to assess the level of service use and conduct community visits to promote health service use. However, some HFS had expressed discomfort with the level of monitoring, particularly the close financial check by FMCs. Kebbi distinguished itself by ensuring each department within a health facility actively engaged in performance monitoring, with a designated head/manager overseeing the quality and efficacy of healthcare delivery within their unit. In addition, Kebbi FMCs extended their responsibilities to community outreach programs, facilitating the uptake of health services and ensuring immediate responses to drug and supply deficiencies. In Zamfara, WDCs reportedly conducted unannounced supervision visits and even reviewed register and receipts of outgoing patients to ensure service and drug delivery was consistent with policy. On the other hand, the FMCs engaged more deeply with the collection of monitoring data, which were harmonized into monthly summaries for issue rectifications and integrated into the National Health Data System (NHDS). The committees also coordinated with the facilities to establish staff disciplinary committees that oversaw staff behavior (e.g., punctuality, patient interactions, and treatment administration) and tackle arising issues.

Data use

In Ebonyi, Kebbi, and Zamfara, data use was reported not just as a recommendation but as an integral standard practice in the day-to-day operations of health facilities.

The OICs interviewed across the three states affirmed that all facilities are engaged in data collection, validation, and use for monitoring and improving the quality of health services. Specifically, these facilities maintained various patient registers that record a wide range of patient information, from name, age, and date of birth to specific medical details like measurements, test results, diagnoses, treatments, and medications prescribed. Specialized data were also collected for separate health services such as immunization, malaria, ANC, and FP. Additionally, data validation was mentioned as a standard procedure across facilities to ensure accuracy and completeness of the collected data. OICs noted that the compiled data served multiple purposes: tracking performance and quality of health services offered, pinpointing operational challenges, navigating solutions for emerging issues, and guiding decisions on healthcare provision. The interpretation of this data enabled the facilities to determine whether there was an upward or downward trend in service usage as well as identify areas that require focused attention or improvement. Both FMC and WDC members reportedly played a supplementary role in enhancing the data use. While WDC members made weekly or monthly trips to health facilities to observe patient care firsthand and verify the data collected by the health facilities, FMC members employed “monitoring charts” to “track trends” in service usage, enabling them to work alongside health facilities to “identify any problems” and “make informed decisions.” Additionally, monitoring data were commonly disaggregated by age and sex in all three states to provide a detailed understanding of healthcare access and outcomes for various demographic groups.

> *“Everyone uses it [data]. Whatever should be done is taken care of. Data is the real work. Without it, every work is useless. If you attend to 100 persons and didn’t record it. It is as good as you didn’t.”* – OIC, Kebbi Central

> *“We come here [facility] to supervise. We monitor and see how the patients are being attended to. Because you know, these patients, sometimes if you are not attended to quickly, maybe tomorrow, they will not come to that service again.”* – OIC, Ebonyi Central

While the core principles of data use were consistent across the states, there were differences in the methods and systems employed. Kebbi employed a similar system with an added layer where each department within a facility had its data collection system, and the collected data were later collated, analyzed, and summarized by Monitoring and Evaluation (M&E) officers on either a weekly or monthly basis. That system focused on addressing and rectifying issues identified and discussed during data validation in departmental meetings. In Zamfara, health facilities were reported to use charts to visualize data, allowing for easier trend analysis and strategy development. Zamfara uniquely maintained a system of "double caring" for data to ensure accuracy and accountability. Specifically, each set of data was usually photocopied, with one copy remaining at the facility and the other being shared with Local Government Area (LGA) officials or M&E officers for further validation. These officers further validated the data, made frequent supervision visits to the facilities, and assessed service delivery performance.

KII and FGD respondents across the three states shared success stories regarding the efficacy of data use in healthcare provision, as well as existing limitations in using data for healthcare monitoring:

State	Successes	Challenges
All three states	▲ **Regular** data **validation**: Monthly processes requiring HFS from various units to present, "cross-verify," and "validate their data" contributed to enhanced accuracy, transparency, and accountability. ▲ **Monthly summaries with disaggregated data**: Monthly reports that included data disaggregated by sex and age assisted in identifying service usage trends among different demographic groups. This helped health facilities identify issues, their root causes, and potential solutions, thereby enabling informed decision-making for future actions. ▲ **Issue identification**: Routine data monitoring involving multiple sources of data (e.g., general registers, lab registers) allowed OICs and other stakeholders to monitor multiple health issues, and preemptively spot areas of concern, such as the provision of mosquito nets, or a decline in the number of women utilizing the facility for labor and delivery services.	▼ **Capacity constraints in data collection**: Limited ability among HFS to use or adapt to new data collection formats and tools often resulted in errors and challenges in effective data management. ▼ **Documentation issues**: Problems with "inadequate/improper documentation of information" contributed to incomplete or inaccurate records, creating discrepancies in the collected data.
Kebbi and Zamfara	▲ **Effective resource allocation**: Consistent monitoring of specific health metrics, like malaria incidence, facilitated a stable supply chain for related drugs and supplies	

	at the facility.	
Ebonyi		▾ **Challenges with sex-disaggregated** data: Due to cultural sensitivities, sex-disaggregated data were not always used, which impacted the ability of WDC to make informed decisions.
Kebbi		▾ **Understanding data for decision making**: HFS sometimes reportedly encountered challenges in identifying the right actions/decisions to be taken based on the data and distinguishing between right and wrong actions/decisions.
Zamfara		▾ **Data sharing obstacles**: Bureaucratic procedures or absence of clear protocols or guidelines for efficient and secure data sharing impeded the efficient use of data. For example, authorization from supervisors was often needed before sharing data with external parties, which sometimes caused delays in access to information for decision-making.

Client-provider interaction

Like increased facility readiness to provide services, improved client-provider interactions are anticipated to promote use of healthcare. FGDs with men, women, FMC and WDC members, as well as KIIs with OICs explored perceptions of respectful care, strategies for its implementation, the successes and challenges of these strategy implementation, and the current state of the client-provider interactions in health facilities.

Respectful care: Perceptions

In Ebonyi, Kebbi, and Zamfara states, the perception of what 'respectful care' entailed in healthcare settings appeared to be largely uniform and well-defined, according to KIIs with OICs. Across all three states, OICs defined respectful care as adhering to standard operating procedures to prevent discrimination and harassment, along with providing treatment that "does not have harmful or negative effect on the patient." A significant point across the three states was the emphasis on interpersonal care: Health providers must "show love and care to patients," which could be demonstrated through gestures such as welcoming patients with a smile, offering them seats, and actively listening to their concerns. There was a common consensus among OICs across the three states that respectful care not only fostered trust and appreciation between patients and providers, but also had broader implications for public health. This form of interpersonal interaction was believed to promote "accessibility" to healthcare

> *"[Respectful care] is important because if you don't carry out this respectful maternity care, they will see it as if you are laughing at their condition. Thereby, instead of coming to you, they may decide staying inside [at their home] and die in silence."*
> – OIC, Ebonyi South

services and ensured the "well-being" and improved health outcomes of community members, regardless of their background or personal circumstances. The OICs interviewed in all three states stressed the consequences of failing to provide respectful care, highlighting that "disrespect" and "stigma" could have severely negative impacts on patients, especially those who were vulnerable.

Respectful care: Implementation strategies

To promote respectful care in health facilities, the OICs interviewed in Ebonyi, Kebbi, and Zamfara indicated that health facilities have adopted various implementation strategies based on the unique needs and constraints of their respective clinics.

- **All three states**
  - **Staff training**: HFS received training in patient respect through official training, step-down training, and monthly staff meetings. Additionally, HFS were reminded to apply the training principles in their day-to-day interactions with patients.
  - **Equal treatment practice**: Health facilities developed guidance on respectful care where all HFS are advised to:
    - Treat all patients equally without discrimination, regardless of their socio-economic status.
    - Show patience, empathy, and tolerance towards patients, even if they present themselves in an unpleasant manner, while avoiding provocation.
    - Ask patients about their well-being, attentively listen to their concerns, and ensure follow-up on their treatment.
    - *Ebonyi and Kebbi:* Adopt individualized patient care approaches, including regular check-ins and health status inquiries, to ensure that all patients receive the attention and care they need.
  - **Prioritizing patient privacy and confidentiality**: Health facilities implemented specific measures to ensure privacy for patients, especially for those with infectious diseases or mothers in labor, to maintain confidentiality and sustain their dignity.
- **Ebonyi and Kebbi**
  - **Family support during births**: If requested by mother, husband or family members were allowed to be present during labor and delivery.
- **Kebbi and Zamfara**
  - **Separate adolescent health services**: Health facilities operated a separate unit to provide adolescent health services to prevent any potential discomfort and embarrassment when they accessed any services within the facility.
- **Kebbi**
  - **Comfortable clinic setting**: Health facilities had a structured system to guide patients to the relevant departments, preventing feelings of confusion or neglect. Moreover, designated sitting areas were provided to enhance patient comfort and show respect for their time and well-being.

Respectful care: Successes and challenges

OICs discussed the successes and challenges that their health facilities had experienced in maintaining respectful care:

State	Successes	Challenges
All three states	▲ **Increased patient satisfaction and engagement**: Respectful care practices have significantly contributed to improving patient-provider communication, "increasing patients' trust," encouraging "patients to be more open about their concerns." These factors had led to better diagnosis and treatment and "improved patient satisfaction," encouraging more community members to "attend or seek health services." ▲ **Greater inclusion**: "Vulnerable populations," such as people with disabilities, women, adolescents, and young adults, had particularly benefited from inclusive healthcare settings and programs where their unique needs were acknowledged and accommodated. ▲ **Staff training and sensitization**: Continuous trainings and sensitization focusing on patient-centered approaches, including respectful care, had changed negative attitude among HFS and kept them up to date with best practices and empowered them to "treat all patients equally," regardless of their age, gender, or disability status. ▲ **Patient-friendly environment and infrastructure**: The adoption of respectful care practices had motivated health facilities to "further support in expanding infrastructure" to create a more comfortable and accessible environment for patients, ensuring the continued improvement and sustainability of these practices.	▼ **Limited funding and resources**: Limited funding and medical supplies sometimes constrained the upgrading of facilities to ensure they are welcome and accessible, and therefore, impacted the implementation of respectful care.
Ebonyi and Zamfara		▼ **Limited staffing**: Limited staffing and long working hours had led to emotional burnout among some HFS and affected their ability to deliver consistent respectful

		care, particularly during high-demand hours.
Ebonyi and Zamfara		▾ **Training gaps**: Despite some successes, "inadequate training" and "limited availability of materials and equipment" for service delivery impacted HFS's morale and their capacity to provide the best possible care, particularly the understanding of how to apply respectful care in complex and novel situations.
Kebbi and Zamfara	▴ **Fostering personal connections**: Respectful care practices had accelerated "a sense of belonging" that encouraged HFS to promote peer-to-peer knowledge sharing, as well as make extra efforts to understand and accommodate the specific needs of patients (e.g., providing temporary housing, emotional support). These factors had reportedly contributed to improving client-provider interactions.	▾ **HFS and community discord**: While strong community partnerships can drive success, the "lack of harmony" and "understanding" between community members and HFS sometimes led to misunderstanding and dissatisfaction among patients and compromised the quality of health services.
Ebonyi		▾ **Cultural barriers**: Social stigmas or cultural norms and beliefs posed challenges to the successful implementation of respectful care practices, particularly for certain vulnerable groups.
Zamfara		▾ **Educational background gaps among HFS**: Differences in educational backgrounds among HFS resulted in inconsistencies in perception and skillset, thus affecting the quality of care provided.

Interaction of providers with clients with disabilities

In Ebonyi, Kebbi, and Zamfara, HFS appeared to share common values of "respectful" and "compassionate" care towards patients with disabilities. FMC and WDC FGD respondents emphasized that HFS in all three states exhibited a high level of commitment to accommodate the specific needs of disabled patients, ensuring that they feel comfortable, inclusive, accepted, and treating them like "brothers and sisters." As one FMC FGD in Ebonyi Central indicated: "The health workers attend to [patients with disabilities] as they attend to normal persons. There is no discrimination… We receive them as brothers and sisters. We don't quarrel." Additionally, the interviewed OICs in these states also stressed the perspective that respectful care was not only a moral obligation but also vital for effective healthcare delivery. They emphasized that their health facilities committed to creating an inclusive

atmosphere that accommodates the unique needs of each patient when interacting with people with disabilities.

Across Ebonyi, Kebbi, and Zamfara, communication emerged as a crucial tool for effective healthcare interactions with patients with disabilities. HFS were reported to prioritize clear, adapted, and attentive communication mechanisms to ensure that patients' needs were well understood and addressed. Another common practice of care across the three states was empathy and sensitivity towards the financial constraints of patients with disabilities. Health facilities in these states acknowledged the unique financial challenges that patients with disabilities may face and made efforts to assist them in the matters, such as offering free registration or medical check-up cards, and providing necessary medications and personal care items.

> *"Some [patients] come with diseases that bring out rashes and foul smell. They would stay away from us, and then we would ask them to come closer with a smile, and when we do that, you find out they are relaxed. We give them seat, and this makes them feel comfortable and accepted. From there, we ask what brought them and when they mentioned it… you can as well tell him that there was someone you know with similar case and after treatment, the person is now cured, and then he becomes comfortable."* – FMC FGD, Kebbi Central

While the overarching perspective of compassionate and respectful care, including the employment of effective communication practice, was common across the three states, there were subtle differences in their approaches and implementation.

In Ebonyi, health facilities reportedly emphasized creating an inclusive environment that not only attended to the physical well-being but also to the emotional/mental health of the patients. There was a focus on maintaining a respectful and non-judgmental attitude towards patients with contagious diseases or injuries and using personal protective equipment to ensure safety for both patients and providers. Health facilities also ruled to prioritize pregnant patients with mobility issues to minimize their discomfort and waiting time.

Similarly, Kebbi health facilities placed a strong emphasis on effective communication. HFS were trained to not only convey medical information clearly but also to become attentive listeners. Moreover, their commitment to effective communication extended to adapting their interaction styles to meet the unique needs of patients with disabilities, such as offering appropriate seating arrangements and prioritizing check-ups based on the severity of the patients' conditions.

Zamfara exhibited similarities with Kebbi in communicating medical information clearly and being attentive listeners, with particular focus on making patients with disabilities feel "welcomed" and "valued" during their medical visits. Specifically, health facilities in the state employed a variety of communication strategies, including speaking clearly, using hand gestures, and involving family members when dealing with sensory impairments like deafness or blindness. In addition, interview respondents noted that special care was taken to allow patients with disabilities to be treated before others in queues, to minimize their discomfort and challenges they may be experiencing. The clinics were also reported to give extra attention to elderly patients and those with special needs. Like Ebonyi, health facilities in Zamfara also focused on safety precautions for both providers and patients, particularly those with contagious diseases, such as the use of personal protective equipment while maintaining a non-judgmental attitude during the service delivery.

Interaction of providers with adolescents and youths

Healthcare facilities in all three states appeared to be making conscious efforts to address the unique needs of adolescents and youth, according to FGDs with FMCs and WDCs, and KIIs with OICs.

Across all three states, interactions between health providers and adolescents and youths in health facility settings reportedly shared common principles of ensuring non-discrimination and equitable treatment, regardless patients' age, gender, and marital status (e.g., treating adolescents and youths with the same level of respect as older patients), maintaining privacy and confidentiality, and employing non-judgmental and tailored approaches, especially when discussing FP services. Specifically, health providers demonstrated a commitment to addressing the unique needs of adolescents and youth with sensitivity and respect. They recognized that this age group may require different styles of interaction due to their emotional and physical state. In all states, discussions related to FP were approached with caution and consideration, considering factors such as age, marital status, and specific circumstances.

In addition to commonalities, interactions between providers and adolescents and youths in the three states also presented some variations influenced by local contexts and practices.

In Ebonyi, health providers stressed the importance of a tailored approach to suit the emotional and physical state of younger patients. They reportedly aimed to be both "cautious" and "considerate," particularly when discussing FP options. Pregnant young adults typically received tailored guidance to prepare them for their first delivery. Discussions around FP with adolescents may incorporate educational elements such as the importance of safe sex and condom use. Providers may also sensitize these young patients about the health risks associated with early childbirth, benefits of FP, and encourage them to delay marriage and/or having children until they are older. Ebonyi FGD and KII respondents also strongly emphasized the importance of privacy, politeness, humility, and equal treatment in the patient-provider interactions.

Kebbi's health system was also reported to value non-discrimination and extend this principle to adolescents and youth seeking FP services. The focus was more on confidentiality and creating an atmosphere of openness and mutual respect where younger patients feel comfortable sharing their health concerns without fear of judgment. Additionally, health facilities appeared to lean more on open communication and immediate problem-solving in fostering a positive healthcare environment, in which the facility leadership actively involved in taking immediate corrective measures if instances of discrimination or unequal treatment occurred. Like Ebonyi, Kebbi facilities also emphasize providing comprehensive guidance and counseling as part of the FP services, aiming to empower patients, particularly younger ones, to make well-informed decisions about their reproductive health.

Zamfara offered a unique blend of the non-discrimination approaches observed in Ebonyi and Kebbi but added a layer of cultural sensitivity to the patient-provider interactions. Health providers aimed to balance modern healthcare needs with traditional norms, particularly when discussing FP services. For instance, in certain cases involving young married patients, health providers may request the husband's presence or at least inform them about the FP decisions to align with cultural expectations while maintaining the patient's right to the FP services. In addition to emphases on good patient-provider relationships, OICs and FMC and WDC representatives in Zamfara also noted time-sensitive, equally attentive, and patient-centered care as

> *"Like adolescents, we normally tell them about FP, how to use this condom instead of having unprotected sex. We tell them the importance and the disadvantages of it, that they should not feel ashamed of coming to the health center to take condoms, and we are giving [them] free of charge."* – FMC FGD, Ebonyi South

> *"[If a girl of 16 years comes for FP], they [providers] will receive her warmly. They will not mind if she is married or not. They will explain to her and if she is satisfied with the method she want, then she will be given."* – WDC FGD, Kebbi North

common practices in their affiliated health facilities.

Interaction of providers with men and women

In Ebonyi, Kebbi, and Zamfara states, FGDs with FMC and WDC members and KIIs with OICs suggested that there were "no significant differences" in the way men and women were treated in health facilities. In all three states, men and women were reportedly welcomed in similar manners, and generally offered the same level of attention and medical care during their medical visits. Interview participants indicated that the overarching aim was to provide accessible and non-discriminatory healthcare for all patients, regardless of their gender and cultural background. There was a common understanding among HFS that equal treatment and privacy are essential for ensuring comfort and open communication between patients and healthcare service providers.

While the primary approach in healthcare settings was of non-discrimination, there were certain differences that emerged in specific situations within the overall patient-provider interactions across the three states.

In Ebonyi and Kebbi, FMC and WDC reported that couples attending health clinics together for services like immunizations or FP were observed to receive some forms of preferential treatment. This practice was not considered as discrimination but as a strategy aimed at encouraging men's involvement in family health matters. The belief is that prioritizing such couples can encourage more men to actively participate in the healthcare of their spouses and children, therefore improving overall health outcomes. The "preferential treatment" practice differed slightly in Zamfara as there was a specific focus on prioritizing women and young children for immediate care, particularly if the women are pregnant or in critical conditions. The practice was rooted in the belief that these groups may have more urgent healthcare needs due to their potentially delicate health statuses. The practice also extended to FP services, where spousal consent was viewed as crucial for streamlined healthcare delivery. Specifically, women attending clinics with their husbands for FP services often received more attentive care. In some cases, there was an added layer in the practice when women were advised to return with their husbands for FP consultations if they initially came alone. As respondents explained, this practice aimed to gain mutual consent and agreement between the spouses in FP decisions, minimize potential misunderstandings, and enhance communication and cooperation between couples, ultimately benefiting the healthcare outcomes.

> *"The health workers here are doing their best. When it comes to emergency, they do well to attend to the person. If they see that they cannot handle any case, they will quickly refer the person to a bigger hospital."* – Women FGD, Ebonyi South
>
> *"Some [providers] are not accommodating, but majority are accommodating… even in the night. Especially our hospital, I brought my child one or two times, they treated him with good attention."* – Men FGD, Kebbi Central
>
> *"The officials [health providers] are caring. Any time we visit the facility, they don't hesitate to attend to us."* – Women FGD, 15–24 years old, Zamfara Central

The practice of separating men and women during examinations was reported in all three states but varied in its rationale. In Ebonyi, this separation aimed to ensure comfort and privacy, allowing patients to communicate openly and comfortably about their health concerns. However, when husbands and wives attended together, joint-counseling was usually offered for the couples. OICs explained that the gender separation aimed to maintain the comfort and privacy of individual patients while the joint counseling focused on facilitating better understanding and cooperation between spouses, particularly in health scenarios where the treatment of one may impact the other. Kebbi also reported similar practices; however, the men-women separations appeared to stem from logistical necessities (e.g., limited space in

facilities) rather than a planned strategy. In contrast, Zamfara did not highlight this practice prominently.

Patient-provider interactions showed similarities in experiences across three states. Both men's and women's FGDs generally shared positive feedback regarding their interactions with health providers, and expressed gratitude for the attentive care and equal treatment provided by HFS at their community health facilities.

While both genders underscored the importance of attentive listening and proper communication for accurate diagnosis and care, opinions diverged on the importance of formalities like providers introducing themselves. Women ages 14–24 in Ebonyi, as well as men across all states, placed a higher value on immediate treatment and quality of care rather than formal introductions. In Kebbi and Zamfara, younger women believed that the introduction of providers could foster trust and be helpful for future patient-provider interactions. While women ages 25–49 in Zamfara predominantly discussed the necessity of providers formally introducing themselves, their peers in Ebonyi and Kebbi states expressed mixed feelings about the introductions. Additionally, while men across three states appreciated providers' name introduction and had mixed opinions about the protocol, they largely agreed on the necessity for HFS to maintain professionalism, calmness, respect, and attentiveness during the patient-provider interactions, and acknowledged that these aspects mattered more than formalities like provider introductions.

Use of health services in community

The use of healthcare services not only indicates health-seeking behavior but also is a critical lens reflecting public health trends, accessibility, and overall well-being of community members. The effectiveness and uptake of these services are often influenced by various factors, such as the direct costs associated with healthcare, the role and availability of health insurance, and the community's perceived quality of health services. FGDs with men, women, FMC and WDC members, as well as KIIs with OICs explored main factors affecting the healthcare use and the current state of the service use in communities across Ebonyi, Kebbi, and Zamfara states.

Healthcare costs

Healthcare costs across Ebonyi, Kebbi, and Zamfara states exhibited a picture of complexities and variances, as revealed by FGDs with men and women. In all three states, individuals seeking healthcare services at local health facilities typically incurred expenses associated with registration cards, diagnosis tests, treatments, and medications. The cost for these services varied depending on the patients' medical conditions, individual status or specific circumstances and, in the case of Zamfara, the location of the clinics. For instance, registration cards ranged from ₦50–₦100 in Kebbi, whereas in Ebonyi, costs for services such as pregnancy tests or FP counseling could range between ₦200–₦500. While tests for conditions like HIV, malaria, and urine tests were generally free in Zamfara, patients might be charge for specific diagnosis tests, which typically ranged from ₦50–₦200.

The states also presented unique nuances. Ebonyi presented a unique situation wherein specific groups, like pregnant women, the elderly, and those with physical disabilities, sometimes benefited from fee waivers for particular services, such as malaria testing and treatment. However, there was reported inconsistency in the state's cost structures, particularly for pregnant women, who sometimes incurred varying fees for different required medical services or drugs. Kebbi's healthcare costs appeared slightly more straightforward. The range for registration cards, a common cost across the states, was notably lower. In contrast, Zamfara presented a more mixed picture, with disparities in healthcare costs across communities and a combination of free and paid health services. In the state, essential tests for conditions like HIV, malaria, and urine tests were generally free, while other tests like hepatitis, syphilis, and blood group tests might require payment. One significant advantage in Zamfara was community health centers often offered drugs at prices lower than private pharmacies, therefore enhancing accessibility for community

members with constrained financial resources. Despite the perceived preference for government facilities among community members due to cost considerations, gaps in service provision were identified in the state. For example, some essential drugs might not be available in government facilities, requiring patients to purchase them at higher prices from outside sources.

Affordability of healthcare services

Affordability of healthcare services in communities of Ebonyi, Kebbi, and Zamfara states reportedly remained a pressing concern, with complex dynamics of poverty, community support systems, and state-specific strategies or interventions affecting the landscape. FGDs with men and women as well as FMC and WDC members highlighted both commonalities and unique challenges posed by healthcare costs in each state.

Although the introduction of beneficial strategies and interventions—such as BHCPF in Ebonyi, community-specific strategies in Kebbi, and free and subsidized medical services for certain health issues in Zamfara—was reported to ease some financial burdens, many community members, particularly those in rural areas and/or from low-income families, still found healthcare costs unaffordable, which had limited their access to essential healthcare services. Across the states, FGD participants emphasized the influence of factors on the gaps in affordability, including financial capabilities, specific ailments, type of medical tests and treatments, and availability of subsidized or free medical services.

> *"It [medical cost] is not easy because of financial constrain in this village. Sometimes, they go to take ordinary herbs rather than going to hospital. ₦200 is a big money here."* – WDC FGD, Ebonyi North

Despite the shared challenges, FGDs revealed state-specific distinctions in the landscape of healthcare cost affordability.

> *"Honestly, it's possible not to have money to visit the hospital. [Pregnant women] can go to [facility to] get anti-malaria drug since most of the time it is given to pregnant women for free."* – Women FGD, Kebbi South

> *"A woman may need to come to the hospital but if she knows that she cannot afford to buy the drugs in the facility, that will discourage her from coming… Most of the women only come to the hospital if they have money."* – Women FGD, Zamfara North

In Ebonyi, healthcare affordability was reported heavily influenced by the high levels of poverty in rural communities. While certain services like malaria testing and medication were generally free or affordable for registered individuals through the provision of BHCPF, community members, particularly those with limited financial resources, continued to struggle with high healthcare costs due to other medical expenses, such as consultation fees, diagnosis tests, specialized treatments, and surgeries. The cost of registration cards and transportation, especially for those residing in remote areas, was also a significant financial strain. Community members often resorted to alternative solutions such as borrowing money or seeking assistance from family and friends. Additionally, community-based solutions, such as informal credit systems, community donations or funds for purchasing medications, and fee waivers for check-ups offered by healthcare workers, were discussed as means to mitigate these challenges.

Kebbi offered a slightly different picture. With numerous community strategies, certain treatments were either free or heavily subsidized. The introduction of registration cards, especially the KECHEMA card, had emerged as vital tools in bridging the affordability gap, as they provided access to free or reduced-cost healthcare services for specific medical conditions (e.g., malaria, pregnancy)

and even covered costs of transferring patients to general hospitals for severe illnesses. Fees for registration and obtaining these cards also appeared to be largely affordable. However, affordability remained an obstacle for comprehensive care. FMC and WDC members emphasized that comprehensive care, characterized by patient cards, tests, and consultations, still posed financial barriers for many community members, especially low-income families. Additionally, FGD participants noted that community members, who struggle financially, might opt for alternative solutions to cover the healthcare costs, like borrowing money or seeking help from family and friends, receiving treatment on credits, choosing traditional medicine, or visiting chemists. Open communication between patients and health providers about patients' financial constraints was also highlighted as an effective strategy to address the affordability issues as these providers could explore potential financial aids or more affordable healthcare alternatives and refer patients to organizations offering free or subsidized care.

Zamfara's FGDs revealed a mix of optimism and concern. While community support and the provision of free or subsidized medical services were recognized as facilitating affordable healthcare for some, financial constraints were still a significant barrier for many, especially those with limited resources. Both community members and FMCs and WDCs acknowledged that even minimal charges for essential services, like registration cards, might remain out of reach for the economically disadvantaged families, therefore limiting their accessibility to the essential healthcare. Moreover, cultural and social norms wherein some women need approval from spouses or in-laws to seek medical care introduced an additional layer of complexity to healthcare accessibility that negatively impacted the affordability dynamics. Community support reportedly served as a safety net for those who might not be able to afford health services, with initiatives such as bulk purchasing of drugs and medical supplies and community financial contributions for fee subsidies. Like Ebonyi and Kebbi, men's and women's FGDs also indicated that assistance from family, relatives, mosque members, and community funds could supplement individual financial resources to cover costs in Zamfara.

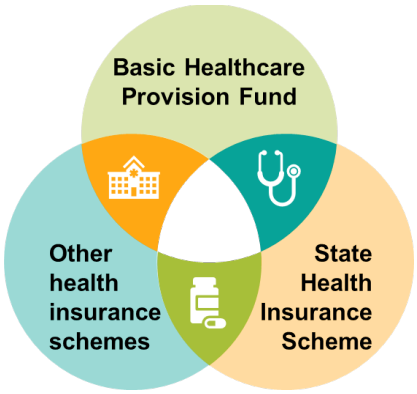
Health insurance: Awareness, successes, and challenges

In Ebonyi, Kebbi, and Zamfara states, awareness of health insurance schemes has made significant headway, as emphasized by feedback from FMC and WDC representatives. In all three states, community members generally were reportedly knowledgeable about the existence of health insurance schemes, with the Basic Healthcare Provision Fund (BHCPF) and the State Health Insurance Scheme standing out as the most widely recognized initiatives (Figure 4). A major catalyst for this awareness came from the distribution of health registration cards and the provision of free drugs and medical services during outreach programs, particularly targeting to vulnerable groups such as economically disadvantaged individuals and families, and children under five.

Specifically, in Ebonyi, the widespread recognition of the BHCPF was enhanced by significant public awareness efforts. FMC and WDC representatives confirmed the communities' broad understanding and enthusiasm to access the scheme. They particularly recalled instances where community members actively approach them for access. As one WDC FGD in Ebonyi Central reflected: "When Basic Healthcare Provision Fund came, the publicity was wide. And everyone knew about it."

Kebbi shared similarities with Ebonyi in terms of awareness origins. A distinctive feature was the emphasis on the collaboration among government agencies and local committees, including FMCs and WDCs, which played an essential role in educating the public, ensuring they were well-versed about

Figure 4. Most familiar health insurance schemes in community.



the schemes, and accessing the benefits of these schemes. As a result, community members had reportedly not only become aware of the insurance schemes but have also witnessed their positive effects on healthcare access and affordability. Men and women FGDs revealed that community members recognized the schemes for their tangible impact on timely getting essential medical assistance, with some community members personally benefitting from them.

Zamfara captured a similar picture regarding awareness of health insurance schemes but employed distinct methods of public engagement. Apart from the familiar methods of distributing health registration cards and offering free drugs and medical services, community gatherings and mosques were reportedly leveraged as effective platforms for sensitization. FGD participants affirmed that the joint efforts of the FMCs and WDCs facilitated the strategic use of religious and communal spaces, ensuring wide dissemination of information about the benefits and enrollment process and contributing to widespread awareness.

As one men FGD in Kebbi North indicated: "I am enjoying this KECHEMA that was introduced, because I had a health issue that I couldn't buy drugs. But with the help of this KECHEMA, I was given medicine. I took them for up to 3 months, and I was healed." – Men FGD, Kebbi North

"There was a time, I made them announce it [the Basic Healthcare Provision Fund] in the mosque so to create awareness among community members. Everyone was informed that they should come to the hospital and get registered to give them the opportunity to benefit from this scheme." – WDC FGD, Zamfara Central

Representatives of FMCs and WDCs highlighted the successes associated with health insurance schemes in communities, and discussed the challenges encountered during the implementation of these schemes:

State	Successes	Challenges
All three states	▲ **Community impact:** Health insurance schemes have significantly contributed to improving community's access to free or subsidized healthcare services, reduce the burden of healthcare costs for some beneficiaries, and positively contributed to community development. ▲ **Enrollment growth**: Enrollment in the BHCPF is increasing as more community members become aware of the benefits of the schemes.	▲ **Access to benefits**: Access to the benefits of the insurance schemes can be a hurdle due to issues such as shortage of drugs and medical supplies, inefficiencies in allocating benefits, and malfunctions in the health cards, which restrict beneficiaries from accessing benefits. ▲ **Information gap**: There is a lack of in-depth knowledge about the enrollment procedures and specific benefits of the insurance schemes.
Ebonyi and Zamfara		▼ **Community dissatisfaction**: Some community members have expressed dissatisfaction toward healthcare providers, who were perceived as not fully using government resources to provide free health services.
Ebonyi and		▼ **Operational setbacks**: Challenges like

Zamfara		shortage of enrollment forms, lack of guidance on the registration protocols, and delays in fund disbursement hampered the successful implementation of these schemes.
Kebbi	**State government's support**: Kebbi state government has been proactive in promoting the insurance schemes through training health workers and ensuring availability of drugs and medical supplies in community health facilities	
Zamfara		▾ **Enrollment limitations**: Financial and transportation constraints can hinder registration for some community members.

Quality of health services: What did clients say?

The quality of health services plays a pivotal role in shaping community trust and engagement with healthcare facilities. FGDs investigated the experiences and perceptions of both men and women in the community regarding the quality of healthcare services they have received in local health facilities in Ebonyi, Kebbi, and Zamfara states. The discussions focused on key aspects of service quality (Figure 5).

Waiting time

In Ebonyi, Kebbi, and Zamfara, FGDs among both men and women consistently indicated that waiting times for check-ups in health facilities generally met the expectations of local service users. On average, most individuals reported waiting times of 30 minutes or less.

The actual duration of the wait often depended on the particular circumstances at the health facility, such as the nature of the services being attended to and the time of the day when users access the services. For instance, in the three states, FGD participants emphasized that if the case was emergent, service providers tend to expedite care; however, for routine or non-emergency situations, patients were required to follow standard procedures, including registration and waiting in queues, which could extend the wait time. This reflection was echoed by community members, who suggested that arriving early to health facilities could help in minimizing waiting times, subsequently improving overall client satisfaction.

Nevertheless, certain differences in experiences emerged across the states. In Ebonyi, while many service users had positive experiences and minimal delays, as some caregivers shared their positive experience with their children's health services, a few did highlight instances where they had to wait for over an hour

Figure 5. Key metrics for quality of health service.

> *"My experience I can share here is that they did not delay me and my son when we came here. They didn't ask us about money. They issued me a card to get a test, after the test they gave us drugs. Do you know, by the next day, my son had recovered."* – Women FGD, Ebonyi

for their check-ups. The extended waiting time was primarily caused by the shortage of available providers and issues related to the punctuality of attending service providers. Similarly, in Kebbi, reflections from caregivers noted the structured process for non-emergency cases, which might require patients to collect a folder, undergo registration, and then join a queue before seeing a doctor for consultation. On the other hand, in Zamfara, the interviewed community members pointed out that the sequence of arrival sometimes determined the waiting time. For example, if several patients arrive before an individual with a similar health problem, the waiting time could be extended.

Facility condition

Across the states of Ebonyi, Kebbi, and Zamfara, community members largely agreed on the significance of cleanliness in health facilities. Men's and women's FGDs indicated that cleanliness not only served as an encouraging factor for healthcare visits but also stood as a critical preventive measure against disease transmission. Despite the consensus about the importance of hygiene and sanitation in clinics, there were variations in perceptions regarding the cleanliness standards in the facilities. In all three states, a significant portion of the FGD respondents believed that health facilities were largely clean, but approximately a third of them held the view that only specific areas—such as the ANC clinics and the labor wards—consistently met the desired cleanliness standards. The primary challenges to achieving consistent sanitation levels across the health facilities were staffing shortages and a lack of effective supervision.

> *"There is a problem that a doctor can see a patient in front of everybody if it is an emergency case, and you will benefit from it if there is no harm. It is nothing if the doctor does that."* – Women FGD, Kebbi

> *"In some hospitals, there are no private places for discussion. If you go to some small hospitals, they have only one room, and all the patients are inside. So, they don't have private place for discussion. You may see a doctor discussing with other clients."* – Women FGD, Zamfara

The issue of privacy during clinical consultations emerged as another focal point of FGDs. Across three states, discussion participants emphasized the practice an essential aspect to ensure effective patient-provider interactions. In Ebonyi, most community members affirmed that privacy was generally well-maintained; however, some argued that the practice was limited to certain types of illnesses. On the other hand, Kebbi presented a distinct perspective. In emergency situations, privacy could sometimes be overlooked or compromised. Acknowledging the urgency and pressure of such circumstances, some respondents suggested that potential breaches of privacy in emergencies might be permissible if they do not result in harm. Meanwhile, Zamfara presented a unique challenge. The physical limitations of health facilities hindered the assurance of privacy during clinical consultations. Specifically, some facilities, constrained by their small size, reportedly struggled with providing private spaces for confidential consultations.

Examination consent

Across the states of Ebonyi, Kebbi, and Zamfara, that there existed a similar trend regarding the practice and perception of obtaining patient consent before conducting a physical examination in health facilities. FGDs with both men and women across the three states indicated that obtaining consent prior to a physical examination was not a common practice among healthcare providers. Most participants were reportedly aware

> *"Yes, this is part of what healthcare providers do. They ask for your permission that you are going to be examined. They will tell her: 'We are all females. We are of the same sex, so that we will be able to check you. Feel free and explain everything to us, we are going to examine you on your health."* – Women FGD, Zamfara

that physical examinations are standard procedures during clinical consultations; however, only a small proportion reported that healthcare providers actively sought their consent before such procedure. Furthermore, the majority of health service users, as per the feedback from FGD participants, did not prioritize the process of obtaining consent but rather centered their attention on the end diagnosis from the consultation.

Differences emerged when looking into state-specific findings. In Ebonyi, the likelihood of a healthcare provider seeking consent was reportedly higher if they perceived the patient as educated or enlightened. The reflection was summarized by a service user who highlighted that healthcare providers often "ignored" the consent process for individuals they believed as "illiterate." In Kebbi, while the overarching reflection mirrored Ebonyi and Zamfara regarding the importance of the final diagnosis, healthcare providers were more inclined to explain the procedure after the examination had already taken place rather than obtain upfront consent. In contrast, Zamfara presented a unique perspective where the acceptability of skipping consent seemed to associate with the gender of the healthcare provider. Women FGDs revealed that consent appeared less critical if the providers conducting the physical examination were female.

> *"I brought my child here for malaria treatment. We were warmly received. After examination, we were given a test, and the child was found malaria positive. The case was severe; therefore, we were admitted. He was treated and within few days, and then they discharged him."* – Women FGD, Zamfara

Diagnostic testing

In Ebonyi, Kebbi, and Zamfara states, FGDs with community members presented a consistent understanding that laboratory testing is a standard component of the diagnostic process in health facilities. This perception applied to both preventive measures, such as ANC, and curative treatments like those for malaria. For example, in Kebbi, an FGD emphasized that women seeking ANC would not receive attention until they underwent a blood test. As the discussion described a standard procedure: "They would take a blood sample to find out the disease, and later give them medicine."

> *"You need to explain to the patient because some of them may not understand what you are using that blood for. They may think that you are collecting their blood for another thing… That's the reason why you will explain to him or her, this test, this blood I'm collecting I want to use it and do this to check this thing for you to know whether it is normal or abnormal."* – Men FGD, Ebonyi

Despite the consistent recognition of the importance of laboratory tests, across all three states, there appeared to be a substantial gap in the communication process between healthcare providers and their clients. FGD participants revealed that slightly more than half of the service providers reportedly did not explain the nature or purpose of the tests to their clients before collecting samples; however, in most cases, clients were informed of their test results once they became available. Although FGD participants agreed on the importance of the patient-provider communication process, the reactions toward the communication gap slightly varied across all three states. In Ebonyi, there was a call for greater transparency, with an FGD emphasizing that providers should explain the purpose of tests to dispel patients' misconceptions or fears. Similarly, discussions in Zamfara noted that while the specific tests might not be explained upfront, providers would reveal the test results and identified diagnosis upon the completion of the diagnostic process.

Prevention and treatment

In the states of Ebonyi, Kebbi, and Zamfara, FGDs with both men and women revealed a generally positive

experience among health service users when seeking prevention and treatment services, especially for malaria. In health facilities across these states, after receiving laboratory diagnoses, it was standard practice for health providers to promptly disclose test results. If treatment was required, the providers would subsequently provide prescriptions. In most cases, health providers reportedly took the time to communicate essential details about the prescribed drugs, including their purposes, benefits, recommended dosages, and administration guidelines. This comprehensive communication practice was widely valued by most service users, as it was believed to play an essential role in enhancing treatment adherence and potentially improving health outcomes.

Despite the general positive feedback on prevention and treatment services, there were some differences and unique aspects across the three states.

Ebonyi differed slightly in its approach to dispensing medications. While most providers generally prescribed and disclosed medication details to patients and caregivers, some reportedly withheld the name of specific prescribed drugs to prevent potential misuse or abuse though unauthorized over-the-counter purchases.

In Kebbi and Zamfara, the provision of free and subsidized drugs and medical services was emphasized as a key driver encouraging community members to seek prevention and treatment. In both states, reflections from men's and women's FGDs highlighted the warmth and efficiency of the care received, even in severe cases which required hospitalization, as well as the absence of financial burdens as factors that facilitated medical consultations. However, continuity of care appeared to be a priority in the two states. In situations where there were stockouts of medications, health providers reportedly still issued necessary prescriptions, enabling patients to purchase necessary drugs from external sources, like pharmacies or chemists, and therefore ensuring that patients received essential treatment they required.

Use of healthcare services: ANC

The use of ANC services in health facilities across Ebonyi, Kebbi, and Zamfara states has witnessed a significant improvement in recent years, as reported by FGDs with FMC and WDC members. This positive shift in ANC service use was reportedly the result of targeted interventions at both state- and national levels.

In all three states, consistent efforts in sensitization, awareness creation, and community dialogue, primarily driven by FMCs and WDCs, were cited as focal and reportedly contributed to incremental improvements in the ANC service uptake. For example, in Ebonyi and Kebbi, sensitizations reinforced the significance of ANC services for pregnant women, while in Zamfara, community dialogues led by WDCs specifically educated husbands on the importance of ANC, as they might prevent their wives to access the services.

Despite the gains, the three states also shared a persisting obstacle. The cost of services, including consumables, remained a substantial barrier, particularly for lower-income households. Additionally, transportation challenges, whether due to the distance to health facilities or associated transportation costs, were consistently cited as added obstacles.

> *"We have improvement in having women come for ANC. Initially, we got less, but now we even get tired of attending to them, the place of palpation, because we get them up to 40 to 60 [clients]. Sometimes, when we do palpation, we get 60+. But in the past, the only time we get palpation may be 20 to 25."* – FMC FGD, Kebbi

While there were shared strategies and challenges, each state presented unique characteristics. In Ebonyi, health facilities were reportedly proactive in enhancing client-provider interactions by replacing HFS who showed poor attitudes, therefore fostering a more welcoming healthcare environment. Kebbi's progress was credited to the provision of free drugs and medical services, a strategy that contributed to alleviating financial barriers to ANC

access. FMC and WDC representatives emphasized that the combination of the strategies that addressed both the demand generation and readiness to provide service, contributed to making ANC more accessible and desirable in the state. On the other hand, Zamfara, while also emphasizing community engagement, also deployed female health workers to administer ANC services. The state's introduction of commercial motorcycles to transport women to healthcare facilities has been an "innovative" and "practical" solution that further facilitated easier access to ANC services, particularly for those who live in hard-to-reach areas.

Additionally, individual states faced unique challenges. Kebbi was reported to struggle with the periodic absence of essential drugs and supplies due to stockouts, which discouraged women from using ANC services. Meanwhile, Zamfara had to navigate the additional challenge of security concerns, which posed a significant risk for women seeking healthcare services.

Use of healthcare services: Child healthcare

The use of child healthcare services in communities in Ebonyi, Kebbi, and Zamfara states illustrated a complex interplay of social norms, cultural influences, and gender roles, as evidenced by the FGDs with members of FMCs and WDCs.

There appeared several common threads across the three states. Like for use of ANC, persistent efforts in sensitization and awareness campaigns were reported to play a vital role in positive shift in attitudes and behaviors towards child healthcare, leading to increased participation in these services. Community members have noted that these positive trends were particularly accredited to the active involvement of FMCs and WDCs in continuous community education. Another common thread in these states was the significant role of both service availability and affordability as primary drivers influencing community members' decision to access child healthcare services, specifically malaria prevention and treatment. Free services coupled with the availability of essential drugs and commodities were cited as prime motivators for parents and caregivers. In addition, in all three states, both men and women were observably involved in accessing healthcare services for their children. For instance, while the gender difference in Ebonyi was marginal, with men being almost as likely as women to take their children to access healthcare services, women were predominantly the primary caregivers in both Kebbi and Zamfara, often taking the lead in seeking treatment for illnesses such as malaria.

> *"Some mothers like to buy medicines at medicine stores. But this time around, some people like to use health center first because of the teaching or information we people are giving them."* – WDC FGD, Ebonyi

> *"It won't be more than 3 out of 10 men that would bring their sick children to the hospital; the remaining 7 would be women. For the women, we usually educate them to make haste and rush to the hospital as soon as they see any sign or symptom of any illness."* – FMC FGD, Zamfara

Besides these similarities, there were distinct variations when it came to malaria prevention and treatment strategies in each state. In Ebonyi, malaria prevention services for children were less mentioned or accessed, with mothers typically being more proactive than fathers in seeking malaria treatment for their children. In Kebbi, the seasonal malaria chemoprevention (SMC) was cited as the predominant platform for child malaria prevention. Meanwhile, Zamfara observed a spike in the use of child malaria services during the distribution events of long-lasting insecticidal nets (LLINs) and SMC.

Use of healthcare services: FP

FGDs with FMC and WDC representatives unveiled complexities surrounding the use of FP services at health facilities

across the states of in Ebonyi, Kebbi, and Zamfara. Discussions with members of the two committees highlighted both commonalities and unique challenges in these three states.

In all three states, the uptake patterns of FP services were significantly influenced by sociodemographic factors. Specifically, elements such as education levels, the nature of residence (e.g., rural versus urban), and deeply rooted cultural and religious beliefs emerged as dominant influencers. Specifically, traditional and religious beliefs in Ebonyi and misconceptions in Kebbi and Zamfara that considered FP as "morally and religiously inappropriate" or "interfering with women's fertility" initially acted as outstanding barriers to the use of FP services. To tackle these challenges, all three states implemented WDC-led sensitization programs, which played a crucial role in enhancing FP acceptance and use. In Ebonyi, the efforts significantly boosted community acceptance, especially among men who became more involved in FP discussions and accompanied their partners to health facilities. Similarly, Kebbi's sensitization campaigns not only shifted the term "family planning" to "child spacing" but also highlighted the health benefits of well-spaced births. This has led to an improved acceptance of FP in the community. In Zamfara, sensitization efforts emphasizing male engagement have reportedly had a considerable impact, with men now commonly seen accompanying their partners to health facilities for FP services and an increase in FP acceptance even within traditionally conservative groups.

In addition to these commonalities, the three states also faced distinct challenges in FP service use. In Ebonyi, FGD participants noted that there were still pockets of resistance, primarily among those with lower levels of education or limited awareness. Contrary to progress in male acceptance of FP in Ebonyi and Zamfara, Kebbi reported that male involvement in child spacing practice remained minimal, with very few men accompanying their partners to health facilities for FP services. Additionally, male consent remained crucial, as most women often sought FP services only if their husbands or partners permitted or granted approval, which has also become an informal requirement by some health providers. Frequent stockouts of supplies and inability of some community members to afford FP services were cited as persisting barriers to the FP uptake in the state. Meanwhile, in Zamfara, the non-availability of preferred contraceptive methods like implants and the occurrence of undesirable side effects were flagged as ongoing barriers to the FP uptake in the state.

> *"They normally come here with their husbands… to access family planning."* – FMC FGD, Ebonyi
>
> *"FP has gained general acceptance in the community. In fact, when the FP commodities ran out of stock, often people come to the facility to request for guidance on where to buy the commodity. [They] also return to the facility for administration of the service."* – FMC FGD, Zamfara

Discussion

The table below presents key insights and discoveries that emerged from the analysis of FGDs with FMC and WDC members (men and women), as well as KIIs with OICs in Ebonyi, Kebbi, and Zamfara states:

Evaluation questions		Key takeaways
1. *Did malaria and other health and service delivery outcomes improve more from baseline to endline in LGAs/states where an integrated approach (IHP) was implemented, a disease-focused approach (PMI-S) was implemented, or a combination of the two?*		**All three states** • There was a perception of improved availability of Essential Drug Delivery Services (EDDS), although malaria drugs were the most widely available. • Drug shortages continued to be cited as a significant barrier to accessing care. **Ebonyi and Zamfara** • There have been noted shortages of SP.
		**All three states** • Community members reported being exposed to messages about malaria, ANC, and FP through similar communication channels. However, there were variations in the level of detail between messages received by men and women in communities. • The availability of FP services in outreach programs was limited. • There was a perceived improvement in the provision of respectful care. • There was a perceived improvement in the use of ANC services. **Ebonyi** • There was minimal mention of the use of child malaria prevention services.
2. *Did relevant commitment/ engagement and capacity outcomes improve more from baseline to endline in LGAs/states where an integrated approach (IHP) was implemented, a disease-focused approach (PMI-S) was implemented, or a combination of the two?*		*Limited information was available for this question.* **All three states** • The end of funding had resulted in cutbacks in outreach services, which suggests a lack of commitment to financially supporting these services. • During outreach activities, there was an increased commitment from healthcare providers, WDCs, FMCs, traditional birth attendants, and town announcers, which has contributed to sustaining the outreach strategy.

3. *Which implementation strategies are associated with improvements in service delivery, and system strengthening in different contexts?*		**All three states** • Ongoing sensitization on healthcare services was associated with improvements in service delivery across different contexts. • The availability of health insurance and free drugs and medical services was linked to improved access to healthcare services. • Availability of drugs contributed to effectiveness of service delivery of and improvement in access to healthcare. **Kebbi and Zamfara** • The implementation of SMC was reported to be significantly associated with improvements in the use of child malaria prevention services in communities. **Zamfara** • The distribution of LLINs was considered to be important for malaria prevention. • The deployment of female staff was seen as important for improving ANC and FP services.

For more information

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