March 2024

Nigeria HPN Multi-Activity Evaluation
FGD and KII Results: Ebonyi State

Introduction

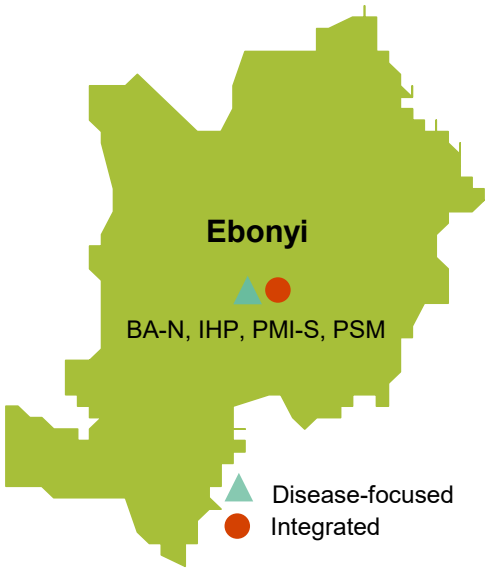
Data for Impact (D4I) is conducting a prospective mixed-methods portfolio evaluation of four USAID/Nigeria Health, Population, and Nutrition (HPN) Activities. The primary focus of this evaluation is to compare an integrated health programming approach with a disease-focused malaria approach. The evaluation 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 following evaluation questions and to provide context for the broader evaluation:

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**: The 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 women who were primary caregivers for children under five in communities. The research team tailored 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 healthcare providers in facilities. All these falls within the scope of interventions supported by USAID through the four Activities involved in the evaluation. The guides were informed by the result areas in the Activities' Monitoring, Evaluation, and Learning plans, the portfolio-level Theory of Change (TOC), and the broader evaluation questions.

Sampling and data collection

D4I conducted FGDs and KIIs in July and August 2022 in Ebonyi state.

D4I collaborated with HPN Activities to identify and approach potential participants. D4I selected an OIC of each of six site facilities for KIIs. In three of the six study facilities, D4I conducted FGDs with members of the FMC and WDC that corresponded to the selected sites. Additionally, D4I held FGDs with men and women. Table 1 summarizes the sampling.

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 Ibo. 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

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

Health planning, management, and coordination at the state level is an integral component for ensuring the effectiveness and efficency of health systems. Central to this coordination are the FMCs and WDCs. OICs, FMC and WDC members discussed the overall roles of FMCs and WDCs, their collaboration mechanisms, challenges, and support systems in place, with a particular focus on the DRF scheme.

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 chairmain. The committee 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 hand, WDCs, which play a 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. Like FMCs, WDCs also held both regular and ad-hoc meetings. Their funding primarily came from NGOs and contributions from membership dues.

FMC and WDC coordination and collaboration

Together, FMC and WDC 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 assist with or provide 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 outreach in markets and villages and home visits. There were reports of certain FMCs assigning individual members to mobilize specific numbers of people monthly for ANC and immunization.

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. The two committess coordinated efforts to mobilize people for these healthcare services and focus sensitization activities accordingly. Specifically, from the registers, FMCs disaggregated the 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 have missed ANC or immunization visits, WDC members, and sometimes FMC members, track these individuals and encourage 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 collaborate with FMCs to oversee the spending of funds from the BHCPF. Typically, the facility OIC and WDC chairmen usually serve as joint signatories. WDC members have been also reported to review and approve spending plans and verify.

Other joint collaborations

In addition to partnering on community mobilization, sensitization, and use of funds, WDCs and FMCs have been reported to collaborate in various other ways. Joint efforts between the two committees have led to initiatives, such as identifying land where medical facilities can build a pit for placenta disposal, and creating food banks for families with nutritional issues in Ebonyi.

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 fail to attend community sensitization activities due to lack of transportation or short notice.

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 were able to provide detailed insights into the operation of a DRF and enumerated their perspectives on observed or potential benefits, which include:

- 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 as a result 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.

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 for a lower cost 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 cease visting 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 managed supplies and monitored 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 were used.

Support from HPN Activities

In Ebonyi, both FMCs and WDCs were reported to receive significant support from HPN Activities, which encompassed various aspects such as community mobilization, specialized trainings for healthcare 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:

- Sensitizing the community on malaria testing, receiving proper medications from health facilities, and accepting test results;
- Mobilizing community members to attend health facilities;
- Providing training on various topics related to family planning (FP), MNCH, and malaria management;
- Assisting community members with enrollment in the BHCPF;
- Offering training related to data quality and reporting standards; and
- Supplying drugs and commodities.

WDC members indicated that with the support from HPN Activities, they had conducted sensitizations on vital health behaviors, including the importance of attending ANC during pregnancy, delivering at health facilities, taking sick children for medical care, sleeping under mosquito nets, maintaining clean surroundings free of standing water, and ensuring child immunization.

- The majority of FMC and WDC respondents stated that they encountered “no challenges” with the support provided by the HPN Activities. The only exception was one FMC FGD in Ebonyi Central, which reported occasional shortages of necessary malaria drugs, such as artemisinin-based combination therapy (ACT), to treat individuals who had been mobilized to attend the health facilities.

Demand generation for healthcare in community

An increased demand for quality health services is 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. In Ebonyi, outreaches and health messages were reported as common strategies generating demand for health services in community. KIIs with OICs and FGDs with men and women in communities highlighted these demand generation strategies, positive impact of as well as challenges affecting the implementation of these initiatives.

Outreach activities

The interviewed OICs confirmed that regular outreach activities were carried out typically every one to two months. The primary targets of these outreaches included communities with limited access to health facilities or difficulty accessing medical services. The outreaches encompassed a wide range of services including immunization, ANC, FP, health education, growth monitoring, food demonstration, nutrition, COVID-19 prevention, and treatment for

ailments like malaria. The activities are mainly conducted by OICs and other healthcare providers, and are 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, FMCs, and WDCs. Others noted that previous support from organizations such as World Health Organization (WHO), United Nation Children's Fund (UNICEF), USAID, and local health authorities has ceased. However, key informants reported that they had never received any support for conducting outreaches.

OICs discussed both successes and challenges of their outreach programs:

Successes	*Challenges*
▲ Improved access to immunization and FP services, reflecting in health registry records.	▼ Transportation difficulties to the outreach communities.
▲ Enhanced public awareness of the benefits of immunization.	▼ Shortage of staff to conduct the outreaches.
▲ Strong acceptance to and participation in the outreach within communities, even from neighboring villages.	▼ Inadequate funding for deploying additional personnel for the outreaches.
▲ Collaboration with the WDCs and town announcers has contributed to sustain the achieved successes.	▼ Withdrawal of support from some organizations, such as WHO, UNICEF, and LGAs, resulting in some services no longer being provided during outreaches.
▲ Increased commitment by healthcare providers and the FMCs has also contributed to sustaining the ongoing successes.	▼ Weather-related disruptions such as rainfall.

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. 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

Malaria messages

In Ebonyi, both men and women FGDs indicated that they have 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, churches, mosques. Some women also reported hearing or seeing the malaria messages from the National Youth Service Corps, village meetings, seminar, pamphlets, the 321 hotline, which were not mentioned by the men's group.

The content of the messages was consistent across both groups, focusing on ways of getting malaria, the need to sleep under mosquito nets, keep the environment clean, avoid self-medication, and conduct tests to confirm malaria before initiating treatment. There were differences in focus on malaria messages between men and women. Men focused more on general awareness and preventive measures, such as the notoriety of "malaria as a killer disease," the importance of "the environmental santiation," "using nets as a preventive mechanism to malaria," and "malaria treatment." Women were more concerned with malaria related to specific demographics of malaria like "danger of malaria to under-five children" and "malaria and pregnant women."

The participants in both groups found the messages about malaria "clear" and "understandable." The majority affirmed that they "liked the messages" and "understood the importance of prevention and treatment of malaria." (Table 2)

Both men and women FGD respondents identified malaria projects in their communities, including net distribution at healthcare facilities and community sensitization about malaria. The men FGD respondents mentioned specific community sensitization projects by BA-N and New Life International Family Church, which were not reported in the women FGDs.

Table 2. Reflections of men and women on health messages

Reflections	Malaria	FP	ANC
"I like the messages."	●		●
"The messages are easy to understand."	●	●	●
"The messages are helpful."	●	●	●

FP messages

Both men and women FGDs reported having encountered FP messages within their communities through various channels within the past six months, such as healthcare centers, radio, television, churches, and schools. Menalso reported sources for FP messages, including newspapers, friends, neighbors, village and market squares, house-to-house sensitization, and women's sensitization groups, not mentioned by women.

Reported messages primarily focused on child spacing, the choice of giving birth, the benefits of FP, and the importance of child spacing to women's health. While messages reported by both groups discussed the benefits of FP, messages reported by women specifically highlighted the need to give birth to the number of children one can care for, and that practicing FP would make women stronger and healthier. Messages reported by men, on the other hand, emphasized spousal communication before adoption of FP, and detailed information about various types of contraceptives.

Most participants from both groups reported they understood and liked the messages (Table 2). They did not find the messages confusing and appreciated their life-saving implications, as well as their role in the prevention of unwanted pregnancy and the improvement of family health. However, some women expressed that they "couldn't understood whether FP was good or not" and "were confused on the side effects of FP" although they heard about certain FP projects. This sentiment was not explicitly reflected in the men's group.

While men acknowledged witnessing FP projects related to community sensitization on the importance of FP and the

establishment of women's committees for FP mobilization, women did not report any such project. Both groups were unable to name any specific FP projects in their communities.

ANC messages

All participants of men's and women's FGDs acknowledged they had heard or seen messages on ANC within the past six months. While both groups identified sources of ANC messages like radio, hospitals, churches, neighbors and mothers, men also mentioned exposure to the messages through unique channels such as village heads and town criers, during wedding ceremonies, at the market square, and on the internet.

There was a significant overlap in the content of the ANC messages received by both groups, encompassing several aspects of pregnancy care such as the importance of regular ANC check-ups, the timing for starting ANC, benefits of ANC, dietary recommendations, and the importance of hospital delivery. Additionally, women reported receiving more specific information about 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.

Both groups expressed a favorable perception of the ANC messages, stating that they "understood" and "liked" them (Table 2). They reported that the messages "were not confusing," and they "found them helpful" in reducing pregnancy-related complications and mortality during delivery.

A majority of participants in both men's and women's FGDs claimed to have seen or heard about ANC projects within the past six months, though a minority in each group said they had never encountered such projects.

Impact of COVID-19 on demand for health services

The readiness of health facilities to provide services is considered an essential factor contributing to influence 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.

Health facility readiness to provide services

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Availability of essential health services

In-facility services

In Ebonyi State, essential health services are generally available at primary healthcare centers (PHCs), according to responses from OICs, FMC, WDC, and community members. These services encompass a broad range of healthcare needs, including treatment of minor illnesses, ANC and postnatal care, FP, labor and delivery, nutritional guidance for pregnant mothers, grow monitoring for children under five, and immunization. Referrals are offered for severe or complicated cases requiring more specialized care or surgical interventions. However, OIC key informants and FMC and WDC FGDs revealed that depending on the infrastructure and size of the facility, labor and delivery services for pregnant women are often unavailable, primarily due to lack of HFS to provide round-the-clock healthcare. This limitation is attributed to the reality that the HFS do not live near the health facilities.

Outreach services

Outreach health services were reported to play an important role in extending healthcare access to remote and hard-

to-reach areas. In Ebonyi, these outreaches, often collaborations between health facilities and WDCs, aimed to improve supply and coverage of essential health services to the catchment areas of each facility. OICs and FMC and WDC members indicated that the primary goals of the outreach efforts were to increase awareness about health issues, mobilize communities to use healthcare services, and directly provide certain essential services. The outreach programs in Ebonyi specifically were supported by organizations such as WHO, UNICEF, and IHP, and offered a range of services including immunization, ANC, and FP. Notably, respondents also emphasized that there were specific limitations when it comes to FP, as approval for the distribution of contraceptives was not always granted for outreach services.

Availability of EDDS

In Ebonyi State, health facilities have reported a "significant improvement" in availability of EDDS; an OIC in Ebonyi Central indicated, "We're not lacking any drugs now." The enhancement in resources has not only filled the shelves with medications and diagnostic tools but has also encouraged more community members to use local healthcare services because "[when] patients, clients, or villagers come to the health facility, they will be able to be served with the service they need. It makes them to come whenever they need it." (OIC, Ebonyi South)

The facilities now offer a wide range of EDDS, including malaria drugs and diagnostic tests, ANC supplies, FP commoditites, and other routine essential drugs for general care. Funding for the EDDS comes from a variety of sources including the state government, DRFs, capitation funds from the National Health Insurance, the Ebonyi State Health Insurance Scheme Agency (EBSHIA), as well as contribution from HPN activities such as PMI-S. Such financial sources have allowed facilities to bulk purchase essential items.

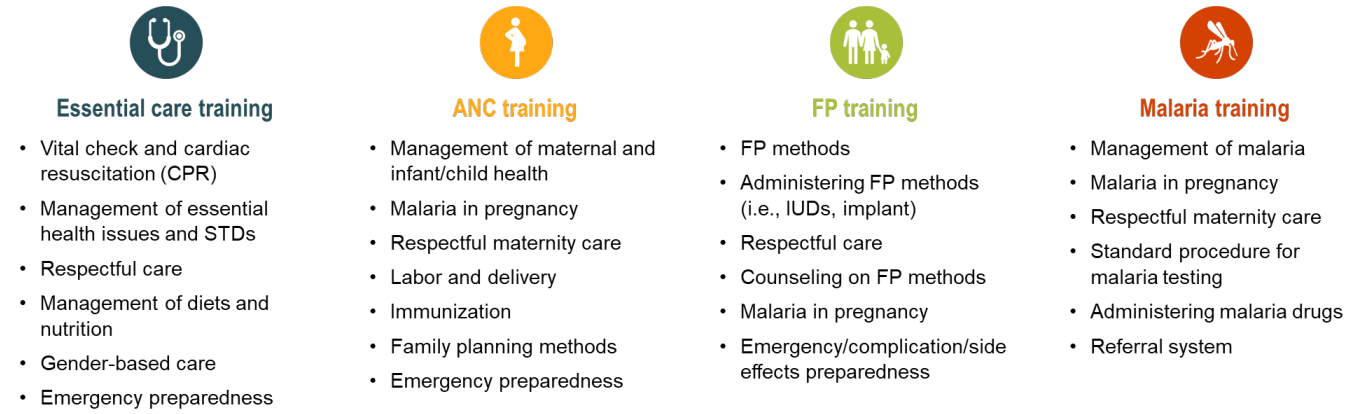
> *"Like Amoxicillin dispersible tablets for the treatment of a pneumonia, we had been buying just a little [when] we could… because there is no money… But since they have been helping us to give us money, we have been buying it in… boxes."* – OIC, Ebonyi Central

Despite these improvements, certain limitations persist. Government support is primarily limited to malaria drugs and FP supplies, and is available only to those enrolled in the EBSHIA insurance scheme. In addition, while there's been a surge in the volume of EDDS thanks to state support and other initiatives, some inconsistencies remain. In OIC KIIs and FGDs with men and women, respondents noted that while certain malaria drugs and supplies (e.g., malaria RDTs and Artemisinin-based Combination Therapies/ACTs) are usually readily available, other types of drugs are not consistently available. Medications like antibiotics (e.g., Amoxil and Ciprofloxacin) or Fansidar/SP (sulfadoxine/pyrimethamine), a drug used for preventing malaria in pregnant women, are often in short supply. A few men's and women's FGDs indicated that they sometimes "had to purchase these from the chemists." The interviewed OICs added that this situation is exacerbated when the health facilities experience a high influx of patients or when the government fails to adequately supply medications

Staffing at health facilities

In Ebonyi, the interviewed OICs emphasized the importance of health staffing in health facilities's readiness to deliver essential health services. They agreed that well-trained staff not only provide "effective diagnoses," "accurate treatment," and quality patient care, but also contribute to enhancing a patient's overall experience, ensuring "patients are treated with respect." There was a consensus among OICs that healthcare facilities have generally seen improvements in service delivery as results of various training programs on health service provision provided to staff. As an OIC in Ebonyi South indicated: "It has increased the patient flow of this health facility. [After] most of the trainings we [have] undergone, we put them into practice, thereby, sensitizing the communities of the new services

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



and the new things we do here."

Organizations, such as USAID-funded agencies, have been instrumental in training healthcare staff. The training programs focus 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 maternity care), and FP (e.g., administering FP methods, and preparedness for complications) (Figure 2).

Successes and challenges of health staff training

OICs discussed both the successes and ongoing challenges of health training programs for HFS:

Successes	*Challenges*
▲ ***Strengthening capacity**:* The training modules have proven successful in strengthening the capacity of HFS through diverse training content and the "stepdown training" approach, where skills and knowledge are cascaded down through the organizational hierarchy.	▼ ***Mismatch of content and needs***: There is the 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 have positively transformed the way HFS practice medicine, 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 has led to staff stress, leaving inadequate time for the practice and mastery of the new skills.
▲ ***Increased patient flow***: The "improved quality of care" has also contributed to "increasing the patients flow" seeking treatment at the facilities.	▼ ***Pandemic-related issues***: The COVID-19 pandemic has presented logistical challenges, particularly in having enough HFS available for training, given social distancing norms and other safety protocols.

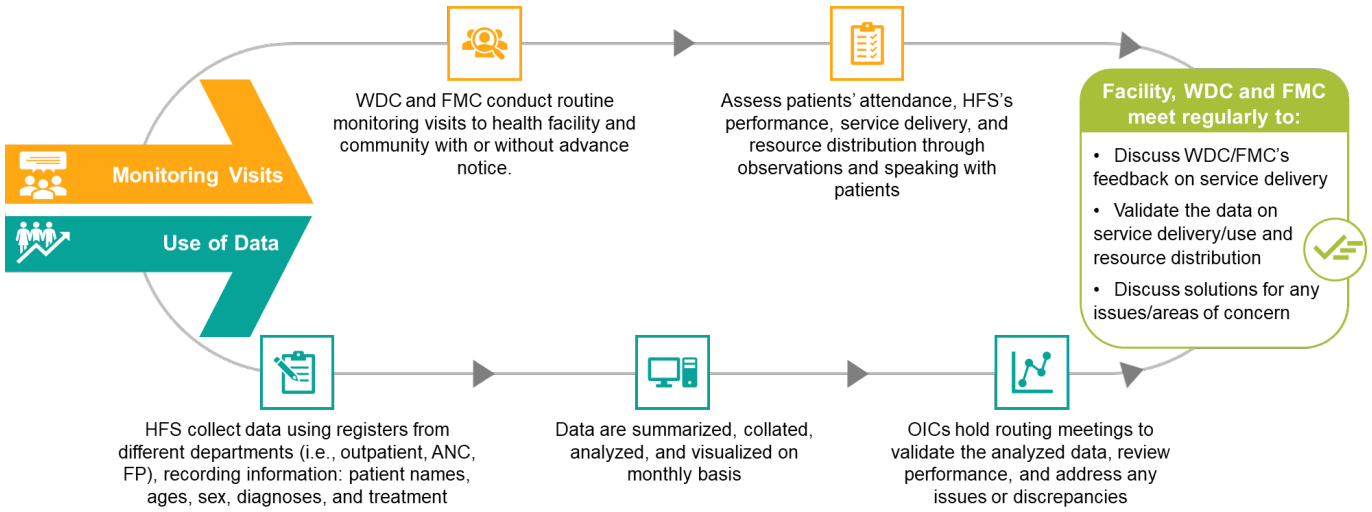
Monitoring health service performance

Monitoring health performance is essential to ensure quality care, patient safety, resource allocation, and accountability. KIIs with OICs and FGDs with WDC and FMC members in Ebonyi 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, the monitoring of health services performance is a collaborative and systematic effort involving various stakeholders such as HFS, FMCs, and WDCs. There are two core multi-layered approaches employed to ensure

Figure 3. Approaches implemented to monitor health service performance



effective monitoring of health service performance across various facilities. These involve using data to validate performance metrics and conducting monitoring visits to different units within health facilities (Figure 3).

All interviewed OICs confirmed that performance monitoring is an integral part of their facilities' routine operations. The HFS use a data-driven approach to assess and improve their services. They employ monitoring charts to track key indicators such as immunization rates, outpatient registrations, and trends in community access to health services. 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.

> *"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."* – WDC FGD, Ebonyi Central

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 engaged in regular monthly dialogues with OICs of health facilities to review performance metrics and updates. Beyond these meetings, they also conducted on-site supervision visits to facilities/clinics to evaluate the quality and efficacy of health service provision. These visits were comprehensive, involving observations, interactions with patients, and consultations with HFS/OICs. The collected real-time assessments are subsequently discussed with OICs to implement any needed changes.

Additionally, FMCs were particularly focused on the financial aspects of health service provision. With the primary objective of ensuring budgetary compliance and effective workplan implementation, they employed a multi-pronged strategy that included reviewing patient registers to assess the level of service use, conducting community visits to promote health service use, and holding routine meetings with facility OICs to validate the collected monitoring data. Like WDCs, FMC members also performed regular on-site visits to directly observe and assess the health services offered by the HFS. While these monitoring practices were generally considered beneficial for health service delivery, some HFS expressed discomfort with the close monitoring. FMC members acknowledged that their on-site visits sometimes make the HFS uneasy because they felt they were being monitored "so closely." However, FMC respondents maintained that such monitoring is essential to ensure that allocated budgets are properly spent and that the facilities adhere to their respective workplans.

Data use

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

> *"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

The interviewed OICs indicated that all facilities were engaged in data collection, validation, and use for monitoring and improving the quality of health services. Specifically, these facilities maintained various 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 are 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, identifying operational challenges, informing solutions to emerging issues, and guiding decisions on healthcare provision. The interpretation of this data enabled the facilities to determine whether there is an upward or downward trend in service usage as well as identify areas that require focused attention or improvement.

FMC and WDC members reportedly supplemented the data use efforts by conducting routine monitoring visits. WDC members, in particular, made weekly or monthly trips to health facilities to observe patient care firsthand and verify

the data collected by the health facilities. On the other hand, FMC members employed "monitoring charts" to "track trends" in service use, enabling them to work alongside health facilities to "identify any problems" and "make informed decisions." FMC FGDs also mentioned that monitoring data were often disaggregated by both age and sex to provide a detailed undersanding of healthcare access and outcomes for different demographic groups.

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

Successes	*Challenges*
▲ **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.	▼ **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.
▲ **Monthly summaries with disaggreated data**: Monthly reports that included data disaggregated by sex and age assisted in identifying service usage trends among different demographic groups. This helps health facilities identify issues, their root causes, and potential solutions, thereby enabling informed decision-making for future actions.	▼ **Documentation issues**: Problems with "inadequate/inproper documentation of information" contributed to incomplete or inaccurate records, creating discrepancies in the collected data.
▲ **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.	

Provider-client 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

KIIs with OICs revealed that there wa a consistent and well-understood perception of what 'respectful care' entailed in healthcare settings. 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." The interviewed OICs emphasized the "vital importance" for health providers to "show love and care to patients," such as welcoming patients with a smile, offering them a seat, and actively listening to their concerns. There was a consensus among OICs that respectful care fostered trust and appreciation between patients and providers, as well as promoted "accessibility" and ensured "well-being" and health outcomes of community members, regardless of their background or personal circumstances. "Disrespect" and "stigma" can have severely negative consequences on patients, particularly those are vulnerable.

> *"[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

Respectful care: Implementation strategies

In an effort to promote respectful care in health facilities, OICs indicated that health facilities have adopted various implementation strategies based on the unique needs and constraints of their respective clinics.

- **Staff training**: HFS received training in patient respect through official trainings, step-down trainings, 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.
  - Adopt individualized patient care approaches, including regularly checking-ins and health status inquiries, to ensure that all patients receive attention and care they need.
- **Prioritizing patient privacy and confidentiality**: Health facilities implement specific measures to ensure privacy for patients, especially for those with infectious diseases or mothers in labor, to maintain confidentiality and sustain their dignity.
- **Family support during births**: If requested by mother, husband or family members are allowed to be present during labor and delivery.

Respectful care: Successes and challenges

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

Successes	Challenges
▲ **Increased patient satisfaction and engagement**: Respectful care practices have significantly contributed to improving patient-doctor communication, "increasing patients' trust," and encouraging "patients to be more open about their concerns." These factors have led to better diagnosis and treatment and "improved patient satisfaction," encouraging more community members to "attend or seek health services."	▼ **Limited staffing**: Limited staffing and long working hours can lead to emotional burnout among HFS and affect their ability to deliver consistent respectful care, particularly during high-demand hours.
▲ **Greater inclusion**: "Vulnerable populations," such as people with disabilities, women, adolescents, and young adults, have particularly benefited from inclusive healthcare settings and programs where their unique needs are acknowledged and accommodated.	▼ **Limited funding and resources**: Limited funding and medical supplies can sometimes constrain the upgrading of facilities to ensure they are welcome and accessible, and therefore, impacting the implementation of respectful care.
▲ **Staff training and sensitization**: Continuous trainings and sensitization focusing on patient-centered approaches, including respectful care, have 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.	▼ **Training gaps**: "Inadequate training" and "limited availability of materials and equipment" for service delivery can impact 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.
▲ **Patient-friendly environment and infrastructure**: The adoption of respectful care practices has 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.	▼ **Low compensations for HFS**: Low wages and lack of "remuneration," "proper accommodation," and "welfare" provisions for HFS, especially qualified ones, can impede their commitment and ability to provide respectful care optimally.
▲ **Fostering personal connections**: Respectful care practices have accelerated "a sense of belonging" that encourages 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 have contributed to improving client-provider interactions.	▼ **Cultural barriers**: Social stigmas or cultural norms and beliefs can pose challenges to the successful implementation of respectful care practices, particularly for certain vulnerable groups like expecting mothers.

Interaction of providers with clients with disabilities

FGDs with FMC and WDC members suggested that in Ebonyi, HFS exhibit a high level of commitment to offering "respectful" and "compassionate" care to patients with disabilities. FGD respondents emphasized that the providers strived to accommodate their specific situations, make them feel comfortable, inclusive, accepted, and treat 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."

Furthermore, the interviewed OICs asserted that respectful care is not just a moral obligation but also essential for effective healthcare delivery. The key informants specified that their health facilities aim to create an inclusive environment that accommodates the unique needs of each patient when interacting with people with disabilities. For example, HFS use various communication mechanisms when dealing with patients who are deaf or blind. OICs also emphasized the importance of maintaining a respectful and non-judgmental attitude towards patients with contagious diseases or injuries, using personal protective equipment to ensure safety for both patients and providers. Additionally, being aware of the financial challenges that patients with disabilities may face, some facilities make efforts to assist these patients in obtaining free registration cards for medical check-ups, necessary medications, and personal care items.

FMC and WDC FGDs also noted that HFS engage in a compassionate treatment approach that attends not just to the physical, but also the emotional well-being of the patients. The approach has resulted in these facilities becoming preferred healthcare destinations for patients with disabilities, even when other options might be geographically closer. One example of the considerate care is the attentive behavior of HFS, who may prioritize a pregnant patient with mobility issues to minimize her discomfort and waiting time.

Interaction of providers with adolescents and youths

In Ebonyi, FGDs with FMCs and WDCs, and KIIs with OICs suggested that HFS appear to be making conscious efforts to address the unique needs of different patient groups, including adolescents and youth. Specifically, health providers' interactions with adolescents and youth are shaped by efforts to understand the unique needs and challenges this age group presents. Although there is no reported complaints about differential treatment, some OICs noted that adolescents and youth may require a different style of interaction compared to older adults. Adolescents and youth are often perceived as being more "impulsive" or "hot-tempered" and therefore may require interactions that are both sensitive and tailored to their emotional and physical state.

This approach is commonly extended to sensitive topics like FP, where health providers aim to be "cautious" and "considerate" when discussing FP options with adolescents and youth, taking into account their age, marital status, and specific circumstances. For example, pregnant young adults typically receive tailored guidance to prepare them for their first delivery. On the other hand, discussions around FP with adolescents may incorprate educational elements such as the importance of safe sex and condom use. Providers may also advise these young patients about the health risks associated with early childbirth, benefits of FP, and encourage them to delay getting married or having children until they are more mature. One FMC FGD in Ebonyi South emphasized: "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."

In addition to addressing unique needs based on age, the FGDs and KIIs emphasized the politeness, humility, and the

importance of privacy in client-provider interactions. Participants agreed on the importance of of ensuring equal treatment without discrimination based on age, gender, or marital status.

Interaction of providers with men and women

According to FGDs with FMC and WDC members and KIIs with OICs, it appears that there is "no significant differences" in the way men and women are treated in health facilities in Ebonyi. Men and women are welcomed in similar manners, and generally offered the same level of attention and medical care during their interactions with health service providers. Interview respondents indicated that the overarching aim is to make healthcare accessible and non-discriminatory for all patients, regardless of their gender and cultural background.

However, FGDs and KIIs revealed certain nuances that emerged in specific situations within the overall patient-provider strategy. Specifically, couples attending the clinic together may receive some forms of preferential treatment, particularly during services like immunizations. FMCs and WDCs emphasized that this practice is not discrimination but is 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.

Similarly, the preferential attention was reported to extend to FP services, where providers find it easier to offer the consultations and procedure when both spouses are present and consent. This practice aims 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.

"Whenever you come to access medical care here, they do attend to you instantly, more than some hospitals in the city. They do take care of everyone. They do educate us on how to keep our surrounding clear to avoid sickness and other ailments. I must confess that they are doing well because they have done that to me and equally my wards whenever we come to access medical care here." – Men FGD, Ebonyi South

"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

Interview participants also highlighted the practice of separating men and women during examinations to ensure comfort and privacy, allowing patients to openly and freely communicate about health concerns. As one FMC FGD in Ebonyi Central noted: "The ward of the woman is different from the ward of the man. You cannot treat them at the same place because if you bring a woman and a man here, both of them will not be comfortable to reveal the secret around themselves. That's the way we normally treat them. We are not treating them at the same room."

However, when husbands and wives attend together, the couples are usually counseled together. OICs explained that the gender separation aims to maintain the comfort and privacy of individual patients while the joint counseling focuses on facilitating better understanding and cooperation between spouses, particularly in health scenarios where the treatment of one may impact the other.

Through FGDs, both men and women in the community reflected on their interactions with healthcare providers, highlighting the nuances in their experiences. Generally, FGD participants 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. Furthermore, women ages 14–24

predominantly emphasized the importance of attentive and respectful care over the formality of providers introducing themselves, with many prioritizing immediate treatment. They reported positive experiences where their needs were met promptly and with care. Women ages 25–49 had mixed feelings about introductions, but unanimously agreed on the critical nature of attentive listening for accurate diagnosis and care. They emphasized the providers' role as not just treatment but also as a source of support and trust. On the other hand, men underscored the significance of attentive listening and cited largely positive interactions with local HFS who prioritize patient concerns. While there were mixed opinions about the need for providers to share their names, the overall sentiment among men was that the quality of care and a mutual respect between the community members and HFS hold more weight than formalities of introduction.

> *"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… big money here."* – WDC FGD, Ebonyi North

In addition, privacy during cinical consultations also emerged as a crucial factor for ensuring effective client-provider interactions. In Ebonyi, while most community members affirmed that privacy is generally well-maintained, some argued that the practice is only applicable for certain types of illnesses.

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 Ebonyi State communities.

Healthcare costs

FGDs with men and women, FMC, and WDC members in Ebonyi revealed complexities surrounding healthcare costs in local facilities. Drawing from their personal experiences and observations, respondents highlighted that community members typically needed to pay for expenses related to registration cards, immunization, ANC, consultations, diagnosis tests, treatments, and medications when seeking healthcare services at local health clinics. These expenses varied widely depending on the medical condition being treated and the patient's individual status. For example, costs associated with services like pregnancy tests or FP counseling typically range from ₦200–₦500. Also, certain groups like pregnant women, the elderly, and individuals with physical disabilities might be eligible for fee waivers for specific services, such as testing and treatment for malaria. However, the cost structure appeared to be inconsistent, especially for pregnant women who might face varying fees depending on service or drugs needed. Some community members noted that pregnant women paid more for their registration cards, while others said they paid more for routine drugs.

Affordability of healthcare services

Although the provision of BHCPFs has been reported beneficial in providing free medical services to some groups of community members in Ebonyi (e.g., patients with malaria), healthcare costs were reported to remain a significant challenge for many, potentially limiting their access to essential healthcare services.

FGDs with men, women, FMCs, and WDCs affirmed that the healthcare affordability appears to be complex in the

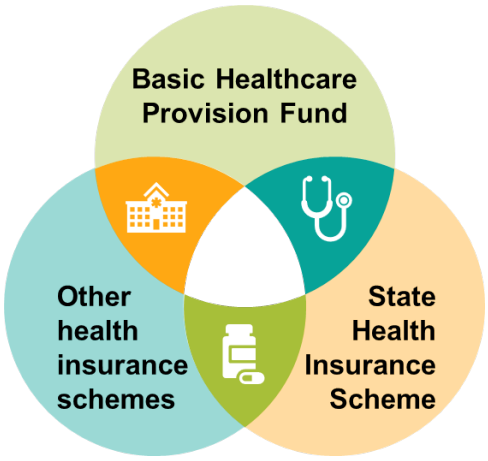
state, and the issue is further complicated by high levels of poverty, particularly in rural communities. The respondents indicated that the affordability of healthcare costs varied, influenced by factors such as type of ailment, specific medications, and individual financial capacity. Specifically, certain treatments like malaria testing and medication were generally affordable or even free for those who have registered at facilities; however, other medical expenses such as consultations, diagnosis tests, drugs for non-malaria ailments, ANC, specialized treatments, and surgeries can pose significant financial barriers, affecting especially those with limited financial resources. Additionally, the costs of patient's registration cards and transportation were also noted as financial challenges, particularly for those living rural communities or far from the facilities. 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.

Regarding the level of concern, while men and women in the community expressed a degree of optimism about managing the healthcare costs, FMC and WDC members were more candid about the financial barriers that existed and the efforts to mitigate them. Both groups discussed community-based solutions to address the issue of affordability, including informal credit systems, community donations or funds for purchasing medications, or fee waivers for check-ups offered by healthcare workers.

Health insurance: Awareness, successes, and challenges

FMC and WDC representatives reported that community members are generally aware of the existence of health insurance schemes, with the BHCPH and the State Health Insurance Scheme being the most popularly known (Figure 4). As one WDC FGD in Ebonyi Central indicated: "When Basic Healthcare Provision Fund came, the publicity was wide. And everyone knew about it. In fact, they met me [and said that] they want to access it."

Figure 4. Most familiar health insurance schemes in the community



The awareness mostly stems from the distribution of health registration cards and free drugs and medical services offered during the outreach programs towards vulnerable groups like the poor and children under five.

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:

Successes	*Challenges*
▲ **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.	▼ **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.
▲ **Enrollment growth**: Enrollment in the BHCPF is	▼ **Information gap**: There is a lack of in-depth

increasing as more community members become aware of the benefits of the schemes.	knowledge about the enrollment procedures and specific benefits of the insurance schemes.
	▼ **Operational setbacks**: Challenges like shortage of enrollment forms, lack of guidance on the registration protocols, and delays in fund disbursement hampered the successful implementation of these schemes.
	▼ **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.

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 State. The discussions focused on key aspects of service quality (Figure 5).

Waiting time

Men's and women's FGDs revealed that waiting time for check-ups in health facilities generally appeared to be acceptable for local service users, reported to be 30 minutes or less on average. The length of the wait often depended on the particular circumstances at the health facility, such as nature of the services being attended to and the time of the day. A participant from one women's FGD in Ebonyi reflected: "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."

Figure 5. Key metrics for quality of health service

However, a few FGD participants indicated that they had to wait for more than one hour. This longer wait was caused by a lack of available doctors and issues with the punctuality of attending service providers.

Facility condition

The community members largely agreed on the importance of cleanliness in health facilities, both as a factor to encourage healthcare visits and as a preventive measure against disease. Despite efforts to maintain clean environments, the perception varied among FGD participants. A significant number of respondents thought the facilities to be clean while about a third

> *"In reference to our health facilities here, a health facility should always be clean, it should always be clean but our problem here is that we don't have cleaner who … take[s] care of this health facility to make sure that it is neat."* – Men FGD, Ebonyi North

felt that only certain areas, like the ANC clinic and labor ward, met the cleanliness standards. The primary reasons cited for the inconsistent sanitation were staffing shortages and lack of proper supervision.

Examination consent

Discussions with men and women revealed that the concept of obtaining patient consent before conducting a physical examination is not commonly practiced among healthcare providers nor particularly valued by most health service users. Although the FGD participants were aware that a physical examination is a standard procedure of the clinical consultation, only a small number reported that providers actively seek their consent before conducting such examinations. Moreover, most beneficiaries themselves did not place significant importance or appreciation on obtaining such consent, but emphasized their focus more on the final diagnosis.

In Ebonyi State, healthcare providers were more likely to seek consent from patients they perceived as educated or enlightened. As one service user indicated: “Not all of them cannot understand. Some of them are… illiterates so you need to explain to the person. The one that don’t understand she [the provider] will ignore.”

Diagnostic testing

In FGDs in Ebonyi, community members presented a consistent understanding that laboratory testing is a standard component of the diagnostic process in health facilities. This applies to both preventive measures (e.g., ANC) and curative treatments (e.g., malaria). However, there appeared to be a notable gap in the communication process between healthcare providers and their clients. FGD participants revealed that slightly more than half of the service providers did not explain the nature or purpose of the tests to their clients before collecting samples; however, most generally did disclose the test results once they are available. As one community member FGD reflected: “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.”

Prevention and treatment

FGDs with men and women suggested that health service users have generally positive experiences when it comes to receiving prevention and treatment services, particularly in the context of malaria. As one Ebonyi caregiver reflected: “I like this clinic because, the way they appreciate patients is nice and the way they attend to them.”

After a laboratory diagnosis, it’s common practice for health providers to disclose the test results and if required, follow up with a prescription for treatment. In most instances, the providers reportedly communicated the purposes, benefits, recommended dosage, and administration of the prescribed drug to patients or caregivers. While most service users valued these explainations for enhancing treatment adherence and potentially improving outcomes, an exception was noted in Ebonyi. 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.

Use of health services: ANC

The use of ANC services in health facilities across communities in Ebonyi state has seen a significant improvement in recent years, according to FGDs with FMC and WDC members. Targeted interventions at both state- and national levels have been reportedly instrumental in driving this positive trend.

In Ebonyi, consistent sensitization efforts by the FMCs and WDCs have played a crucial role in encouraging pregnant

women to access and use ANC services. Additional, FGD participants revealed that health facilities have facilitated staff replacements to improve client-provider interactions. As a result, HFS who exhibit poor attitudes toward clients have been replaced, contributing to promoting a more welcoming healthcare environment.

> *"The awareness has been created, so many are coming [to ANC] now. Before, many do seek attentions of some TBA. But today because of what they've seen and regularly reminded, they are responding everyday… So, we are winning."* – FMC FGD, Ebonyi.

Despite these gains, several challenges persist. In Ebonyi, the cost of services, including consumables, remained a substantial barrier, particularly impacting lower-income households. Additionally, the distance to health facilities and the associated transportation costs created further obstacles.

Use of health services: Child healthcare

The use of child healthcare services in communities in Ebonyi State reflects a complex interplay of social norms, culture, and gender roles, according to FGDs with members of FMCs and WDCs.

The ongoing efforts in sensitization and awareness creation appeared to have made positive impacts. The interventions have been effective in changing behavior and attitudes towards child healthcare, encouraging a wider portion of thecommunity to engage in these services. Reflections from community members highlighted the active role of FMCs and WDCs in continuous community education, which seemed to be contributing to this positive trend.

> *"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

Both men and women participated in taking their children to access healthcare services. While women were generally more inclined to seek child healthcare, in Ebonyi, the gender disparity in taking children for healthcare is marginal, suggesting that men are almost as likely as women to engage in accessing child healthcare services.

Also, like with other healthcare services, both availability and affordability appeared to be key drivers for community members to access child healthcare services, including malaria prevention and treatment. Specifically, free services and availability of necessary drugs and commodities were cited as primary motivation factors.

When it comes to malaria prevention specifically, malaria prevention services for children were rarely mentioned or used in Ebonyi. FGDs suggested that mothers were generally more proactive than fathers in seeking malaria treatment for their children.

Use of health services: FP

In Ebonyi, FGDs with FMC and WDC members revealed complexities surrounding the use of FP services. Respondents indicated that the use of FP services were largely influenced by sociodemographic factors such as education level, rural or urban residence, and cultural and religious beliefs.

Prior to the launch of sensitization programs led by WDCs, uptake of FP services in Ebonyi was considerably lower. Traditional and religious beliefs served as barriers to service usage, as FP was viewed as morally and religiously inappropriate. However, the sensitization efforts have contributed

> *"They normally come here with their husbands… to access family planning."* – FMC FGD, Ebonyi

to significantly improving the acceptance and use of FP methods within the community. These efforts also facilitated more engagement from men, who actively participated in FP discussions and were more willing to accompany their partners to health facilities for FP services.

Nonetheless, challenges still existed. FGD participants noted that there were still pockets of resistance, primarily among those with lower levels of education or limited awareness.

Discussion

The table below presents key insights from the analysis of FGDs with FMC and WDC members, men and women, as well as KIIs with OICs in Ebonyi State, mapped to the relevant evaluation questions:

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?*		• 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. • There have been noted shortages of SP.
		• 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 is limited. • There is a perceived improvement in the provision of respectful care. • There is a perceived improvement in the use of ANC services. • There is 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?		• This question is addressed in the "Nigeria HPN Multi-Activity Evaluation – FGD and KII Results: Ebonyi, Kebbi, and Zamfara states" brief that compares state-level results.

3. *Which implementation strategies are associated with improvements in service delivery, and system strengthening in different contexts?*		• Ongoing sensitization on healthcare services is associated with improvements in service delivery across different contexts. • The availability of health insurance and free drugs and medical services is linked to improved access to healthcare services. • Availability of drugs contributed to effectiveness of service delivery of and improvement in access to healthcare.

For more information

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