March 2024

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

Introduction

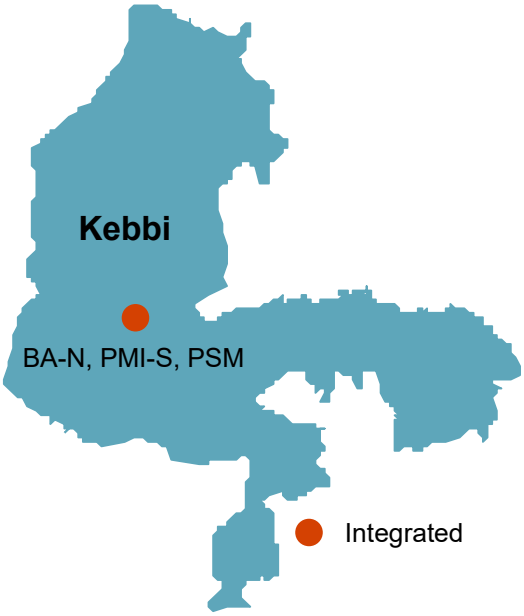
Data for Impact (D4I) is conducting a prospective mixed-methods portfolio evaluation of four USAID/Nigeria Health, Population, and Nutrition (HPN) Activities. The primary focus of this evaluation is to compare an integrated health programming approach with a disease-focused malaria approach. The evaluation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

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 Kebbi 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 Hausa. 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	Kebbi
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 efficiency 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 chairman. 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 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). Participants noted that men outnumbered women as members of WDCs. Like FMCs, WDCs also held both regular and ad-hoc meetings. Their funding primarily came from NGOs and contributions from "well-to-do" community members, and soliciting donations from store owners (e.g., for drugs or construction supplies), or other non-government funded 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 the 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 and villages and home visits. WDC FGDs reported that 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 an increase in malaria. The two committees coordinated efforts to mobilize people for these healthcare services and focus sensitization activities accordingly. Specifically, from the health facility 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 indicated that community members have missed ANC or immunization visits, WDC members, and sometimes FMC members, reportedly 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 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. Some WDCs in the state have taken further measures by visiting health facilities to confirm the presence of drugs and exploring chemists and marketplaces to identify where drugs can 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 have been reported to collaborate in various other ways. Joint efforts between the two committees have led to initiatives, such as raising funds for ice blocks and generator fuel to maintain cool temperatures for certain medicines in Kebbi.

Challenges

Most FMC and WDC FGD respondents expressed positively about their collaboration and joint achievements, indicating minimal challenges in working together. However, some specific issues were noted. In a discussion in Kebbi, participants observed that WDCs might misinform community members by stating that drugs are free, but this only applies to those registered with KECHEMA.

Drug Revolving Fund (DRF) scheme

In a DRF, government, donors or communities 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 Kebbi 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 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.

Most FMC and WDC respondents in Kebbi reported encountering no issues with their DRFs. Similarly, OICs described a generally favorable experience with 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 played 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.

Support from HPN Activities

In Kebbi, both FMCs and WDCs were reported to have received significant support from HPN Activities, which encompassed various aspects such as community mobilization, specialized trainings for healthcare workers, and the supply of necessary drugs and commodities.

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

- Mobilizing community members to attend health facilities through various means such as community meetings, home visits, and the "Albishirin Ku" (Glad Tidings) social behavior communication (SBC) messaging campaign that focused on RMNCH+MN
- Training health workers on ANC and administering Sulfadoxine-Pyrimethamine (SP), treatment of malaria (including proper response to malaria testing results and identifying other potential causes of fever), family planning (FP), childhood illnesses, managing postpartum hemorrhage, new labor and delivery techniques, and immunizations
- Engaging in seasonal malaria chemoprevention campaign
- Providing training related to data quality and reporting standards
- Supplying essential drugs and commodities

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

- Assisting with maintenance of health facilities
- Sensitizing community members on gender issues and the importance of exclusive breastfeeding
- Providing necessary drugs and commodities.

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 Kebbi, outreaches and health messages were reported as common strategies of 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 health facilities in Kebbi State have implemented various outreach strategies to increase awareness and provide essential health services in the communities. The healthcare providers conducted these outreach programs in collaboration with WDCs, with the support from the State Primary Health Care Development Agency (SPHCDA), BA-N, and IHP. Additionally, community leaders, traditional birth attendants, and local people were reportedly informed in advance, fostering a sense of collaboration and community engagement.

The outreaches offered a broad range of services, such as ANC, FP, childhood diseases, hygiene practices, nutrition, immunization, and community sensitization on general health issues (e.g., malaria control, breastfeeding practice,

and COVID-19). Decisions on the focus areas for the outreaches were often based on the specific needs of the community, allowing for targeted interventions. Town announcers, posters, and songs played a crucial role in publicizing these outreach events and disseminating health messages.

OICs discussed both successes and challenges of their outreach programs:

Successes	*Challenges*
▲ Improved awareness about immunization and better vaccine coverage for childhood diseases like measles, yellow fever, TB, and whooping cough.	▼ Limited or absent supplies of specific nutritional supplements, like peanuts, during the outreach sessions have contributed to a decrease in hospital attendance among mothers.
▲ Increased ANC attendance, use of FP services, personal hygiene practices, and environmental sanitation.	▼ Non-acceptance of HIV tests among many women during the outreaches.
▲ 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.

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

Malaria messages

In Kebbi, both men's and women's 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, such as radio, television, newspapers, churches, hospital/healthcare facilities, and healthcare providers. Additionally, the men FGDs reported a broader range of channels for receiving malaria messages, including bullhorn-mounted vehicles, mosques, signboards, social media, neighbors, friends, and WDCs.

The information received by both men and women revolved around "danger of malaria," general "signs and symptoms of malaria," and preventive measures against malaria, including the need to "maintain personal hygiene," "keep the environment clean," and "sleep under mosquito nets."

Both groups expressed satisfaction with the malaria message as they were "clear," "understandable," and "helpful" to them. Some men's FGD respondents also specifically mentioned that they reserved time to listen to the messages and noticed positive impacts of the information (Table 2).

The men's FGD respondents specifically identified projects they had heard or seen, focusing mainly on the distribution of free malaria drugs and the subsequent perceived reduction in malaria cases, an aspect not covered by the women FGDs.

FP messages

Both men's and women's FGDs reported having encountered FP messages within their communities through various channels within the past six months. While there were common channels (e.g., radio, television, health facilities, and health providers), women also received messages on mobile phones and during special ceremonies (e.g., naming ceremonies), whereas men cited sources like neighbors, friends, workplaces, gatherings, and *Albishirin Ku!*, which is a new short-form Hausa radio drama program on maternal and child health.

The content of the FP messages varied slightly between the groups. 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.

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."	●	●	●

Reflections on the FP messages from both men's and women's FGDs were mostly positive (Table 3). Respondents expressed that they "liked" and "understood" the messages, and "found the messages educating." They acknowledged that because of the messages, they themselves and other community members have become more "enlightened" about and accepting of FP, resulting in a perceived improvement in FP service use.

While men FGDs acknowledged witnessing an outreach program where women visited houses to sensitize others about FP and distributed free FP commodities, women FGDs did not report any such specific program.

ANC messages

All participants of men's and women's FGDs acknowledged they have heard or seen messages about ANC within the past six months. Both groups identified radio, television, and healthcare centers as sources of ANC messages. While women listed more diverse channels through which they witnessed the messages, including mobile phones, and drama *Albishirin Ku!* on the radio, neighbors, relations, bullhorns-mounted motor vehicles, newspapers, and mosques, men's sources of ANC information were more limited to health facilities, radio, television, and outreaches.

While messages for men mainly focused on the need for pregnant women to go for ANC, women were reported to receive more comprehensive information about ANC, covering various aspects of ANC like period of start of ANC visits, availability of free ANC drugs, dangers of not attending ANC, different ways of pregnancy care, and protection against malaria.

The reflections on ANC messages from both groups were overwhelmingly positive, with both men and women stating that they "understood" and "enjoyed these messages because they were very effective and helpful" (Table 3). The respondents also agreed that: "We try to practice what we learned from the messages," and "there is a great turnout on the issue of ANC," which have been reflected on the increased awareness and use of ANC services.

Both men's and women's groups identified different projects related to ANC. Men's FGD respondents highlighted specific projects like IHP, BA-N, meetings on ANC in hospitals, and gift presentations to women attending ANC. Women respondents mentioned specific 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.

Impact of COVID-19 on demand for health services

Most interviewed OICs highlighted that in the initial stages of the COVID-19 pandemic, patients' demand and use of healthcare services at the facility were negatively affected. Many individuals, fearing contraction of the virus, refrained from visiting health facilities. However, with the intervention of the WDCs, which worked to dispel these fears, normalcy has since been restored, and community members have resumed using healthcare services.

Health facility readiness to provide 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.

Availability of essential health services

In-facility services

In Kebbi 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, growth monitoring for children under five, and immunization. Referrals are offered for severe or complicated cases requiring more specialized care or surgical interventions. A unique feature in Kebbi is that these essential services are delivered through specialized units within the same facility, even if the services are administered by the same set of HFS. Moreover, unlike some other states, Kebbi's facilities were said to be routinely offering childbirth services as well.

Outreach services

Outreach health services were reported to play an important role in extending healthcare access to remote and hard-to-reach areas. In Kebbi, 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. FGD and KII respondents 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 (e.g., immunization, ANC, and FP). However, unlike in some other states, funding from multilateral organizations for the outreaches in Kebbi was reported to be minimal, resulting in a limited scope of services like FP. OICs and FMC and WDC members emphasized that the outreaches were strategically focused on areas with identified service gaps. While primarily healthcare-focused, the programs also addressed broader community development issues that were relevant to public health, such as promoting good hygiene practices, and encouraging the use of toilets to eliminate open

defecation.

Availability of EDDS

In Kebbi, health facilities have reported "a lot of positive changes" and "significant improvement" in availability of EDDS, as an OIC in Kebbi Central indicated: "We were able to get some test equipment we never had before. The drugs we didn't purchase, we now purchase them. Whoever feels sick will come, he will be tested, and will be given drugs free of charge. We actually have progressed." OICs revealed that the enhancement in resources has not only filled the shelves with medications and diagnostic tools but has also resulted in higher quality services, and encouraged more community members to use local healthcare services, contributing to "improving health and nutrition" among community members. 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. In line with this, one OIC from Kebbi South noted: "Truly, people now come to the hospital far more than we expected/thought."

The facilities now offer a wide range of EDDS, including vaccines for measles and pneumococcal diseases, malaria drugs and diagnostic tests (e.g., RDTs), ANC supplies, FP commodities, other routine essential drugs for general care, as well as more advanced diagnostic tools like microscopes and hearing-test machines. Funding for the EDDS comes from a variety of sources including the state government, DRFs, community-raised funds, and contribution from HPN activities such as GHSC-PSM.

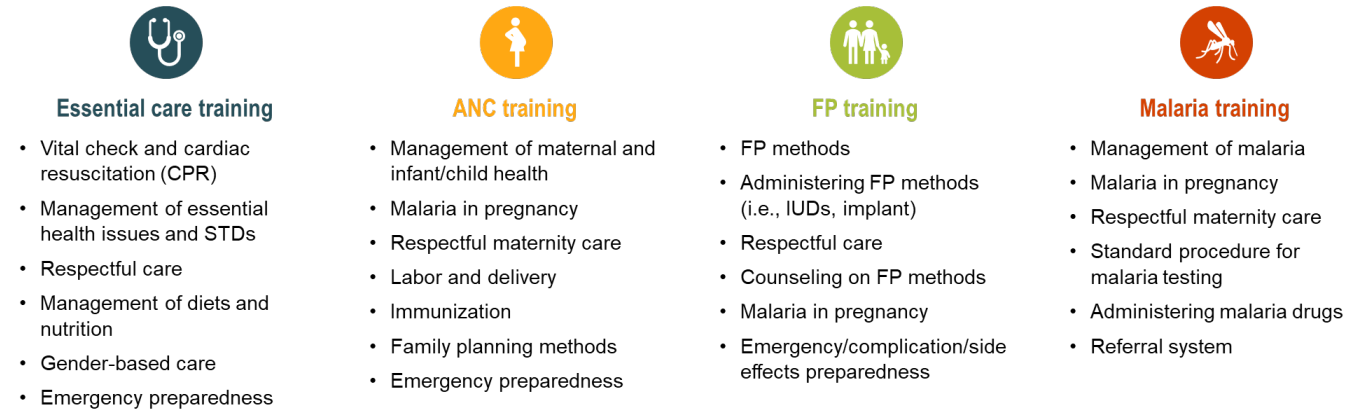
Although both men's and women's FGDs affirmed the availability of diagnostic tests for common diseases like malaria and typhoid, they noted that the availability of certain drugs, such as antibiotics, could sometimes be inconsistent due to either high demand or delays in restocking. Additionally, some OICs reported that there was an insufficient supply of Fansidar/SP (sulfadoxine/pyrimethamine) for pregnant women, a malaria medication crucial for ANC. An OIC in Kebbi Central reported: "SP for pregnant women is not enough for two months. It is the only drug that is not sufficient. We have to buy."

Staffing at health facilities

The OICs interviewed in Kebbi emphasized the importance of staffing in health facilities' 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 improvement in service delivery as results of various training programs on health service provision provided to staff. As an OIC in Kebbi South indicated: "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."

Organizations, such as USAID-funded implementing partners, have been instrumental in providing training to healthcare staff. The training programs focus on several critical areas, from essential care (e.g., vital checks, gender-sensitive 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, preparedness for complications) (Figure 2).

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



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 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 have 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 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 presented logistical challenges, particularly in having enough HFS available for training, given social distancing norms and other safety protocols.

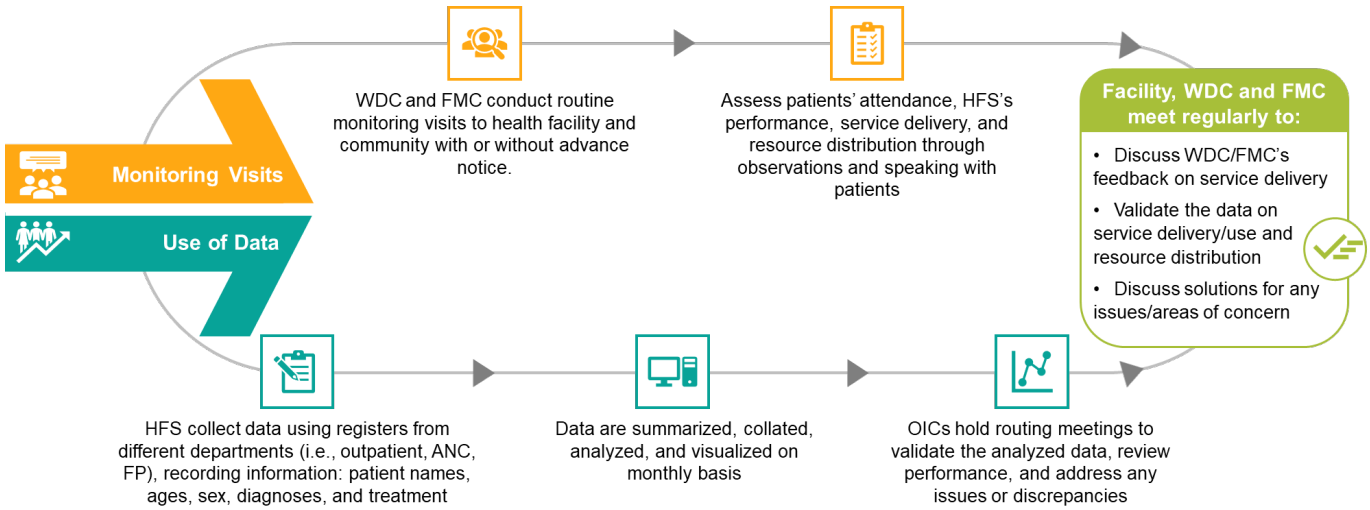
Monitoring health service performance

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 Kebbi 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 Kebbi, 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 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).

Figure 3. Approaches implemented to monitor health service performance



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 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. As one OIC in Kebbi Central articulated: "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."

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 contributed to the monitoring efforts by conducting on-site supervision visits to facilities for direct assessment and providing needed support, such as distribution of malaria drugs and mosquito nets. During their supervision visits, WDC members collected real-time assessments of the quality and efficacy of health service provision through observations, interactions with patients, and consultations with HFS/OICs. Then they discussed their findings with OICs during monthly performance review meetings to implement any needed changes.

Further reinforcing the monitoring activities was the active involvement of FMCs. The committees not only conducted routine facility visits to observe day-to-day operations but also engaged in community outreach programs to facilitate uptake of health service and follow up with patients for return

> *"We monitor every health care activity and ensure that problems encountered are mitigated. Let's say a patient comes for treatment, and we don't have drugs in stock. We would ensure that we restock the drugs immediately in order not to disappoint the patient as patients are most likely to be discouraged when they come and there are no drugs to treat them."* – FMC FGD, Kebbi Central

visits. Particularly, they also reviewed weekly data reports and worked closely with OICs to validate monitoring data, ensuring that any anomalies or challenges were immediately addressed.

Beyond data use and supervision visits, OICs noted that departments within each health facility regularly engaged in performance monitoring. Specifically, each department had a designated head/manager responsible for ensuring the quality and efficacy of healthcare delivery within their unit. This included overseeing of nursing care, patient engagement to diagnostic procedures, adherence to medical protocols for specific treatments, drug administration, and the recording of outpatient registrations. Additionally, to address real-time challenges and review operational efficacy, health facilities regularly convened meetings to analyze performance metrics, collaboratively discuss, and resolve solutions to arising issues.

Data use

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

The interviewed OICs indicated that all facilities were engaged in data collection, validation, and use for monitoring and improving the quality of health services. Each department within the facility employed its data collection system, usually through 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. The collected information was then collated and analyzed by Monitoring and Evaluation (M&E) officers at the end of specific periods, often weekly or monthly. 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 reportedly enabled the facilities to determine whether there was an upward or downward trend in service usage as well as identified areas that required focused attention or improvement.

> *"All the departments have their register that we collect data with. At the end of the month, we will place it on a summary form. then, we take them for data validation. Anywhere that has a problem, we will note them down, and when we come back, we will meet and resolve the matter. Once it is resolved, we will move on."* – OIC, Kebbi Central

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 service records collected by the health facilities. FMCs worked together with WDCs to review "monitoring charts" to "track trends" in service use, enabling them to work alongside health facilities to "identify any problems," "address challenges," and "make informed decisions." OIC KIIs and FMC FGDs also mentioned that monitoring data were often disaggregated by both age and sex to provide a detailed understanding 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 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.	▼ **Documentation issues**: Problems with "inadequate documentation of information," particularly during outreach programs, 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.	▼ **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."
▲ **Effective resource allocation**: Consistent monitoring of specific health metrics, like malaria incidence, has facilitated a stable supply chain for related drugs and supplies at the facility.	

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 provider-client interactions in health facilities.

Respectful care: Perceptions

KIIs with OICs revealed that there was 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" could have severely negative consequences on patients, particularly those who are vulnerable.

> *"The disabled, if you don't show him care, it will add to his problem. Youths are being molested; and some might be brought to hospital. A married woman might have issues with her husband, it leads to ailment, and she comes to the hospital. If they are not cared for, it will worsen."* – OIC, Kebbi Central

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, irrespective of their social or economic status.
  - Show patience, empathy, and tolerance towards clients, 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.
- **Separate adolescent health services**: Health facilities operated a separate unit to provide adolescent health services to prevent any potential discomfort and embarrassment when they access any services within the facility.
- **Comfortable clinic setting**: Health facilities have 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 have experienced in maintaining respectful care:

Successes	*Challenges*
▲ **Increased patient satisfaction and engagement**: Respectful care practices have significantly contributed to improving patient-provider 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 infrastructure enhancement and facility expansion to ensure they are welcome and accessible, and therefore, impacting the implementation of respectful care. Specifically, the scarcity of private spaces in health facilities is a significant concern, especially for adolescents and patients with conditions requiring confidentiality, such as HIV/AIDS.
▲ **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.	▼ **HFS and community discord**: While strong community partnerships can drive success, the "lack of harmony" and "understanding" between community members and HFS that may lead to misunderstanding and dissatisfaction among patients and compromise the quality of health services.
▲ **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.	

Interaction of providers with clients with disabilities

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

> *"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

OICs asserted that respectful care is not just a moral obligation but also essential for effective healthcare delivery. Whether dealing with patients who have physical, hearing, or visual impairments, or even conditions like leprosy, HFS must create an atmosphere where patients feel not just comfortable, but also accepted and well cared for. The respondents indicated that staff in their health facilities make efforts to prioritize the needs of patients with disabilities, avoid stigmatization and discrimination, and offer their care with sensitivity and empathy.

OICs, FMCs, and WDCs highlighted communication skills as critical to effectively deliver healthcare to patients with disabilities. HFS are trained to not only communicate medical information clearly but also to be attentive listeners. This commitment to effective communication extended to adapting their interaction styles to meet the unique needs of patients with disabilities. For example, they reported that patients with physical impairments are offered seating and prioritized based on the severity of their condition. Those with conditions that may cause foul smells or rashes are treated with a non-judgmental and respectful attitude.

Additionally, being aware of the financial challenges that patients with disabilities may face, some facilities make efforts to assist these patients in obtaining free cards for medical check-ups, necessary medications, and personal care items.

Interaction of providers with adolescents and youths

In Kebbi, 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. Interview respondents consistently emphasized that HFS at their affiliated facilities treat adolescents and youth with the same level of respect and care as older, married patients. This non-discrimination principle is commonly extended to adolescents and youth seeking FP services, where health providers focus on confidentiality, privacy, and non-judgmental care when discussing FP options with them. Interview participants explained that this balanced approach not only makes adolescents and youth feel comfortable sharing their health concerns without fear of judgment or unwanted exposure of their personal information but also promotes an atmosphere of openness and mutual respect. As one WDC FGD in Kebbi North shared: "[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[s], then she will be given [it]."

OICs, FMCs, and WDCs highlighted the vital role of open communication and problem-solving in fostering a positive healthcare environment. FMC and WDC FGDs noted that health facilities are committed to addressing any instances of discrimination or unequal treatment. The leadership at these facilities takes immediate corrective measures to

maintain a friendly and respectful atmosphere.

Beyond adopting the principles of non-discrimination, OIC and FMC respondents pointed out a strong emphasis on providing comprehensive guidance and counseling to those seeking FP options. This approach aims to empower patients, particularly younger ones, to make well-informed decisions about their reproductive health. A consensus emerged among the interviewed OICs, FMCs, and WDCs that enabling adolescents and youth to access FP methods significantly contributes to preventing unwanted pregnancies and improving overall well-being. For instance, HFS aim to be "thoughtful" and "considerate" when discussing FP options with adolescents and youth, taking into account their age, marital status, and specific circumstances. Typically, HFS make efforts to assess the individuals' situation, asking about their past experiences with FP, provide tailored advice to these circumstances. Depending on the circumstances, providers may also incorporate educational elements such as the importance of safe sex and condom use. The HFS may advise these young patients about the health risks associated with early childbirth, the benefits of FP, and encourage them to delay getting married or having children until they are more mature.

For example, when counseling adolescent and youth patients, HFS reported typically making efforts to assess their prior experiences with FP, provide tailored advice to these circumstances but also incorporated 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, the benefits of FP, and encourage them to delay getting married or having children until they are more mature.

Interaction of providers with men and women

According to FGDs with FMC and WDC members and KIIs with OICs, it appears that there are "no significant differences" in the way men and women are treated in health facilities in Kebbi. 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. As on FMC FGD in Kebbi Central indicated: "We don't discriminate on the basis of gender—male or female. Whoever comes is treated equally. Either men or women, we accommodate them the same way."

Despite the overarching theme of non-discrimination and equal treatment practices, some FGD participants did note that men and women are occasionally separated in healthcare facilities. The arrangement, however, was cited to arise more from logistical necessities (e.g., limited space in facilities) and social conventions (e.g., cultural norms) rather than an explicit form of gender discrimination.

FGDs and KIIs also highlighted certain nuances emerged in specific situations. Spousal involvement, specifically husbands accompanying their wives, may receive some forms of preferential treatment, particularly during healthcare appointments related to pregnancy, labor, FP, and child immunization. FMCs and WDCs emphasized that this

> *"Some [providers] are not accommodating, but [the] 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

> *"Not too long ago, they did something that I was honestly happy about. I came with my daughter who was ill. It got to a point where I was confused. Then they were talking to me, and I didn't realize that tears were running down my cheek. The health provider took me aside and spoke with me. They attended to her, and she got better. And for days they kept calling me to ask about her health till she recovered."* – Women FGD, Kebbi South

practice is not discrimination but is aimed at encouraging husbands' involvement in family health matters. They noted that when husbands were present, there tended to be greater empathy, understanding, communication, and agreement on the medical directions provided between spouses. The joint-spouse participation was believed to not only foster a supportive environment but also encourage better adherence to healthcare recommendations, and ultimately contribute to improved health outcomes for both mother and child.

In addition to equal treatment, privacy and confidentiality emerged as critical factors in healthcare interactions. FDG and KII participants noted that providing a confidential environment enables patients to feel comfortable sharing their concerns or preferences, which is especially important in FP contexts where individuals might have sensitive personal preferences which they prefer to keep confidential.

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.

Younger women ages 14–24 emphasized the importance of open communication. They believed that the introduction by healthcare providers could bolster trust, and attentive listening was crucial for proper diagnosis and effective treatment. Women ages 25–49 focused on the broader roles and responsibilities of healthcare providers. They highlighted the importance of effective communication and stressed the significance of attentive listening in establishing a fruitful patient-provider relationship. While they engaged in debates about providers formally introducing themselves, they also noted that providers should be sensitive and considerate to the broader life contexts and challenges patients may face. On the other hand, men expressed diverse opinions on introductions by providers, but largely agreed on the necessity for HFS to maintain professionalism, calmness, and respect during the patient-provider interactions. They appreciated the dedication of many providers, and acknowledged that certain behaviors by providers might serve as lessons for patients on the importance of seeking timely medical care.

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 the main factors affecting and current state of health service use in Kebbi State communities.

Healthcare costs

FGDs with men and women in Kebbi revealed insights into the costs of healthcare services 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, diagnosis tests, treatments, and medications when seeking healthcare services at local health clinics. These expenses varied widely depending on the type of treatment and medicine being offered and the patient's individual status. For example, costs for registration cards typically ranged from ₦50–₦100.

> *"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

Affordability of healthcare services

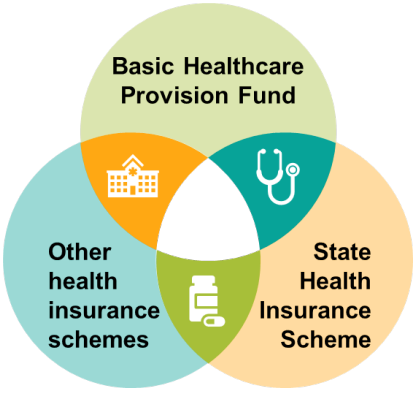
FGDs with men, women, FMCs, and WDCs revealed multiple layers of complexity when it comes to the affordability of healthcare services in Kebbi State, particularly in its rural areas. While healthcare services appeared to be generally affordable and accessible for most community members, there was also an acknowledgment that healthcare costs could be a significant burden, especially for low-income families.

The discussions indicated that thanks to various community-specific strategies and initiatives, some health facilities were able to offer entirely free services or provide drugs at subsidized rates. Specifically, treatments for conditions like malaria were reported to be offered entirely free of charge, while in others, costs for registration cards and other services were only charged at minimal fees. Some facilities charged medical tests and medications at prices lower than private pharmacies while certain communities even offered UNICEF-sponsored drugs for free. Additionally, registration cards, including the KECHEMA card, stood out as a significant factor in facilitating accessibility, as they served as gateways to free or reduced-cost healthcare services for certain 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 appeared to be largely affordable. The FGD participants affirmed that the availability of these subsidized or free services contributed to make healthcare generally affordable and accessible in the communities, as evidenced by reports of high patient numbers in facilities offering services at lower rates.

On the other hand, FMC and WDC members discussed the challenges of healthcare affordability to some community members, particularly for low-income families. They noted that while some drugs were affordable due to DRFs, there were still financial barriers to more comprehensive care. The high costs of patient cards, tests, and consultations were indicated challenging factors. Men, women, FMC and WDC FGD participants emphasized 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. Additionally, the role of family support in covering healthcare costs, especially for women, was particularly highlighted, as some women might rely on financial contributions from their husbands or other family members to access medical care. Interview respondents also stressed the importance of communications between patients and health providers, particularly those unable to afford the initial costs but needing medical attention. Many community members reportedly were open to discussing their financial constraints with providers. In turn, these providers could explore potential financial aid or more affordable healthcare alternatives, and refer patients to organizations offering free or subsidized care.

Regarding solutions to address the issue of affordability, both the community members and the FMC and WDC representatives agreed that healthcare was costly but essential, and community-based programs or interventions could alleviate some of the financial burden, ensuring accessible and affordable healthcare for all.

Figure 4. Most familiar health insurance schemes in the community



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 BHCPF and the State Health Insurance Scheme being the most popularly known (Figure 4). The respondents noted that the schemes have had a positive impact on healthcare access and affordability in the communities. As one men's 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 three months, and I was healed.”

The awareness mostly stemmed 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. The FGD participants also highlighted the role of collaboration among government agencies and local committees, including FMCs and WDCs, in educating the public and ensuring that they were well-informed about these schemes.

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, reduced 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 could be a hurdle due to issues such as shortage of drugs and medical supplies, inefficiencies in allocating benefits, and errors/malfunctions in the health cards, which restrict beneficiaries from accessing benefits.
▲ **Enrollment growth**: Enrollment in the BHCPF was increasing as more community members became aware of the benefits of the schemes.	▼ **Information gap**: There was a lack of in-depth knowledge about the enrollment procedures and specific benefits of the insurance schemes.
▲ **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.	▼ **Community dissatisfaction**: Some community members expressed dissatisfaction toward healthcare providers. These providers were perceived as not fully using government resources to offer free health services yet were still improperly charging patients for these 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 communities regarding the quality of healthcare services they have received in local health facilities in Kebbi State. The discussions focused on key aspects of service quality (Figure 5).

Figure 5. Key metrics for quality of health service

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 circumstances at the health facility, such as nature of the services being attended to and the time of the day. As a caregiver from a women’s FGD in Kebbi shared: “It depends. If it is an emergency case, doctors will rush to attend to him without wasting time. But if it is not emergency, then

he has to follow due process, i.e., go and collect a folder or get registered, join the queue, before he can see a doctor."

Community members noted that arriving early to the health facility could further reduce waiting time, contributing to overall client satisfaction.

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 felt that only certain areas, like 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.

Privacy during clinical consultations also emerged as a crucial factor for ensuring effective client-provider interactions. The Kebbi FGDs revealed that privacy tends to be compromised during emergency situations where protocols might be overlooked due to urgency. Yet, one FGD seemed to find this acceptable, noting: "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."

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 clinical consultation, only a small number reported that providers actively sought 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 Kebbi, the emphasis appeared to be largely on the final diagnosis. Providers tended to explain the procedure after the examination rather than obtaining upfront consent. As one service user reflected: "Until she [the provider] checks her body [child's body] before explaining what will be done next. She is supposed to diagnose and discover what is wrong with her."

Diagnostic testing

In FGDs in Kebbi, community members presented a consistent understanding that laboratory testing was a standard component of the diagnostic process in health facilities. This applied to both preventive measures (e.g., ANC) and curative treatments (e.g., malaria). As one community member FGD reflected: "Once a woman comes for ANC, they will not attend to her until she does blood test. They would take a blood sample to find out the disease, and later give them medicine."

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 were available.

Prevention and treatment

FGDs with men and women suggested that health service users generally had positive experiences when it comes to

receiving prevention and treatment services, particularly in the context of malaria.

After a laboratory diagnosis, it was 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. Majority most service users valued these explanations for enhancing treatment adherence and potentially improving outcomes.

In Kebbi, the availability of free drugs and medical services was cited as a significant facilitator for seeking treatment. As one caregiver reflected: "We have registered with KECHEMA. Then the doctor gave us a referral to Sir Yahaya Hospital. When we got to Sir Yahaya, we were welcomed nicely. We did not spend a single penny on drug purchases. All the drugs were given to us free of charge." However, FGDs respondents also noted that in instances of stockouts, providers would still prescribe the needed medications for patients to purchase from pharmacies or chemists, ensuring continuity of care.

Use of health services: ANC

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

In Kebbi, the availability of free drugs and medical services has emerged as a significant contributing factor, incentivizing pregnant women to access and use ANC services. Respondents indicated that this intervention has especially been vital in addressing financial barriers that might have discouraged women from using these essential services. The awareness campaigns around the importance of ANC have reportedly contributed to incremental improvements in the service uptake. FMC and WDC representatives emphasized that the combination of these strategies contributed to tackling both the demand generation and readiness to provide services, therefore, making ANC more accessible and acceptable to women in the state.

> *"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

Despite these gains, several challenges persisted. In Kebbi, the cost of services, including consumables, remained a substantial barrier, particularly impacting lower-income households. The distance to health facilities and the associated transportation costs also created further obstacles. In addition, the periodic absence of essential drugs and other commodities due to stockouts were also reported as a discouragement for women seeking ANC services.

Use of health services: Child healthcare

The use of child healthcare services in communities in Kebbi State reflected 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 make positive impacts. The interventions have been effective in changing behavior and attitudes towards child healthcare, encouraging a wider portion of community 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

> *"Because of the meeting we hold every end of the month with the WDC. They sensitize them that if their children are sick, they should bring them to the facility. That is why we see changes."*– FMC FGD, Kebbi

contributing to this positive trend.

Generally, both men and women participated in taking their children to access healthcare services, although women were more commonly the ones to do so, including seeking malaria treatment.

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 as well as availability of necessary drugs and commodities were cited as primary motivation factors.

When it came to malaria prevention specifically, seasonal malaria chemoprevention (SMC) emerged as the main platform for access to child malaria prevention services in Kebbi.

Use of health services: FP

In Kebbi, 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 efforts led by WDCs, uptake of FP services in Kebbi was low due to the misconception that FP "interferes with women's fertility." However, the sensitization programs, which focused on reframing terminology from "family planning" to "child spacing," have notably contributed to changing perceptions. The shift in terminology was also paired with awareness campaigns about the health benefits of adequately spaced births for both the mother and her children. The sensitization initiatives, including those targeting men, have contributed to significantly improving the acceptance and use of FP methods within community, including men and even traditionally conservative communities.

> *"Nowadays, many women use the birth spacing methods because we usually tell them when they come for post-natal family planning here and demand for it. We give them whatever method they need."* – FMC FGD, Kebbi

Nonetheless, challenges still existed. Although male engagement in FP has increased, FMC and WDC representatives indicated that men rarely accompany their partners to health facilities for FP services. They reported that male consent remains crucial, as most women often seek 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.

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 Kebbi 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*		• 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.

disease-focused approach (PMI-S) was implemented, or a combination of the two?		• 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.
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. • Availability of health insurance and free drugs and medical services is linked to improved access to healthcare services. • Availability of drugs contributes to effectiveness of service delivery of and improvement in access to healthcare. • The implementation of SMC is reported to be significantly associated with improvements in the use of child malaria prevention services in the community.

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