March 2024

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

Introduction

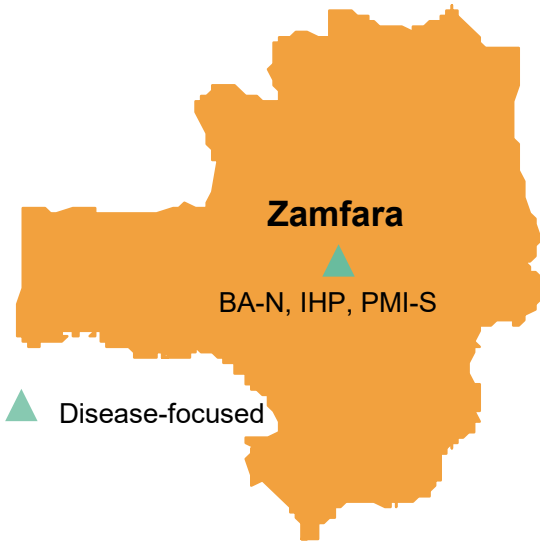
Data for Impact (D4I) is conducting a prospective mixed-methods portfolio evaluation of four USAID/Nigeria Health, Population, and Nutrition (HPN) Activities. The primary focus of this evaluation is to compare an integrated health programming approach with a disease-focused malaria approach. The evaluation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



- **Disease-focused approach**: The PMI-S focuses on malaria health programming and health system strengthening.

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 health care 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 Zamfara 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	Zamfara
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 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 hands, WDCs, which played an essential role in planning community health activities, were largely comprised of community representatives (e.g., village heads, civil servants, business leaders, women leaders, and imams) and FMC members (often the OICs). When discussing the gender breakdown of WDC membership in FGDs, men outnumbered women. Like FMCs, WDCs also held both regular and ad-hoc meetings. Their funding primarily came from NGOs and other contributions.

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 meet 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 receive 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 use 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, villages, and home visits. There were reports that certain FMCs assigned their individual committee members the responsibility of reaching monthly targets of mobilizing/sensitizing specific numbers of people to attend ANC and immunization in facility.

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. The two committees were reported to coordinate efforts to mobilize people for these healthcare services and focus sensitization activities accordingly. One WDC FGD in Zamfara reported that they proactively reviewed the health facility registers to determine if cases, for example malaria, had increased or decreased from month to month, to guide their sensitization activities. From the register, FMCs also disaggregated the data by sex and age to target efforts and participate in monthly meetings to improve data quality.

Additionally, if the registers indicated that community members have missed ANC or immunization visits, WDC members, and sometimes FMC members, tracked these individuals and encouraged them to return to the health facility to complete their full schedule of appointments.

Management of health facility funds

To ensure accountability and transparency, WDCs collaborated with FMCs to oversee the spending of funds from the BHCPF. Typically, the facility OIC and WDC chairmen usually serve as joint signatories. However, in one FMC discussion in Zamfara, it was reported that only FMC members were signatories. WDC members also reviewed and approved spending plans and verified receipts. WDC members also were reported to review and approve spending plans and verify expenses.

Other joint collaborations

In addition to partnering on community mobilization, sensitization, and use of funds, in Zamfara, WDCs and FMCs were reported to collaborate in various other ways. An OIC explained that following advice from the WDC, the facility constructed separate male and female wards and a temporary structure for admitting clients.

Challenges

Most FMC and WDC FGD respondents expressed positivity about their collaboration and joint achievements, indicating minimal challenges in working together. However, some specific issues were noted in Zamfara.

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.

In Zamfara, DRFs were reported to be functional across all facilities. Interviews with OICs revealed that both FMCs and WDCs play essential roles in managing the funds. FMCs were tasked with overseeing the sale of drugs and depositing funds and ensuring that those funds were used judiciously. Additionally, they ensured that drugs were available and managed in a manner that the expiration of drugs was either minimized or completely eliminated. Some FMCs even had authority to approve expenditures for restocking. One OIC explained that their FMC had a specialized subcommittee dedicated to drugs and commodities that regularly monitored stocks to ensure a two-month supply was maintained, and determined if restocking was needed.

WDCs were similarly involved in drug monitoring to ascertain that drugs and commodities were available and aligned with community needs. They ensured that the revenue generated from drug sales are allocated toward restocking drugs and commodities. In one facility, the OIC explained that the WDC chairman, as the signatory on the DRF account, must approve all drug purchases.

Support from HPN Activities

In Zamfara, both FMCs and WDCs were reported to receive significant support from HPN Activities, which encompassed various aspects such as community mobilization, specialized trainings for health care workers and WDC members, and the supply of malaria drugs and commodities.

FMC members detailed the support they received from the HPN Activities, including:

- Training on malaria management
- Mobilizing mothers of malnourished children to seek assistance at health facilities
- Providing malaria drugs, which were free of charge to women, children, individuals with disabilities, the

elderly, and those unable to afford payment

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

- Providing antimalarials and mosquito nets to community
- Establishing partnerships with WDCs and support them to sustain community sensitization
  - Training WDC members on Rapid Diagnostic Tests (RDTs) and treatment of malaria, as well as public speaking techniques for more effective community sensitization.

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 Zamfara, outreach 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 the communities highlighted these demand generation strategies, indicating a positive impact as well as challenges affecting the implementation of these initiatives.

Outreach activities

OICs interviewed confirmed that outreach has become an essential element of Zamfara's healthcare infrastructure, designed to generate demand and ensure healthcare accessible for communities hindered by distance and security issues. The programs were strategically planned with monitoring charts and guidelines, and carried out by health professionals with the help of community volunteers. Outreach was conducted three to four times a month and covered a broad spectrum of services including routine immunization, minor ailment treatments, malaria prevention and treatment, child health, essential medication for children, ANC, and education on hygiene. The outreach services were also flexible, allowing for adjustments depending on prevailing diseases and health conditions in the communities.

Support in carrying out this outreach came from a variety of organizations, such as Global Alliance for Vaccine and Immunization (GAVI), United Nation Children's Fund UNICEF, the State Government, PMI-S, WDCs, and local representatives like the Senator for Zamfara North. OICs noted that support ranged from financial incentives to transportation assistance and mobilizing communities.

OICs discussed both successes and challenges of their outreach programs:

Successes	*Challenges*
The commitment of healthcare workers and the cooperation of traditional rulers and WDCs were noted having played a significant role in sustaining these achievements:	▾ Low FP acceptance and use (reported to be high priority concern).
▴ Increased use of healthcare services in hospitals	▾ Non-availability of various FP commodities.
▴ Enhanced routine immunization coverage	▾ Lack of consistent support from traditional and religious leaders.
▴ Improved ANC attendance	▾ Shortage of staff to conduct outreach activities.

▲ Positive reception of services offered during outreach	▼ Inadequate incentives for health personnel and WDCs have hindered further success to the outreach.
▲ Decrease in under-five mortality rates	▼ Lack of dedication by some health workers in conducting outreach activities.
	▼ Insecurity in the state
	▼ Poverty

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 Zamfara, 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, including radio, mosques, hospital/health facilities, health providers, and town criers. The men's FGDs highlighted additional sources of malaria messages like the World Health Organization (WHO), the internet, and community traditional and religious leaders, while the women FGD respondents mentioned mobile phones, and wedding ceremonies.

While messages that women had heard or seen focused more on specific topics such as "danger and causes of malaria," "environmental sanitation," "use of mosquito nets," and the "need to test for malaria," messages that men reported covered mainly general prevention and treatment measures of malaria.

Both men's and women's FGDs expressed "understanding," "enjoyment" and appreciation for the malaria messages, and highlighted that they have adopted the key tenets of these messages (Table 2). Respondents underscored that the adoption led to significant "improvements in their personal health and the well-being of their children. Specifically, women's FGDs emphasized on broader community benefits, such as improvements in health status, acceptance of preventive mechanisms, uptake of drugs, community encouragement, and knowledge of access to free healthcare services. Men's FGDs spoke more about their personal commitments to adhering precautionary measures.

Both men's and women's FGDs reported that they were aware of and benefited from malaria projects implemented

in their communities, such as WDC sensitization campaigns on malaria, access to free medication, and cleanliness, and house-to-house distribution of malaria drugs to children.

FP messages

Both men's and women's FGDs reported having encountered FP messages in their communities within the past six months. The channels identified by both groups for receiving these messages were quite similar, including television, radio, social media, health workers, religious scholars, and friends. Women participants also noted the role of friends, neighbors, relatives, spouses, and hospitals in receiving FP messages, which were not mentioned by the men's groups. Furthermore, women referred to specific programs such as distributing and inserting implants for free, whereas men's reflections were more oriented towards broader sensitization campaigns by organizations such as WDC, the government, schools, and mosques.

There was general agreement that the messages revolved around the importance and benefits of using FP, availability of various FP methods, and problems associated with non-use of FP. The contents of messages received by women were more centered around aspects like giving birth to healthy children, providing quality life to children, and promoting a good livelihood. In contrast, men's messages seemed to be more aligned with general enlightenment on the importance of FP, the availability of various methods, and problems associated with non-use of FP.

The reactions to these messages were overwhelmingly positive among both men and women (Table 2). Respondents acknowledged "understanding the messages" and "finding them useful," with many claiming to have used FP and observed positive impacts.

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."	•	•	•

Both groups also reported witnessing FP projects, such as sensitization campaigns and programs involving house-to-house visits by health workers for FP commodity distribution.

ANC messages

All men's and women's FGDs acknowledged they had heard or seen messages on ANC within the past six months. These messages were widely disseminated through common channels such as radio and television. Hospitals and health workers were also cited as common sources of information among women, while there was an emphasis on traditional leaders among men.

While both groups revealed receiving ANC messages, they reported differences in content and focus. Women's FGDs emphasized messages centered pregnancy care and the health of a pregnant mother. On the other hand, men's FGDs received messages specifically aimed at encouraging them to accompany their wives for ANC.

Positive reflections were common across both genders, with a clear understanding of the messages (Table 2). They "understood," "enjoyed," and appreciated the content as the messages "enlightened the people in the community." Many claimed to have put the messages into practice, resulting in positive outcomes, such as improved their health as pregnant mothers and increased use of ANC services.

In terms of projects, women in FGDs seemed less familiar with ANC projects in their community, with only a mention of a program for teaching pregnant women how to breastfeed. On the other hand, men reflected on specific ANC initiatives, such as monetary incentives to women who attended ANC implemented by UNICEF and special in-clinic

care to women who attended ANC regularly.

Impact of COVID-19 on demand for health services

During the COVID-19 pandemic, the healthcare demand in Zamfara State was significantly affected, as described by key informants. The OICs revealed that many community members avoided healthcare centers during the lockdown due to the fear of "contracting the virus" or "knowing they are infected" if they were required being tested for COVID-19, leading to a decline in the use of healthcare services. This situation interrupted some of the positive outcomes that were previously achieved by health facilities' outreach programs. Despite outreach efforts that led to increases in immunization coverage, healthcare awareness, and overall demand for healthcare services, the pandemic was reported to introduce new challenges, including insecurity in the state and unavailability of FP commodities. The drawbacks posed by COVID-19 has therefore resulted in a sharp decline in healthcare demand and use in the community.

Health facility readiness to provide services

The readiness of health facilities to provide services is considered an essential factor influencing 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 Zamfara State, essential health services are generally available at primary health care centers (PHCs), according to responses from health facility staff, FMC, WDC, and community members. These services encompassed a broad range of healthcare needs, including treatment of minor illnesses, ANC and post-ANC, FP, labor and delivery, nutritional guidance for pregnant mothers, growth monitoring for children under five, and immunization. Referrals were reportedly offered for severe or complicated cases requiring more specialized care or surgical interventions. Furthermore, respondents revealed that healthcare services were organized into separate preventive and curative care, which were operated in distinct sections within the health facilities. This included dedicated areas for childbirth services. Additionally, the state's facilities were reported to incorporate pre-consultation rapid diagnostic tests (RDTs) for malaria as a standard procedure for all fever cases.

Outreach services

Outreach health services were reported to play an important role in extending healthcare access to remote and hard-to-reach areas. In Zamfara, 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. UNICEF, GAVI, and the PMI-S are currently the principal supporters of the outreaches, particularly for the immunization and ANC components. Like its in-facility services, Zamfara's outreach programs also included RDTs for malaria as part of its protocol handling all fever cases. However, interview respondents indicated that FP, which was once part of the outreach services, has been discontinued due to the end of a project that previously funded it.

Availability of EDDS

In Zamfara, the availability of EDDS within health facilities presented a mixed picture, marked by both improvements and challenges. On the one hand, a few OICs and community members acknowledged notable "positive changes" or

increase in availability, as an OIC in Zamfara North noted: "We actually have supplies of most of those things when we talk of essential drugs." Respondents specifically emphasized that essential drugs like folic acid, antibiotics, anti-diarrheal medications, and malaria drugs were sufficiently stocked and often provided free of charge to ANC clients and other patients. One men's FGD in Zamfara West confirmed: "For us here, malaria is very common and therefore the medicine is always available at the facility." On the other hand, a majority of health facilities reported "no changes" or "little improvement" in the overall availability of EDDS over the past year, except supplies for malaria diagnostics and treatment. As an OIC in Zamfara North indicated: "[Over the last] 12 months, there is not any availability of essential drugs in our facility."

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

OICs mentioned that funding for these essential drugs and supplies often came from DRFs, which enabled facilities to purchase necessary drugs like amoxicillin and paracetamol. These were then sold to clients, creating a revolving stock. However, OICs cited that these measures have not completely addressed shortage. In particular, healthcare facilities still reported a shortage of key diagnostics and supplies, like Respiratory Syncytial Virus (RSV) antibody tests, hepatitis B and syphilis screening tests, and Fansidar/SP (sulfadoxine/pyrimethamine), a malaria prevention drug for pregnant women. As an OIC in Zamfara West revealed: "Concerning malaria, there are changes. Now, they are giving us enough commodities. Only [issue is that] we don't have SP for more than two years… SP is very important, especially for the pregnant women. It is out of stock for two years."

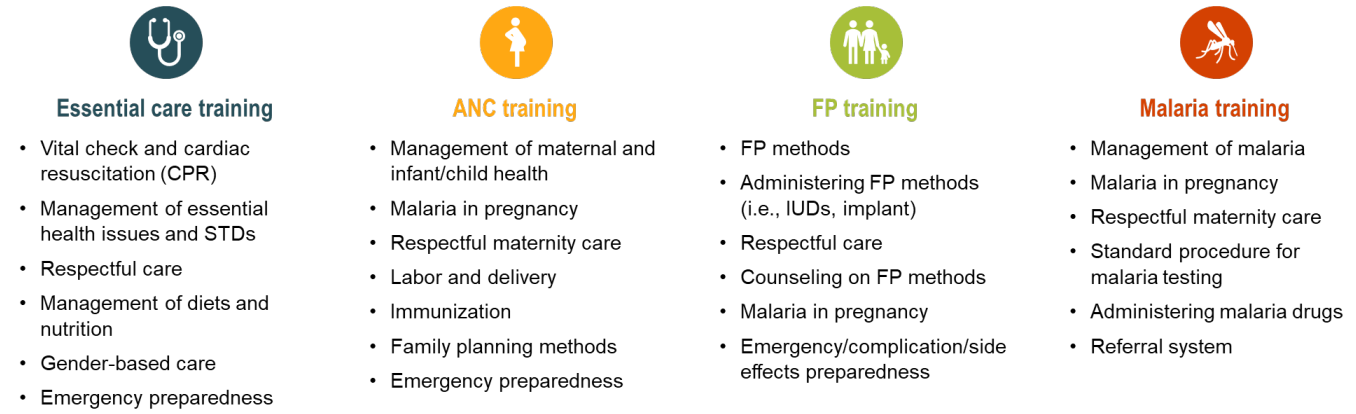
The availability or shortage of EDDSs has consequential impacts on patient behaviors and healthcare use in community, reflecting both OIC key informants and men's and women's FGDs. Where there has been an increase in essential drugs, more people were reported to frequent the health facilities. However, limited supplies, especially of free EDDSs, have resulted in a decline in patient numbers. Further, some patients may refuse to buy medications, preferring to wait for free treatment, while others might not adhere to alternative treatment regimens when prescribed.

Staffing at health facilities

In Zamfara, the interviewed OICs emphasized the importance of health 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 improvements in service delivery as results of various training programs on health service provision provided to staff. As an OIC in Zamfara West indicated: "Some of our staff… they did not know how to do malaria tests during ANC. Some of them did not know how to take blood pressure by using a thermometer. But after the training, we know how to do all these properly… [And] the caregivers now come for healthcare services more."

Organizations, such as USAID-funded agencies, 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-based care, and emergency preparedness), malaria treatment (e.g., standard testing procedure, administering malaria drugs), ANC (e.g., management of malaria during pregnancy, respectful maternal care), and FP (e.g., administering FP methods

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



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 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 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.

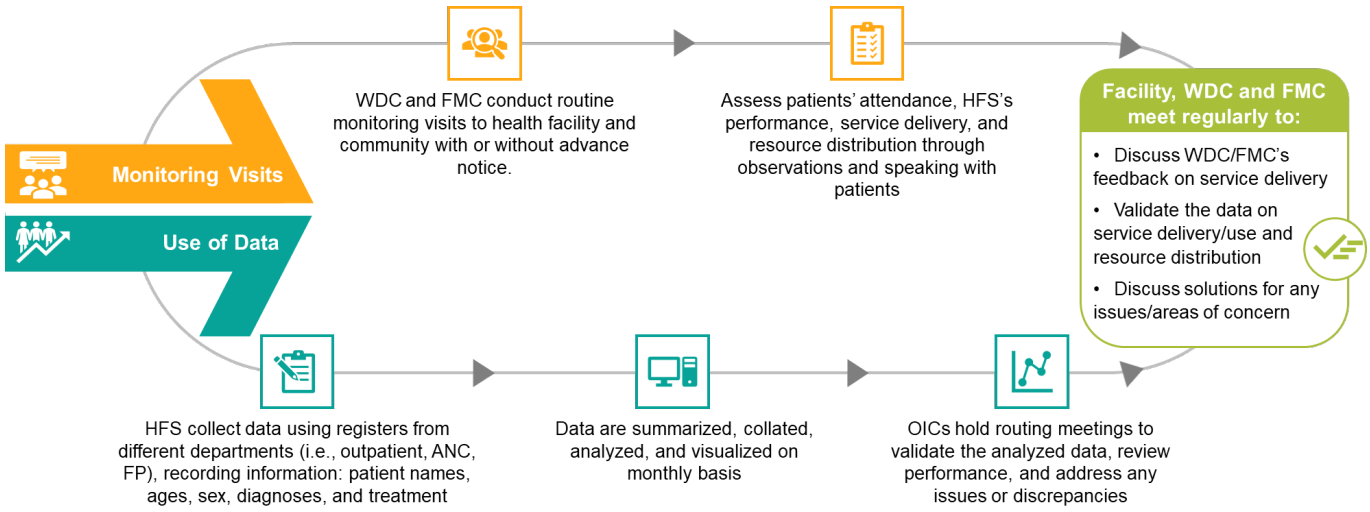
Monitoring health service performance

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 Zamfara 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 Zamfara, 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

Figure 3. Approaches implemented to monitor health service performance



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. As one OIC put it, "each [health] service needs to be monitored to assess its impact. So that you can plan ahead." Health facilities 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. For example, as one OIC noted, the monitoring data also extend to the stock and dispense of various essential drugs and commodities, enabling the health facilities to monitor closely and prevent stockouts, especially of crucial medications like malaria drugs.

FGD and KII respondents indicated that both FMCs and WDCs were actively involved in supervising and supporting health service performance at the facility level. The WDCs acted as a liaison between the health facility and the local community, ensuring that services met the needs of the population. Committee members often conducted unannounced supervision visits to the facility to assess the quality of healthcare delivery. These visits were comprehensive, involving observations, interactions with patients, and consultations with HFS/OICs. WDCs maintained real-time assessment records for monitoring purposes, made their findings available for necessary actions, and subsequently discussed the information with OICs to implement any

> *"We normally ask patients on their way out to check their papers or receipts to be sure the service and the drug he is given for free. If the patient collects a drug, we normally stop him to check if it is given free or if it is being sold to him. He will confirm which of the drugs are for free or not. This is how we know that their work is done correctly or not."* – WDC FGD, Zamfara Central

needed changes. They also conducted home visits, encouraging community members to seek medical attention when needed.

FMCs also integrated themselves deeply within the health facilities and collaborated closely with WDCs and OICs. The committees coordinated the collection of monthly monitoring data, reviewing them in both regular and ad-hoc meetings with OICs. Data collection included monthly attendance registers across all departments (e.g., outpatient department (OPD), ANC, routine immunization, labs, and pharmacies), duty rosters, and open registers. These data were then compiled and harmonized into monthly summaries by Monitoring and Evaluation (M&E) officers and integrated into the National Health Data System (NHDS). The analysis results also became part of a broader discussion during review and validation meetings, which aimed to identify problems and discuss potential solutions. Moreover, the FMCs also coordinated with the facilities to establish staff disciplinary committees, that oversaw staff behavior (e.g., punctuality, patient interactions, and treatment administration) and tackle arising issues.

Respondents affirmed that the monitoring practices have led to improvements in service quality. For example, an FMC FGD in Zamfara North noted that the benefits of their performance monitoring have extended to drug availability and cost-effectiveness for patients. Patients were now able to purchase drugs at a lesser cost within the health facility, saving them both money and time compared to traveling to town for the same medications.

Data use

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

OICs highlighted the importance of collecting and using data on facility's activities and "hospital works" because "if you don't keep records of you are doing, there is no way you would know what you did" (OIC, Zamfara West). The respondents indicated that all facilities were engaged in data collection and use to guide decisions on healthcare provision, as well as monitor and evaluate performance and quality of health services offered.

> One OIC from Zamfara Central emphasized the value of data in enabling HFS to make informed decisions on service provision, citing that monthly data comparisons revealed areas of improvement and decline, therefore informing strategies to address gaps.

Data collection systems were reported to be well established across departments within healthcare facilities. Each department within the facility employed its data collection system, usually through patient registers that recorded 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 data were then collated, analyzed, and visualized using charts that that allow the HFS to assess whether their performance is improving, stable, or decline. By analyzing trends and patterns over specific periods, HFS could identify issues and gaps and resolve necessary corrective measures/strategies to address them.

Additionally, OICs revealed that Zamfara health facilities were maintaining a system of "double caring" for data to ensure accuracy and accountability. Specifically, each set of data was photocopied, with one copy remaining at the facility and the other being shared with Local Government Areas (LGA) officials or Monitoring and Evaluation (M&E) officers. These officers further validated the data, made frequent supervision visits to the facilities, and assessed service delivery performance.

FMC and WDC members supplemented the data use efforts by reviewing service registers that included comprehensive patient information. At the end of each month, the OICs, FMCs, WDCs, and even the Emir met to evaluate the status of service delivery in facilities and discuss solutions for any arising issues. Moreover, FMC FGDs highlighted 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/improper 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, 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.	▾ **Data sharing obstacles**: Bureaucratic procedures or absence of clear protocols or guidelines for efficient and secure data sharing impeded the efficient use of data. For example, authorization from supervisors was often needed before sharing data with external parties, which sometimes caused delays in access to information for decision-making.

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 ensures "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 who are vulnerable.

> *"[Respectful care] is very important. Disable patients… if you disrespect them, you are doing more harm than good to their health condition. They came with a problem, and they are disrespected. You are making life terrible for them."* – OIC, Zamfara West

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 training, step-down training, and monthly staff meetings. Additionally, HFS were reminded to apply the training principles in their day-to-day interactions with patients.
- **Equal treatment practice**: Health facilities developed guidance on respectful care where all HFS were advised to:
  - Treat all patients equally without discrimination, regardless of their socio-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.
- **Prioritizing patient privacy and confidentiality**: Health facilities implemented specific measures to ensure privacy for patients, especially for those with infectious diseases or mothers in labor, to maintain confidentiality and sustain their dignity.
- **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 facilities.

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	▼ **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

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."	implementation of respectful care.
▲ **Greater inclusion**: "Vulnerable populations," such as people with disabilities, adolescents, and young adults, have particularly benefited from inclusive healthcare settings where their unique needs are acknowledged and accommodated.	▼ **Educational background gaps among HFS**: Differences in educational backgrounds among HFS can result in inconsistencies in the quality of care provided.
▲ **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.	**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.

Interaction of providers with clients with disabilities

FGDs with FMC and WDC members suggested that in Zamfara, 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."

Furthermore, the interviewed OICs asserted that respectful care is not just a moral obligation but also essential for effective healthcare delivery. Whether dealing with patients who are in wheelchairs, have physical, hearing, visual

impairments, or mental illnesses, the HFS are responsible for creating an atmosphere where patients feel not just comfortable, but also accepted and well cared for. As one OIC in Zamfara West indicated: "People with disabilities, for instance, may feel abandoned or treated as lesser normal people when they are not given the respect they should have."

The interviewed OICs, FMCs, and WDCs revealed that staff in health facilities made efforts to prioritize the needs of patients with disabilities, avoided stigmatization and discrimination, and offered their care with sensitivity, "empathy," and "understanding." Specifically, HFS were reported to strive to be attuned to the challenges faced by individuals with disabilities, ensuring that such "patients feel welcomed" and valued during their medical visits. One common practice was to allow patients with disabilities to be treated before others when waiting in queues to minimize discomfort and challenges they may be experiencing.

> *"When I was [here], I met a disabled person. When he came and met a queue, he was asked to enter through the back door. As I observed, he was treated well. We later met on his way out, and he said he was given his drugs and all that concerned his visit."* – WDC FGD, Zamfara Central

Additionally, FGD and KII participants also emphasized safety and effective communication as top priorities for effective healthcare delivery to patients with disabilities. When it came to specialized situations, such as treating contagious diseases or injuries, HFS reportedly maintained a respectful and non-judgmental attitude towards patients and use personal protective equipment to ensure safety for both patients and providers. Furthermore, HFS were 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. In instance, where communication could be a barrier for patients with sensory impairments (e.g., deaf or blind patients), HFS were reported to use variety of strategies like speaking clearly, using hand gestures, or encouraging presence of patients' family members who can assist in communication and ensure that their needs were well understood and address. Interview respondents also noted that special attention was also extended to elderly patients and those with special needs, providing them with extra attention and care they require.

> *"When a teenage girl comes to seek for FP, I will explain to her in detail the advantage or importance of FP. Sixteen year old[s] are married out and then have issues during childbirth. So, we explain to them in detail to stay a bit more matured at least, 20 or 21 [years] of age, before getting married, and in that instance, they appear stronger than when they are 16 years old."* – FMC FGD, Zamfara Central

Interaction of providers with adolescents and youths

In Zamfara, interactions between health providers and adolescents and youth appeared to be guided by principles of fairness, cultural sensitivity, and patient-centered care. FGDs with FMCs and WDCs, and KIIs with OICs suggested that HFS at their affiliated facilities aimed to treat adolescent and young adult patients with the same level of care and attention as older individuals. Time-sensitive and equally attentive patient care was highlighted as a common practice among the HFS with emphasis on good patient-provider relationships.

Additionally, health providers were reported to adopt a comprehensive approach when it comes to sensitive matters like FP and birth control. Interview respondents highlighted that HFS aim to exhibit a respectful and informed attitude toward their patients' individual needs and circumstances. For example, when counseling adolescent and youth patients, HFS typically make efforts to assess their prior experiences with

FP, provide tailored advice to these circumstances but also incorporate 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.

Furthermore, HFS's commitment to the comprehensive care approach was demonstrated through their "cautious" and "conscious" considerations between cultural and traditional norms and modern health care needs, acknowledging the importance of FP, while being sensitive to cultural expectations that may impact young patients' ability to engage in FP. For instance, in situations involving young married patients, the health providers might request the patient's husband to be present or at least inform about the decision, as an act of following cultural norms while still maintaining patient's right to the FP services.

Interaction of providers with men and women

According to FGDs with FMC and WDC members and KIIs with OICs, there were "no significant differences" in how men and women were treated in health facilities in Zamfara. Men and women were 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 was 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, healthcare providers were reported to prioritize women and young children for immediate care, particularly those women who are pregnant or in critical conditions. Interview participants noted that the priority was rooted in the understanding that pregnant women and children may require urgent medical attention due to their potentially delicate health statuses.

> *"The health official is not only educated, but he is disciplined by virtue of his profession. So, he will use his professional training to listen attentively to patient's complaint."* – Men's FGD, Zamfara West

> *"I was brought to the hospital because I felt ill. I was like unconscious. Opening my eyes, I saw lots of the health providers attending to me. Like they were waiting for me."* – Women's FGD, 25-49 years old, Zamfara Central

> *"The officials [health providers] are caring. Any time we visit the facility, they don't hesitate to attend to us."* – Women's FGD, 15-24 years old, Zamfara Central

Referential attention was reportedly extended to FP services. Women attending the clinic with their husbands tended to receive more attention and possibly more streamlined care. In some cases, women may even be advised to return with their husbands to proceed with FP consultations if they initially come alone. As respondents explained, this practice aimed to gain mutual consent and agreement between the spouses in FP decisions, minimize potential misunderstandings, and enhance communication and cooperation between couples, ultimately benefiting the healthcare outcomes.

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 highlighted the importance of providers introducing themselves for future patient-provider interactions and emphasized the essential role of clear

communication and respectful and attentive listening in the care and treatment process. The young women voiced concerns about potential arrogance in the healthcare settings and the neglect of patients who arrive late for the appointments. Women ages 25–49, on the other hand, predominantly discussed the necessity of the providers' name introduction, and stressed the importance for providers to listen attentively and respectfully. Despite recognizing challenges like demanding workloads, these women firmly believed in the providers' obligation to maintain professional standards and build trust in healthcare. Although the act of providers introducing their names were appreciated, men generally viewed the protocol as secondary to the actual quality of medical care received. There was a consensus among men FGDs on the importance of providers listening attentively as an integral part of their professional responsibility. While men mentioned some instances of patient autonomy, such as the right to refuse certain medical procedures, the overarching focus remained on the provider's responsibility to ensure the well-being of patients.

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 Zamfara State communities.

Health care costs

In Zamfara, FGDs with men and women in Zamfara suggested a mixed picture of healthcare costs where some healthcare services were offered free of charge, whole others required payment. Drawing from their personal experiences and observations, respondents highlighted that community members typically needed to pay for expenses related to registration cards, consultations, diagnosis tests, treatments, and medications when seeking healthcare services at local health clinics. These expenses could fluctuate significantly depending on the medical condition being treated, the patient's individual status or specific circumstances, and the location of the clinics. For example, there was a noticeable disparity in healthcare costs across different communities, with some offering services for free and others charging normal fees. The range of free services was reported to vary: While tests for conditions like HIV, malaria, and urine tests are generally free, other tests such as hepatitis, syphilis, and blood group tests are not. ANC check-ups were often free; however, there might be charges for specific tests or additional health issues that arise during the visits. Fees for testing, where they existed, typically ranged from ₦50–₦200. Patient cards, which were used to record medical histories and reasons for clinic visits, were another common cost, though they were usually a one-time fee. Furthermore, some community healthcare centers sold drugs at prices lower than those found at private chemists, increasing accessibility for people with limited financial resources. Also, both men and women indicated a preference for government facilities largely due to the lower service costs. However, FGD participants identified existing gaps in service provision. For example, some essential drugs might not be available in government facilities, requiring patients to purchase them at higher prices from outside sources.

Affordability of healthcare services

FGDs with men, women, FMCs, and WDCs suggested that while community support and free and subsidized medical services contributed to affordability for some community members, financial constraints remained a significant barrier for many to access to healthcare, particularly those with limited financial resources. Affordability remained a

complex issue, influenced by factors including financial capabilities, availability of drugs and tests at local healthcare facilities, community support, and cultural and social norms.

While FMC and WDC members had a slightly more optimistic perspective on the affordability situation, suggesting that costs were generally "manageable" for most, they agreed with community members that the affordability of healthcare services was closely linked to individual's financial situation. The provision of free or subsidized drugs and tests at local facilities was highlighted as a significant relief for many families, particularly those facing financial constraints. Yet, both groups acknowledged that even with the availability of the free services, certain gaps still existed. Minimum charges for services, such as registration cards, might remain out of reach for some community members, therefore limiting their accessibility to essential healthcare services.

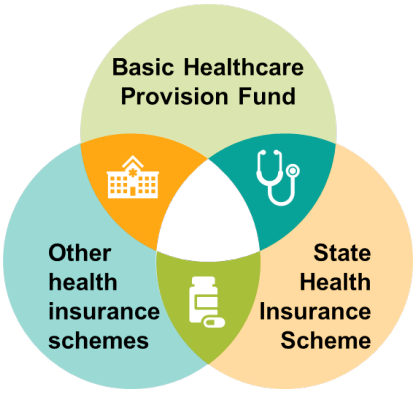
Additionally, FGD participants also emphasized the role of community support in alleviating the healthcare costs. Men's and women's FGDs indicated that assistance from family, relatives, mosque members, and community funds could supplement individual financial resources costs. In the meantime, FMC and WDC representatives described initiatives such as buying drugs and medical supplies in bulk to subsidize costs and community financial contributions to subsidize fees for those who can't afford them. The respondents noted that this community support serves as a "safety net" for those who might not be able to afford healthcare services.

Furthermore, the men's and women's FGDs highlighted cultural and social factors as additional existing barriers to healthcare affordability. For example, some women in the community reportedly required approval and financial support from their husbands or in-laws to seek medical attention, a factor that was said to affect access to and affordability of healthcare.

Health insurance: Awareness, successes, and challenges

FMC and WDC representatives reported that community members were 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). The respondents noted that the schemes have had a positive impact on healthcare access and affordability in the community.

Figure 4. Most familiar health insurance schemes in the community



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 community gatherings and mosques as platforms for sensitizing the public and ensuring that they were well-informed about the insurance schemes. The FMC and WDCs, particularly, were credited for their joint-efforts in popularizing the benefits and enrollment process in the community. As one WDC FGD in Zamfara Central indicated: "There was a time, I made them announce it [the Basic Healthcare Provision Fund] in the mosque so to create awareness among community members. Everyone was informed that they should come to the hospital and get registered to give them the opportunity to benefit from this scheme."

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 the community's access to free or subsidized healthcare services, reduce the burden of healthcare costs for some beneficiaries, and positively contributed to community development. Especially, specific initiatives provide free healthcare services to vulnerable groups, including pregnant women and children under five, and were reported to further extend the benefits of these schemes.	▼ **Enrollment limitations**: Financial and transportation constraints can hinder registration for some community members.
▲ **Enrollment growth**: Enrollment in the BHCPF is increasing as more community members become aware of the benefits of the schemes.	▼ **Access to benefits**: Access to the benefits of the insurance schemes can be a hurdle due to issues such as shortage of drugs and medical supplies, inconsistent delivery of promised free or subsidized medical services (e.g., lack of basic medications like paracetamol, limited quality of services), inefficiencies in allocating benefits, and malfunctions in the health cards, which restrict beneficiaries from accessing benefits.
	▼ **Information gap**: There was a lack of in-depth 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.

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 Zamfara 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' 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 depends on the particular circumstances at the health facility, such as nature of the services being attended to and the time of the day. A caregiver from women's FGD in Zamfara reflected: "It depends. If there are people that came before [us] with [a] similar problem or issue, there is the tendency that [we] will spend more minutes in waiting."

Community members also 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 were clean while about a third 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.

Privacy during clinical consultations also emerged as a crucial factor for ensuring effective client-provider interactions. Zamfara presented a unique challenge: The small size of some health facilities reportedly resulted in space constraints, limiting the extent to which privacy could be ensured.

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

Examination consent

Discussions with men and women revealed that the concept of obtaining patient consent before conducting a physical examination was not commonly practiced among healthcare providers nor particularly valued by most health service users. Although the FGD participants were aware that a physical examination was a standard procedure of the 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 Zamfara, acceptability of skipping consent seemed to be associated with the gender of the clinician. Consent appeared less critical if the healthcare provider conducting the physical examination was female. As one service user indicated: "Yes, this is part of what healthcare providers do. They ask for your permission that you are going to be examined. They will tell her: 'We are all females. We are of the same sex, so that we will be able to check you. Feel free and explain everything to us, we are going to examine you on your health."

Diagnostic testing

In FGDs in Zamfara, 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). 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. As one community member FGD

reflected: “She [the provider] will not tell her the type of test. But when the result is out and identify the problem, they will tell her.”

Prevention and treatment

FGDs with men and women suggested that health service users had generally positive experiences when it came 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. Most service users valued these explanations for enhancing treatment adherence and potentially improving outcomes.

In Zamfara, the availability of free drugs and medical services was cited as a significant facilitator for seeking treatment. As one Zamfara caregiver reflected: “I brought my child here for malaria treatment. We were warmly received. After examination, we were given a test, and the child was found malaria positive. The case was severe; therefore, we were admitted. He was treated and within few days, and then they discharged him.” 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 Zamfara 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.

Zamfara has adopted a multi-pronged approach that includes awareness creation, community dialogue by WDCs (e.g., educating husbands on the importance of ANC as they may prevent their wives to access the services), and the deployment of female health workers to provide ANC services. Furthermore, the introduction of commercial motorcycles to transport women to healthcare facilities has been an “innovative” and “practical” solution that further eased the access to ANC services, particularly for those who lived in hard-to-reach areas.

Despite these gains, several challenges persisted. 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, Zamfara, faces the unique challenge of insecurity, which poses a significant risk for women accessing healthcare services.

> *“The problem of refusal to attend ANC by pregnant women has ceased to exist. Now, we can say 100% of pregnant women attend ANC. This was a result of certain actions taken by the WDC, such as community dialogue. Also, in the past we had problem with pregnant women not coming to the hospital for ANC because there was no female staff to examine the pregnant women. The LGA provided female staff in all our hospitals to provide ANC service. Therefore, the pregnant women become satisfied and return to the hospital for ANC services.”* – WDC FGD, Zamfara

Use of health services: Child healthcare

The use of child healthcare services in communities in Zamfara 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 the 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 contributing to this positive trend.

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

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

When it comes to malaria prevention specifically, in Zamfara, the use of child malaria services reportedly spikes during the household distribution events of long-lasting insecticidal nets (LLINs) and seasonal malaria chemoprevention (SMC).

Use of health services: FP

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

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

Prior to the launch of sensitization efforts led by WDCs, uptake of FP services in Zamfara was considerably low due to the misconception that FP "interferes with women's fertility." However, the sensitization programs, which emphasized male engaging in FP, had significantly contributed to widespread acceptance of FP methods, even in traditionally conservative communities. Men were more commonly seen accompanying their partners or wives to health facilities for FP services. Additionally, the availability of free FP supplies and services and the strategic deployment of HFS specialized in FP were noted as major facilitators to FP acceptance and use within community.

Nonetheless, challenges still existed. FMC and WDC representatives cited the non-availability of preferred contraceptive methods like implants and the occurrence of undesirable side effects 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 Zamfara 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.
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 was linked to improved access to healthcare services. • Availability of drugs contributed to effectiveness of service delivery of and improvement in access to healthcare. • The implementation of SMC was reported to be significantly associated with improvements in the use of child malaria

		prevention services in community. • The distribution of LLINs was considered to be important for malaria prevention. • The deployment of female staff was seen as important for improving ANC and FP services.

For more information

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