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# Enabling Citizens' Collective Actions towards Improving Transparency and Accountability through the District Health System in Enugu State

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Accountability Research Center

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# Background

Government transparency and accountability together with citizen's participation are key components of governance. Yet, these are lacking in Nigeria's health system, which contributes to poor healthcare delivery in the country. In most cases, the citizens who are users of the health facilities are alienated from the health system, leading to poor access to healthcare by the citizens. Following the emergence of Dr. Chimaroke Nnamani[1] as the executive governor of Enugu state in 2003, reforms were initiated and implemented in the health sector. These reforms sought to reconfigure the power structure and enhance transparency and accountability by opening up the space from above to catalyze citizens' actions from below in the health system. The then-governor and the Hon. Commissioner for Health were the key state reformers who initiated and drove the reform aimed at improving transparency and accountability in the health system by empowering the citizens to actively participate in the health system administration. The reformers conceptualized the District Health System (DHS)[2] and in October 2003, mobilized the state health council composed of critical stakeholders such as private actors, public health service providers, donor agencies and development partners including United Nations Children's Fund (UNICEF) and World Health Organization (WHO).

The reformers invited the U.K Department for International Development (DFID) to join the health council to provide technical expertise through the Partnership for Transforming Health Systems (PATHS) and help with conceptualization and operationalization of the DHS (Uzochukwu, Onwujekwe and Ezumah 2014). In line with the reform agenda of mobilizing citizens for collective action, the Commissioner for Health, with prior written approval of the Governor, established a District Health Board (DHB) for each of the health districts in the state. Further, in September 2004, the governor inaugurated the various bodies of the District Health System (PDPD, SHB, DHB, and LHA [3]). In July 2005 the Enugu State House of Assembly signed the Bill establishing the District Health System (DHS) into law. The bill was signed into law by the Governor of the State in August 2005, thus establishing the DHS Policy document as a legally binding working tool for health care delivery system in the state.

The DHS had the Drug Revolving Fund (DRF) program as an integral component, designed to ensure the availability of medical supplies in health facilities. The idea of DRF and community participation in the management of such fund for effective health service delivery in health facilities is traced to the Bamako Initiative (BI). The BI was a set of strategies sponsored by UNICEF and WHO, adopted by African Health Ministers in 1987. The BI aimed to increase access to primary health care by raising the effectiveness, efficiency, financial viability and equity of health services through community involvement in decision making, financing and management of health facilities (Uzochukwu, Onwujekwe, and Akpala 2004). Nigeria adopted the BI in 1988 and the DRF component of the BI was first implemented in selected Local Government Areas (LGAs) across Nigeria including Enugu state in 1993. Hence, to ensure accountability and transparency in the management of the drug fund, the reformers mainstreamed the DRF into the DHS reform.

The DRF ensured that funds meant for drugs were not diverted. It also enhanced accountability and community participation in funds management. Available studies have shown that the DRF enhanced availability of drugs in health facilities where it was implemented under the BI (Uzochukwu, Onwujekwe, and Akpala 2002). However, little is known in the body of knowledge as to how the implementation of the DRF under the DHS in Enugu state opened up the space

from above through the actions of state reformers and catalyzed collective actions from the citizens. In the light of the foregoing, this study adopted the Sandwich strategy to analyze the triggers and effects of state reforms initiated and implemented by actors from above in the healthcare system of Enugu state. The Sandwich strategy in this case examined the activities of pro-accountability actors within Enugu state government in driving pro-accountability institutional change by cultivating synergy with civil society [citizens]. This strategy relies on the mutually reinforcing interaction between pro-reform actors in both state and society, not just initiatives from one or the other arena.

# Purpose and Scope of the Study

The purpose of this study was to analyze the triggers and effects of state reforms initiated and implemented by reformers from above. Specifically, the study applied the Sandwich strategy to explain how reforms initiated by state actors opened up spaces from above which enabled citizens' collective action and mobilization from below. The scope of the study was restricted to reforms initiated in the health sector of Enugu state since 2003. Hence, it focused on the DHS and the DRF component of the reform as was implemented in Enugu state between 2003 and 2017, when the law establishing the DHS was repealed.

# Methodology

## Study area

The study was conducted in Enugu State in South East Nigeria. The state has 366 primary health facilities scattered across its seventeen Local Government Areas (LGAs) (Uzochukwu et al. 2015). The state has an estimated population of 3.3 million based on the 2006 census figure (National Population Commission 2010).

## Data collection and analysis

A mixed methods approach was adopted for the study. Hence, both secondary and primary data were collected for the study. Primary data were obtained through a survey approach involving in-depth interview (IDI) of sampled respondents. This was complemented by documentary data from secondary sources. Data collected were analyzed using qualitative descriptive analysis based on a thematic process whereby quotes were organized into common themes and subthemes.

## Sample size and sampling technique

Cluster and purposive sampling techniques were adopted for the study. Cluster sampling was adopted to select at least one LGA from the seven health districts in the state as shown in table 3.1. Thereafter, purposive sampling was adopted to select respondents such as members of FHCs, staff of health department in the LGAs, staff of Enugu State Ministry of Health (SMoH) and Enugu State Primary Healthcare Development Agency (ENS-PHCDA), frontline health workers of the primary health facilities and health service users in the state. In all, 20 respondents were sampled and interviewed across the sampled LGAs.

**Table1. Categorization of health districts in Enugu/LGAs sampled from each district**

| Sn | Health Districts | Sampled LGAs |
|---|---|---|
| 1 | Enugu Ezike | Udenu |
| 2 | Nsukka | Nsukka |
| 3 | Udi | Udi |
| 4 | Agwu | Orji River |
| 5 | Ikem | Isi-Uzo |
| 6 | Agbani | Nkanu East |
| 7 | Enugu Municipal | Enugu East |

Source: Researchers' Field Work 2019

# Enugu Context and Sandwich Theory of Change

## District health system in Enugu State

The DHS was officially adopted in Enugu State in 2004 as part of a health system reform aimed at addressing the gaps in the states' health system. Prior to the introduction of the DHS, the state's health system was characterized by centralized administration, poor community participation, weak drugs supplies and management systems, and an ineffective referral system, particularly between the secondary health care and primary health care. There was a need to address these lapses by engendering community participation in healthcare governance in the state.

Through the DHS, each health district was structured to consist of the district hospitals which were at the apex of the referral system, followed by cottage hospitals, health centers, health clinics and health posts. Each level of care had a defined level of service package, manpower requirements, health equipment and infrastructure requirement. To strengthen referrals across the various levels of care, local transport union were engaged to assist in transportation of patients from one

location to another. Administratively, each district was semi-autonomous and had District Health Boards (DHBs) made up of Chief Executive Officers (CEOs) drawn from Faith Based Organizations (FBOs), Community Based Organizations (CBOs), Non-governmental organizations (NGOs) and Civil Society Organizations (CSOs) and appointed by the Governor. At the local government level, there was a Local Health Authority which reported to the DHBs while the CEOs of DHBs reported to the State Health Board. Each DHB also had Ward Development Committees (WDCs), Village Development Committees (VDCs) and Facility Health Committees (FHCs).

The DRF was mainstreamed as an integral component of the DHS to ensure availability of medical supplies in the health facilities. Hence, a committee made up of all stakeholders was created at the Central Medical Store to monitor drug supplies. Drug information system was introduced to ensure electronic management of drugs. Generally, DHS in Enugu state aimed to increase transparency and accountability in the state's health system through decentralization of health governance and increasing community participation in health governance. The expected output of the DHS included:

- Increased participation in monitoring and supervision of health facilities through the FHCs;
- Increased capacity of medical personnel to deliver quality health services;
- Enhanced infrastructural development in the health facilities, particularly the primary health system; and
- Increased access to drugs and health services by members of the community through the DRF and improved referral system.

The expected outcome of the DHS was deepened relationships between community members, health care services providers and state reformers by opening the space for community actions in the health system.

## Sandwich theory of change

The sandwich strategy demonstrates how the activities of pro-accountability state actors facilitated institutional change by cultivating synergy with civil society and mobilizing the citizens for collective action from below. Based on the analysis of health system reform in Enugu state initiative since 2003, sandwich theory of change underpinned the mutual reinforcement of the relationship between pro-reform actors in both state and society that catalyzed collective action from below. The Sandwich theory of change transcended the conventional two-dimensional framework for understanding state-society relations, to identify state-society pro-reform coalitions that collaborated for change—possibly by engaging in conflict with anti-accountability coalitions that also bring together actors in state and society.

In line with the Sandwich theory of change, the reforms initiated by Governor Chimaroke Nnamani and his Commissioner for Health had far reaching impacts in the health system in Enugu state. By decentralizing health system governance through the implementation of the DHS and the establishment of the DRF mechanism, state actors opened up the space for citizens to interface with government. The reform further mobilized non-state actors and created awareness among the citizenry on the need to demand transparency and accountability in health administration. Through the mechanisms of DHBs and FHCs, which were the key components of the DHS, the reform triggered and institutionalized local participation in the administration of primary health facilities because the FHC provided the platform for citizens' mobilization, interaction with state actors and participation in health administration.

However, there was resistance from the power-holders at the local government level such as elected councilors and bureaucrats who resisted the DHS because they felt it undermined their authority and supplanted their positions as critical stakeholders in the health system governance of the state. Hence, under the DHS, there was lack of agreement between the LGAs and State Ministry of Health (SMoH) over administration of primary health in the state.

# Insight from existing literature: health system reforms and citizens' collective action

This section deals with literature review which provides the basis for understanding the contexts in which citizens' collective action in the health sector emerges and the iterative movements between citizens' collective action and health system governance, particularly as it concerns reforms in the health system. It specifically examines the DRF and DHS both in terms of their differential impacts and mechanisms for reconfiguring the power structure in the health system. The review is guided by three key themes arising from the research puzzles raised in the study around issues of accountability and transparency in Nigeria's health system and community participation in health system administration.

## Accountability and transparency in Nigeria's health system

Issues of accountability and transparency are components of the health governance of any country. Health governance has to do with the range of policy making and implementation functions in the health sector as performed by institutions of government in the country. The state of accountability and transparency in Nigeria's health system reflects the poor state of health facilities in many countries and the challenges of healthcare delivery. This is not entirely due to the level of fiscal pace on health care but on how lack of transparency has negatively impacted the health system to the point of it affecting health care access.

In addition, evidence shows that Nigeria over the years has progressively shown commitments both at the national and international scenes on its efforts to fight practices that are not in line with best fiscal transparency conduct through its several policies and legal framework. One example is the 2014 National Health Act that established the Basic Health Care Provision Fund (BHCPF) to separate its account from the State health account, making financial reports available to the public. Yet, these commitments have not been followed through religiously to improve health outcomes. These gaps have caused a global concern on whether these commitments are mere political rhetoric.

However, Brinkerhoff et al. (2017) also demonstrate that accountability connects to health, governance, and links to health system performance. The study showed that accountability interventions matter considerably to health governance. However, the extent and nature of their impacts depend greatly on how interventions are carried out. The finding further showed that increased

access to information, social accountability efforts, increased effective health reporting, pay-for-performance financing, financial audits, and other strategies are associated with improved accountability and health system performance.

Uzochukwu et al. (2018) investigated accountability mechanisms for implementing basic health care financing options in Nigeria. The cross sectional study adopted purposive semi structured interview tool respondents at the national, state and LGA level to evaluate the different layers of implementation of primary health care and the levels of accountability and key stakeholders to implement the Basic Health Care Provision Fund (BHCPF) like Federal government (Federal Ministry of Health, NPHCDA, NHIS, Federal Ministry of Finance); the State government (State Ministry of Health, SPHCB, State Ministry of Finance, Ministry of Local Government); the Local government (Local Government Health Authorities); Health facilities (Health workers, Health facility committees (HFC) and External actors (Development partners and donors, CSOs, Community members). The finding showed that the strategies for accountability encompass planning mechanisms, strong and transparent monitoring and supervision systems, and systematic reporting at different levels of the healthcare system while non-state actors, particularly communities, must be empowered and engaged as instruments for ensuring external accountability at lower levels of implementation. In sum, studies reviewed have demonstrated that accountability and transparency are linked to improved health systems across the globe.

## Community participation in health system administration

State responsibility, especially as it relates to provision of equitable health care, has been a daunting task for most sovereigns; and to others, it is a responsibility they would rather evade. But the Alma Ata Declaration of 1978 presented a roadmap through which this challenge can be dealt with. The Declaration situated matters of health and conditions that promote good health as a fundamental human right (LeBan et al. 2013) and encouraged States to guarantee it through the instrument of community participation in health systems administration. States were required to promote and encourage communities to actively participate in the planning, organization, operation and management of health care delivery across the territories of the State (World Health Organization (WHO) 1978).

In spite of the above challenges, studies like LeBan, et al. (2013) contend that community participation is one of the potent ways to create opportunities for grassroot citizens to present a common front in ensuring that the State meet their need of primary health care, contribute to the effective and efficient administration of health care delivery, as well as building and rebuilding trust between the public and the health systems.

Further, 1978 Alma Ata Declaration refers to community participation in health systems administration as individual and collective involvement of people, through self-reliance and participation in the planning and implementation of their health care. With the foregoing, it is essential to note that the framers of community participation in health systems administration seek to engender both horizontal and vertical relationships among the key actors and stakeholders in health administration of any society. This tends to reduce the inequality gap in access to health care. Unequal access to health care will inevitably defeat the attainment of the lofty aims of Sustainable Development Goals (SDGs) 3, 10 and 16 by 2030.

# Global and Regional Drivers of Community Participation (CP) in Health Systems Administration

The need to restructure health systems administration in order to enhance access led to the concerted action by world and regional leaders at different fora to enhance inclusion of those at the grassroots in matters relating to their health needs.

## The 1978 Alma Ata Declaration

In 1975, the need to address the conspicuous inequalities prevalent in health and health related services within and between countries led to the proposal to convene an international conference on Primary Health Care (PHC) by the Executive Board of the World Health Organization and the World Health Assembly (WHO 1978). To this end, the International Conference on Primary Health Care was convened 41 years ago in Alma Ata, culminating in the Alma Ata Declaration of 1978.

## Bamako Initiative of 1987

The Bamako Initiative (BI) of 1987, was co-advanced by Ministers of Health in Africa and WHO African Region. The BI is an initiative committed to actualizing universal health coverage through increased community participation in health administration (Uzochukwu et al. 2004). The Initiative draws extensively from the Alma Ata Declaration by prioritizing Primary Health Care (PHC), especially for women and children. Community Participation through community financing of health care was one of the high points of the Bamako Initiative. Thus, BI encouraged community participation but with the central objective of getting communities to fund healthcare. Within the BI, community funding (user fees) became a key indicator of community participation in healthcare administration. The choice of participatory or community co-financing is in line with the principles of Structural Adjustment Programme (SAP), which encouraged reduction in government provision for social services and forced most African countries into adopting austerity measures as part of the World Bank conditions for indebted African countries (Yates 2019; Oluwole 2008).

Under the BI, the issue of "user-fee" charges, an amount paid by an individual in a community before they can access the primary health center, presents serious challenges for the smooth growth and development of the Initiative across Africa because of the inability of the underprivileged in society to pay (Garner 1989). Another argument for user-fee is that it will reduce government burden in its health spending and budget. With this, administration of primary health facilities under user-fee system will be dependent on the amounts levied on drugs that will also be sufficient to defray operational cost, drug replenishments and payment of salaries (Kanji 1989). When this becomes the case, Wilkinson contends that "Equity is at risk: charging users may reduce utilization by the poor. UNICEF maintains that people are willing to pay, but the real issues are whether they are able to and at what cost to themselves and their families" (Garner 1989, 227).

The BI has been criticized as having perpetuated the very health inequities they set out to address (Yates 2019). The reasons is connected to the fact that the co-financing component of

DRF by locals meant that that health care needs by them will have to be paid for. Consequently, access to primary health care hinges on the ability to pay. In accessing the successes and failures of the BI with its DRF ancillary in South East Nigeria, Uzochukwu et al. (2002) found that the PHCs were the BI/DRF were in operation had high availability of essential drugs, both in number and in average stock compared to those PHCs where BI/DRF were not implemented.

# Health Systems Reforms

Health system reforms have been adopted across countries for different objectives and with varying outcomes as can be seen by the experiences of various countries including Nigeria. Much of the health system reforms across Africa and in many developing countries tend to emphasize decentralization of health systems, which aims to grant more responsibility to government at the local level and the communities. Sue (2001) contends persuasively that decentralization is a key objective and outcome of health system reforms anchored on the basic principles of neoliberalism. This decentralization in the health system entails transfer of power arrangements and accountability systems from one level of government to another. Thus, health system reforms anchored on neoliberal decentralization leads to cutting down healthcare expenditure and transfer of healthcare provision to lower levels of government. Similarly, Mohan and Stokke (2000) agreed that decentralization in its neoliberal guise is mainly proselytized by global lenders and treats the local levels of government as functional economic space with policies designed to increase efficient service delivery. This position reflects how the local levels of government were mainstreamed in the health system through decentralization in order to enhance health service delivery as can be seen in the Bamako Initiative.

In a seminal study, Yip and Hsiao (2015) offered explanation on how neoliberal and communist ideologies have shaped China's healthcare system over the years. They illuminated how ideological struggle between pro-market and pro-government groups shapes government health reform and how such ideologically influenced reforms impact on the overall health service delivery in the country. The writers went further to reveal that by 1978, the government introduced neoliberal economic reforms characterized by health sector privatization and marketization. This resulted to introduction of user-fee, over-prescription by private practitioners, introduction of high-tech medical equipment, prioritization of curative over preventive medicine, disappearance of social insurance mechanism and re-appearance of out-of-pocket expenditure and a health system guided by profit motive. The outcome of such neoliberal reforms according to the authors was retrogression in general health condition in China as health indicators like child and maternal mortality soared, inequality in healthcare access also widened. This deteriorating health condition and the outbreak of deadly diseases like Severe Acute Respiratory Syndrome (SARS) in 2003 engendered widespread public outcry against the China's healthcare system. By 2009 the government retracted from the neoliberal health system to reform the healthcare sector and introduce a more benign healthcare system. As a result of the retraction from market-based healthcare system, China healthcare gradually began to experience improvements recorded before the 1978 neoliberal reforms.

While China has been lucky to retrace its step from neoliberal healthcare reforms leading to a more efficient health system, the story is different from Africa where reforms leading to decentralization have had mixed outcome. Drawing from the experiences of Kenya, Wamai (2009) revealed that neoliberalism shaped the country's healthcare when in 1978 the World Bank/ IMF neoliberal policies encapsulated in the Structural Adjustment Programs (SAPs) led to the introduction of user-fees, health insurance system, increased decentralization of healthcare management and involvement of non-governmental organizations (NGOs) in healthcare provision. Consequently, government spending on healthcare nose-dived, leading to increase in out-of-pocket payment for healthcare by households which increased to about 53.1 percent of total healthcare expenditures in Kenya. What the experience of Kenya shows is that the decentralization of health system was simply meant to absolve the government of its responsibility in healthcare provision. Though it increased participation of non-state actors in healthcare provisioning, households had to pay more for health services.

In Nigeria, decentralization of health systems is traced to the adoption of 1988 National Health Policy which led to recognition of primary healthcare as pivotal to Nigeria's healthcare system. Initially, the responsibility for managing and providing primary healthcare services was devolved to the local government, the third tier of Nigeria's federal structure. However, by 1992 the government set up the National Primary Healthcare Development Agency (NPHCDA) to enable the federal government to provide technical assistance and to assist in mobilization of both local and international resources for primary healthcare development. The role of the NPHCDA is to represent the federal government's support to primary health care with a mandate to provide technical assistance to states for primary health care development, planning, management, monitoring and evaluation, and mobilization of national and international resources. The states and local governments remain individually responsible for provision of services, recruitment, retention and deployment of staff, mobilization and allocation of funds, development of support systems for information management, supply chain, and logistics (Tilley-Gyado et al. 2016, 277–278). At the subnational levels, far reaching reforms were also implemented leading to decentralization in the health care system. For instance, Uzochukwu et al. (2014) examined the decentralization of health systems in Enugu state and argued that the District Health System (DHS) is a form of decentralized provision of health care where health facilities, healthcare workers, management and administrative structures are organized to serve a specific geographic region or population.

# Key Findings

## Enabling citizen collective action through the District Health System and Drug Revolving Fund

The implementation of DHS led to decentralization of health administration in Enugu state in ways that created spaces for citizens' participation in health system governance. Through the DHS, state actors decentralized the health system and put in place specific mechanisms to enable citizen collective action. This catalyzed power shift within the period of the reform because

it enabled the people to influence health policies from below through their membership of various bodies established at the district and community levels such as the DHBs and facility health committees (FHCs) which functioned effectively in many districts and communities within the reform period. Through the DHBs, the people participated in monitoring and supervision of health policy implementation in the districts. The DHBs also managed financial resources, determined health services rendered at the District, ensured regular supply of drugs and proper utilization. Members of the DHBs were selected by the Commissioner for Health from the LGAs within the District.

Furthermore, health committees were established across the villages to serve as a platform through which the communities engaged state actors and health administrators. In this regard, the facility health committees (FHCs) were put in place as a veritable platform for community mobilization and collective action as it allowed community members to make inputs in health planning, supervise, monitor and contribute to improved service delivery across health facilities. FHCs consisted of staff of the health facilities and members of the host communities selected by the community leaders. There were no universal criteria for determining membership of FHCs across all the communities. However, membership of the FHCs must include youth, women and people with disabilities who were selected for a renewable term of three years. Members of the FHCs were not paid salaries but communities were encouraged to reward them in any manner they considered appropriate (Ogbuabor and Onwujekwe 2018a). The FHCs operated at the facility level i.e. each health facility (health clinic) in the LGAs had FHCs that oversaw the activities of the health facility. This is because the DHS allowed for layers of health authorities: there was the State Health Board at the state level, DHB treated issues at the District level, Local Health Authority treated issues at the LGA level while the FHCs were formed at community level for participation in management of healthcare at facility level.

There was a general agreement across communities in Enugu state that creation of the FHCs by government enabled collective action and citizens' participation in health system governance. This view can be gleaned from some of the interview responses as follows:

> There was a committee called the facility health committee that the government created which membership was drawn from the community members and staff of the health facility. That was the only channel that the government created that enabled us make inputs in the health planning and management (Interview #10).
>
> The Facility Health Committees (FHC) helped the health facilities to function better by demanding that the government provide the requisite manpower needed to run the health center (Interview #1).
>
> I participated in the management of the health facilities in our community. I participated through the facility health committee. During the meetings, challenges that confronted the facility were discussed and resolved (Interview #3).
>
> There was community involvement in the DHS/DRF in our facility and it was done through the facility health committee (Interview #15).
>
> There was community involvement in the administration of the health facilities. We had what we called facility health committee which involved both the members of the community and staff members of the facility (Interview #2).

Apparently, the establishment of the FHCs was able to facilitate a power shift which endured within the period of the reform, 2004 to 2017. Although there was never a complete count of the FHCs in Enugu, the DFID-funded PATHS2 program supported the establishment and training of FHCs in about forty-five percent of Enugu State communities, including 228 FHCs in seventeen LGAs ("Sustaining Community Participation in Health" 2016). In 2016, eighty-four percent of people in PATHS2 program areas in Enugu indicated that FHCs had contributed to improvements in health facility services in the previous two years ("Study on PATHS2 Capacity Development: Final Report" 2016).

However, the FHCs are no longer active in various communities as many FHCs withered over time due to challenges related to non-remuneration of members, but more particularly, because of weak support from above [the state and local government authorities], the repeal of the DHS legal framework and the end of the PATHS2 project, which provided support and encouragement to the FHCs. Some members of the FHCs are still available in their various communities but they no longer perform any of their functions as FHC members and FHC meetings are no longer held as was done during the heydays of the DHS system, which lasted between 2004 and 2017.

Drug Revolving Fund (DRF) was another mechanism through which the government catalyzed citizens' collective action, creating a power shift in many communities within the period of the reform. Through the DRF, the government mandated the established FHCs to open financial [bank] accounts for their respective health facilities. The accounts were meant to be managed by members of the FHCs while the government would fund the account with initial capital. Expenses incurred by the communities were meant to be reimbursed through such accounts while the committees would give periodic reports to the government.

Essentially, the DRF provided avenue for members of the community to participate not only in supervision and monitoring of drug supplies, but also to ensure the timely replacement of drugs in the health facilities and the judicious use of funds meant for drugs. The success of the DRF in opening up the space for community action varied from community to community. In some locations, community members were given access to financial information of the health facilities and were allowed to participate in the operation of the DRF as signatories and/or co-signatories to the account. This however depended on whether the health facility staff/local government health authority were transparent and cooperative with community members. It also depended on the strength of the community members to carry their advocacy to the state health board and influence the SHB to mandate the facility staff and LGA health authority to grant requests of the community. As expressed by some respondents during the fieldwork:

> The DRF was a very good channel that brought our involvement in the supervision and monitoring of drug supplies. As signatories to the DRF bank account, we played active roles in drug supplies as we sign and approve every transaction for drug replenishment (Interview #11).

> We had full access to the finances and financial reports of the hospital and majority of the financial transactions of the hospital was managed by the committee... that as the chairman of the committee, that I also kept the bank cheque of the facility (Interview #5).

> We were involved in the day to day running of the hospital to the extent that a community member in the committee acted as the facility cashier around year 2003 when I was the committee chairman (Interview #5).

In some other communities, citizens' participation was suppressed as members of the communities were either not availed financial information relating to the DRF nor allowed to act as signatories to the DRF. This could have been because of suspicion by the facility and local government staff who felt that involving members of the communities in the financial operation of the facilities may negatively affect their interest and power position. For instance, some of the respondents remarked that:

> We had no information or access to the financial information of the facility. My participation in that regard ended with co-signing the cheque and going to the central medical store for drug procurement (Interview #9).
>
> We were not allowed any form of supervision on services, supplies or any transactions of the hospital, though, we severally complained [were to members of Facility staff/LGA Health authorities during the meetings with the community members] during the meetings about lack of seriousness on the part of the hospital staff, but nothing changed (Interview #9).
>
> We had no access or information about the hospital finances or financial reports. We also did not have information on drug availability and how they were procured (Interview #9)
>
> We were given access to financial information and reports, but we were not allowed to be signatories to the bank account. Though every financial transactions were discussed and approved at the committee meetings (Interview #12).

In other instances, expenses incurred by some FHCs to replenish drugs in the facilities were not reimbursed by the government as proposed by the DRF framework. Recall that the FHC system allowed the FHCs to incur expenses like replenishment of drugs. Such expenses were to be reimbursed by the state upon receipt of financial report from the FHCs. This failure by the government to reimburse the expenses incurred by the FHCs discouraged members of the FHCs and made them lose faith in the DRF. This was revealed by a respondent who remarked that: "All funds we raised and spent on the facility were never reimbursed by the government" (Interview #8). Another respondent who shared this view reported that: "There was no form of government support to us because we never received any incentives or even reimbursement of our personal expenses on the facility" (Interview #9).

## Role of external agents: Partnership for Transforming Health Systems (PATHS2)

The Partnership for Transforming Health Systems 2 (PATHS2) was a DfID program implemented between 2008 and 2016 as the health sector component of DFID's suite of State Led Programs (SLPs) being implemented in selected states across Nigeria including Enugu state. The SLPs, which began in 2007, were a set of interlocking programs at the state level designed within the context of DFID's joint Country Partnership Strategy for 2005–9 with the World Bank, which aimed to support Nigeria's economic reforms programs as contained in the NEEDS and SEEDS. Within the health sector, the SLPs conceptualized the PATHS2 program to serve as the overarching framework for healthcare intervention by DfID at both national and state levels.

The broad objective of PATHS2 was to improve the planning, financing and delivery of sustainable and replicable pro-poor health services for common health problems in the selected states. The specific goals of PATHS2 were amongst others to:

(i) Improve national health sector governance and management systems;
(ii) Improve state and Local Government Area (LGA)/district health sector governance and management systems to support appropriate health services;
(iii) Improve ability of citizens and civil society to demand accountability and responsiveness from the health system; and
(iv) Strengthen capacity of citizens to make informed choices about prevention, treatment and care (UK Department for International Development (DFID) 2017, 14)

Through the PATHS2 program, the DfID as an external agent contributed tremendously to opening up the space for citizens' collective action in the health sector in Enugu state. PATHS2 assisted in major revisions of the state's health policies particularly in the area of restructuring DHS to coincide with the existing LGAs and made it easier for the citizens to take ownership and influence health reforms at local level. It assisted in institutionalization of Facility Health Committees by facilitating monthly Monitoring and Evaluation (M&E) meetings of the FHCs and developed the supervision checklist for health supervisors at various levels. It mobilized citizens at the local level through awareness creation on the need for citizens to participate in health administration.

In the area of the DRF, PATHS2 assisted in turning the Central Medical Store (CMS) into an autonomous agency. It also worked together with the State Ministry of Health (SMoH) to establish the Sustainable Drugs Supplies System (SDSS) management committee with membership from both the private and faith-based organizations within the State.

PATHS2 helped in the establishment of in-state teams that included LGAs and chairmen of FHCs, who monitored health facilities to ensure accountability and that they procured from the CMS. The reactivated a M&E team supervised the secondary health facilities and also received and reviewed reports from the in-state team. The FHC chairmen became signatories to the facility DRF accounts. The DRF account had a component for M&E and capacity building which ensured that the entire system was self-funding. The DRF became self-sustaining because the system allowed the government to provide seed stock (initial stock of drugs) for the health facilities. The health facilities then dispensed the drugs to users who were charged user fee. In order to avoid stock out, the health facilities purchased required drugs when in need. At the end of the month, the health facilities sent financial reports to the government who reimbursed the facility of the amount expended in purchasing drugs.

In the past, the DRF management committee of Enugu state was in the SMoH but since 2012, the committee evolved with a management committee that has members outside the SMoH to include other ministries such as finance, representative of LGAs, CSOs and private providers, amongst others. PATHS2 helped them through these changes and also helped review the procurement process and the procurement manual to ensure that the DRF money was not used for non-DRF related expenditures (DfID 2017). This helped grow the purse and prevented decapitalization of the DRF. This further opened up the space from above allowing citizens to mobilize and influence the drugs supplies and management system from the grassroots.

It was unanimously affirmed from respondents across the sampled communities that the interventions of DfID through the Partnership for Transforming Health Systems (PATHS)2 played significant role in opening up the space from above to enable citizens' collection action from below. In this regard, a respondent said "… we were trained by PATHS2 on how to mobilize support from the community and create awareness" (Interview #6).

## Forms and extent of citizen collective actions in health system administration in Enugu State

Citizens' collective action arising from opening up the space from above included participation in health facility administration, involvement in ensuring drug availability and mobilizing community members to access health services.

### Facility administration

In the area of facility administration, the implementation of the DHS and the consequent establishment of the FHCs enabled members of the communities to play various roles such as planning and decision making, supervision, monitoring, and rendering of certain administrative services as was required from time to time. The extent of participation differed from one community to the other. In some places, participation was poor because of ineffectiveness of committee members, low level of awareness on the role of the committees, poor cooperation and lack of transparency/accountability from staff of health facilities, absence of effective feedback mechanisms from community members to health facility staff. In other places, participation was high because of the awareness of community members and the resilience of members of the committee in ensuring their health facilities were operational, cooperation of health facilities etc. This finding is also supported by Ogbuabor and Onwujekwe (2018b). According to some of the respondents:

> Our functions were to supervise and monitor staff attendance and behavior at work, provide health awareness to the community members, provide community services like cleaning and clearing of weeds, provision of security as well as fund raising from the community's political leaders for infrastructural maintenance at the facility (Interview #6).

> The committee did not actually play roles that involved the recruitment and request for health personnel, but we made good effort to supervise and monitor staff attendance and behavior at work. We monitored the staff that came to work late, those that did not come at all, as well as those that did not wear their uniforms while at work, our reports/complaints were promptly lodged with the office in charge (Interview #12).

### Availability of drugs

Prior to the reforms, many facilities were faced with problems such as stockouts i.e. exhausting of drugs in the facilities without replenishment; lack of access to existing drugs by users; diversion of drugs meant for facilities and general lack of accountability. Through the DRF established by the government with support of external agents like DfID-PATHS2, community members participated in the area of ensuring adequate utilization of the drug fund and availability of drugs in the health facilities. Again, the extent of participation in the DRF and successes recorded varied from location to location. Locations like Enugu East and Oji River recorded success in community participation in the DRF as can be gleaned from the responses of respondents below.

> Through the facility health committee, we monitored drug availability and requested for procurement and replenishment accordingly. As signatories to the DRF bank account, community members co-signed and approved all withdrawals and transactions for drug replenishment (Interview #10).

> We asked for information concerning drug availability in order to know which one to get and replenish and we also gave logistic support of transportation to the health worker assigned to go and get the drugs from the Central Medical Store (Interview #10).

However, in certain locations like Udi and Udenu, there were reports that the members of the communities were alienated from management of the DRF largely because of suspicion, lack of transparency and accountability by facility health staff together with LGA health authorities:

> We were not allowed to take part in the management of drugs or finances of the hospital. The then chief administrator informed me in one of our meetings that I would be made a signatory to the hospital's bank account, but that never happened as the same staff gave one reason or the other each time I asked about my being signatory to the bank account (Interview #6).

> We were not allowed to perform such function. Drug management was entirely a function performed by the management staff of the facility (Interview #6).

> We didn't participate much. Most times, all we hear is that drugs are no longer available. Sometimes, we hear that drugs were diverted and sold to private individuals (Interview #9).

The DRF mechanism helped to engender accountability and transparency in the drug management system of Enugu state healthcare. This was possible because community members as signatories ensured that all cash withdrawals were used only for drug procurement. Fund diversion from the DRF to another purpose was also mitigated. Various forms of checks and balances were introduced to ensure transparency. For instance, receipts and evidence of transactions were presented to the committee during the meetings, accountability was enhanced.

**Funding health facilities**

The implementation of DHS created space for communities to participate in funding health facilities particularly in the area of infrastructure and medical equipment. As noted by some of the respondents: "We made efforts to raise funds for the hospital" (Interview #11). Another respondent added: "In many occasions we were able to raise some fund for the maintenance of the facility, example was the money we used to provide borehole and water tank at the facility" (Interview #10). Obviously, the implementation of the ideals of the community participation in some locations was selective. Selective in the sense that government and health facility staff focused more on getting the communities to bear financial burden of healthcare provision with less emphasis on accountability/transparency. Yet, the health facility staff and some government officials did not want the community to demand accountability as regards the use of the funds.

**Community mobilization for accountability and health access**

The DHS enabled mobilization of communities to access health services and to demand accountability and transparency in healthcare governance in their various communities. For instance, some of the respondents explained how community members were mobilized to access available drugs in the health facilities. According to the respondents:

> When drugs became available, we educated the members of the community on the need to buy cheaper and quality drugs from the Health Center than to patronize local chemist and get fake or substandard drugs (Interview #10).

> The community members through the facility health committee carried out series of sensitization with regards to the availability of products and services in the facility. With that effort, the community members became more aware of the available services and utilized same. Community involvement in monitoring of staff and drugs also enhanced service delivery and availability of drugs which also attracted the patronage of the community members (Interview #15)

Yet in some other instances, leaders of the communities tried to negotiate for members to access health services at affordable rate. For instance, a respondent noted that: "we also intervened in negotiating payments by instalment for indigent patients (Interview #9). Another respondent added that: "The community intervened severally to make sure that child-bearing charges were slashed and made affordable for pregnant women due for delivery" (Interview #10). This view was supported by another respondent who reported that the FHCs:

> canvassed for reduction in the prices of some drugs for pregnant women undergoing their Antenatal Care (ANC); and also educated the community on the importance of patronising the health centres (Interview #1)

In the area of accountability and transparency, some of the communities convened meetings to discuss issues regarding the optimal productivity of the health center and also to make demands on the government to provide the necessary support for the health center. In the words of one respondent, "The Facility Health Committees (FHC) helped the health facilities to function better by demanding that the government provide the requisite manpower needed to run the health center" (Interview #1).

## Challenges and resistance to the reform

Although, the health system reform encapsulated in the DHS opened up spaces from above which enabled citizens mobilization and provided opportunities for their voices to be heard, the reform faced various challenges and resistance. First, the citizens in some cases could not fully utilize the opportunity provided by the reform particularly the FHC platform established. This was because some communities expected further monetary incentives from the government to continue functioning as members of the FHCs. For example, some of the respondents noted that:

> Government support to community participation in the management of health facilities came through the formation of the facility health committee which membership included both the members of the community and staff members of the hospital. But there was no form of government encouragement to the committee or community members. And because of lack of such logistics, many members of the committee stopped participating in the committee activities (Interview #10).

> Apart from our involvement in the facility health committee, which was made possible by the government, there was no other support provided by the government that was known to me (Interview #5)

Again, there was suspicion on the part of some healthcare personnel and LGA staff who felt that participation of community members in healthcare administration would undermine their authority as health officials. For instance, one of the respondents revealed that: "The refusal to

include community members as signatories to the bank account was the decision of the management staff of the facility" (Interview #18).

Further, the dichotomy between the staff of primary and secondary healthcare made it difficult for staff mobilization. Local government staff and personnel of primary healthcare feared they would be dominated and supplanted by staff of the secondary health facilities. Thus, due to this unfounded fear, the primary health care remained unintegrated. Recall that one goal of the DHS was to deepen collaboration between the primary health care and secondary health in the areas of administration, and service delivery through two-way referral system which would enable users to access quality health. However, LGA staff feared that this would undermine their powers at the local level given that there may be more senior officers at the secondary health facilities who would dominate decision making and to whom they may be mandated to report. Consequently, the two-way referral system was undermined because primary health staff were not always willing to communicate with the secondary health facilities. This challenge of distrust particularly impacted negatively on the two-way referral system and undermined access to healthcare.

## Outcome of citizens' collective action in Enugu State health system

The collective action of the communities arising from the opening from above enabled by the DHS reform brought about a power shift in the health system of the state wherein power shifted to the citizens as part of decision makers in the health system. Citizens were able to demand accountability and transparency as well as participate in the administration of the system unlike before the reform. For instance, through the DRF, an internal control process was introduced into the procurement process of the health system. This contributed to accountability in the health system. This was captured in the responses of some of the respondents.

> Because I was also a signatory to the DRF bank account, I co-signed and approved all withdrawals and transactions, it thus provided us an opportunity to monitor expenses which in turn ensured accountability and transparency as no single transaction would be carried out without our consent (Interview #10).

> Our demand was that the government should allow us full participation in the management of the facility including the drug and fund management so that we could make our own contributions and ensure as well that proper services are provided to our people and that financial accountability are observed (Interview 11).

> The fact that a community member was a signatory to the DRF bank account, there was a high level of accountability because he approved and signed every transaction. After the transactions, receipts were made available for the committee members to scrutinize (Interview #11)

> Since a community member was a signatory to the DRF account, every withdrawal received approval and it ensured accountability. The system also enhanced accountability and transparency following the fact that no single individual or staff was allowed to undertake any financial transactions on behalf of the facility alone. Every withdrawal must be signed by all the signatories to the bank account and after every transaction, receipts were presented to the committee members during the meeting for confirmation (Interview #9)

> Shortages were promptly noticed and the community member who was also a signatory to the DRF bank account would issue cheques after the committee must have approved the purchase. That process of strict monitoring of drug usage by people other than the facility administrators, made it possible that every drug used was replenished promptly. The system enhanced drug availability because it reduced both wastage and fund diversion. If fund meant for drug procurement cannot be diverted to other uses in the facility due to the fact that a community member was required to sign before the withdrawals, drug availability was then enhanced (Interview #9)

Again, transparency was introduced in the pricing system of drugs as health facilities were made to display the approved prices of drugs on their notice board to ensure users were not extorted. This was also revealed by some of the respondents as can be seen in the responses below.

> We ensured that prices of drugs were listed on the notice board and we informed the community members about it to avoid exploitation. (Interview #11).

In the area of equipment and infrastructural development, citizens' collective action arising from the DHS/DRF reform resulted in provision of various equipment and infrastructure for various health facilities across the state as presented in table 2.

**Table 2. Examples of contributions of the community members to primary health development**

| Items | Enugu |
|---|---|
| Infrastructure | Facility Health Committee (FHC) for Nsude Health Center, Udi LGA mobilized 500,000 naira from the Nsude Development Union in the United States to construct the generator house |
| | FHC Iji Nike, Enugu East LGA mobilized 500,000 naira to support construction of the staff quarter for the facility |
| | FHC Ozalla health center, Igboetiti LGA volunteered to dig placenta pit |
| | FHC Ukopi Health Center, Igboetiti LGA contributed in building of a new facility |
| | FHC Odoru Health Center in Nsukka LGA mobilised about 300,000 to be used for construction of a new health center |
| Hospital equipment | FHC Ozalla Uwelu Health Center, Igboetiti LGA mobilized 500,000 for procurement of hospital equipment |
| Water | FHC Agbamere Health Center, Nsukka LGA dug underground water tank |
| | FHC Ozalla Health center, Igboetiti LGA dug underground water tank |

Source: Partnership for Transforming Health Systems Phase Two (PATHS2) (2016)

However, this power shift did not endure beyond the reform period (2004 to 2017) and was not universal across all the communities in the State. The power shift did not endure because of three key factors: first, the change in political administration of the state in 2007 meant that much of the pro-reformers left government and were no longer in place to sustain the reform. This led to gradual weakening of the reform. Secondly, the end of the PATHS2 project in 2016 meant that both

state and non-state pro-reformers no longer got the external support that sustained the reform. Thirdly, the repeal of the DHS legal framework in 2017 brought to an end the structural framework on which the DHS operated.

The power shift was not universal across all the communities in Enugu State largely because of the localized internal weaknesses of the FHCs in some communities such as absence of incentives for FHC members as well as resistance by anti-reformers within the state health administration who frustrated attempt at ensuring transparency and accountability in the health system.

# Lessons Learned and Future Direction

The reform in Enugu state health system was far reaching because institutions were established to galvanize collective actions by the citizens from below. In this regard the establishment of the Facility Health Committees and the Drug Revolving Fund gave the citizens a sense of ownership in the reform and platform for mobilization and collective actions. This brought about a power shift in the health system of the state.

The case of Enugu State has shown that power shift brought about by reforms enabling opening from above may not endure when: there is a change in political administration leading to exit of pro-reformers who initiated the reform; the external actor which supports the reform exits or terminates the project through which the reform was supported; the legal framework enabling the reform is repealed.

The DfID through its PATHS2 project demonstrated the critical role of external actors in deepening reforms aimed at opening the space from above. The PATHS2 intervention institutionalized the FHC platform and thereby engendered iterative relationship between state reformers and non-state actors at the grassroots and at the same time built the capacities of both parties to actualize reform objectives in mutually beneficial ways.

There is a need to deepen awareness of community members and their ownership of reform processes so that they can look beyond immediate gratification in terms of monetary rewards for participating in community development and focus more on the output arising from such activities which stands to benefit the entire community. As the Enugu case study demonstrated, membership of the FHCs was voluntary but lack of incentives to the committee members also made several members to withdraw from active participation in the committees.

Resistance from anti-reformers because of fear of losing their power position if the status quo is changed and general poor understanding of the reform objectives could undermine power shift desired by the reform. The case of Enugu revealed that local government staff arising from fear of being dominated by more senior personnel from the secondary health facilities was not properly addressed by the reform. The fear of domination meant that reports from the LGAs were not sent to the secondary health, referrals were not done by the primary facilities. As such, citizens could not access the required services from the secondary health based on the referral system.

# Conclusion and Recommendations

The poor state of healthcare facilities and service delivery in Enugu state occasioned by absence of transparency and accountability in health system governance necessitated the initiation of the reform initiated by Chimaroke Nnamani in 2004. The reform saw the establishment of DHS in the state. The DRF, which was first adopted under the Bamako Initiative in 1987, was mainstreamed into the reform to ensure transparency and accountability in the drug management system of the state. Using the Sandwich theory of change, this study demonstrated how the reform by state actors encapsulated in the DHS and the DRF opened up the space from above and enabled citizens' mobilization and action from below.

The reform in Enugu state health system which was motivated by various factors such poor access to healthcare, poor health indicators of the citizens, weak community participation in healthcare administration had far reaching and was able to galvanize collective actions by the citizens from below. The Facility Health Committees and the Drug Revolving Fund gave the citizens a sense of ownership in the reform and platform for mobilization and collective actions from below.

The participation of citizens in health system governance paid off in various ways by deepening accountability and transparency in the health system in some locations where enhanced infrastructural development and increased access to healthcare were experienced. For instance, in communities like Nkanu West, staff quarters were built by the community, placenta pit was dug in Igboetiti, funds (300,000 naira) was raised for construction of new health center in Nsukka LGA. In places like Enugu East LGA and Nkanu East LGA, members of the local communities were made co-signatories of the DRF account, which enabled members of the community to know how funds were spent. Apparently, the DHS reform catalyzed power shift but the power shift did not endure beyond 2017. The power shift gradually weaned with the changes in political administration leading to exit of pro-reformers, the repeal of the DHS system in 2017 and end of the PATHS2 project. Currently, the FHCs have withered away in many communities because members hardly meet as they used to nor do they perform any of the functions they used to perform during the heydays of the reform (2004 to 2017).

## Recommendations

**State Reformers:**

- Mainstream conflict management mechanism in reform so as to ensure that conflicts arising from power shift due to implementation of reforms are quickly addressed. This will ensure that reform objectives are not thwarted.
- Deepen community participation in project design to ensure ownership and participation in reform implementation. This will ensure sustainability of the reform and replication of the lessons learned by the communities.

**Development Partners:**

- Enhance capacity of state reformers in the area of institutionalizing reform outputs so that reforms would last beyond the lifespan of the regime.
- Increase capacity of community leaders in the area of community mobilization and agenda setting. This will enable communities properly take advantage of openings from above to influence policies.

**Community Leaders:**

- Take ownership of reform and continue to strengthen established local institutions which serve as platforms for community mobilization and intervention in governance process.

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# Appendix

## List of State and Non-State Actors Interviewed

| Sn | Category (State or Non-State Actor) | Location (Town/ LGA) | Date |
|---|---|---|---|
| 1 | State actor | Isi Uzo LGA | 16 December, 2019 |
| 2 | State actor -Facility Health Worker | Isi Uzo LGA | 16 December, 2019 |
| 3 | State actor -Facility Health Worker | Nsukka LGA | 18 December, 2019 |
| 4 | State actor -Facility Health Worker | (Udenu LGA) Igugu Community | 12 December, 2019 |
| 5 | Non state actor | Nsukka LGA | 18 December, 2019 |
| 6 | Non state actor | Igugu community (Udenu LGA) | 12 December, 2019 |
| 7 | State actor | Udenu LGA | 12 December, 2019 |
| 8 | Non state actor | Enugu East LGA | 12 December, 2019 |
| 9 | Non state actor | UDI LGA | 12 December, 2019 |
| 10 | Non state actor | Oji River LGA | 12 December, 2019 |
| 11 | Non state actor | Nkanu East LGA | 13 December, 2019 |
| 12 | Non state actor | Nkanu East LGA | 12 December, 2019 |
| 13 | State actor | Enugu East LGA | 16 December, 2019 |
| 14 | State actor | Udi LGA | 12 December, 2019 |
| 15 | State actor | Oji River | 12 December, 2019 |
| 16 | State Actor | Oji River | 12 December, 2019 |
| 17 | State actor | Nkanu East LGA | 12 December, 2019 |
| 18 | State actor | Enugu Metropolis | 13 December, 2019 |
| 19 | State actor | Enugu Metropolis | 13 December, 2019 |
| 20 | State actor | Enugu Metropolis | 13 December, 2019 |

## Sandwich Project: Instrument for Non-State Actors

**Section A. Demographic Data**

1. Community: _____
2. LGA:_____
3. Category: a) Member of FHC ☐ b) Traditional Ruler ☐ c) Women Lead ☐
   d) Youth Leader ☐ e) Religious Leader ☐ f) Others (specify) ☐
4. Gender: a) Male ☐ b) Female ☐

**Section B. Community Participation in Health Facility Management**

5. Do you participate in management of health facilities in your community?
   a) Yes ☐ b) No ☐
6. In what specific areas do you participate in management of health facilities in your community
   a) Decision making ☐ b) Fund raising ☐ c) community service ☐
   d) Supervision & Monitoring ☐ e) Health awareness ☐ f) Others (specify) ☐
7. Do you have any form of meeting with other members of the community to address health related issues?
   a) Yes ☐ b) No ☐
8. If yes, how often do you have this meeting at the community level?
   a) Month ☐ b) Quarterly ☐ c) Once a year ☐ d) As need arises ☐
9. Do you know about the Drug Revolving Fund (DRF)?
10. In what way do your community participate in the management of drug supplies under the Drug Revolving Fund (DRF)?

**Section C. Government support/enabling environment**

11. In what ways did the government support community participation in management of health facilities through the District Health System (DHS)?
12. What specific channels/forum did the government (local & state governments) to enable your community make input in health planning, decision making and implementation?
13. What specific channels did the government establish to enable the community supervise and monitor drug supplies and service delivery in the facilities?
14. Did the government give you access to the financial reports (revenue and expenditure) of the health facilities?
15. Did government reimburse money spent by the community on drugs and other health expenses?

**Section D: Mobilization from Below/Actions by Community Actors**

16. How did you participate in mobilizing funding for healthcare at the local level?
17. How were members of the community mobilized to participate in decision making in healthcare?
18. What did your community do to ensure community members accessed drugs and other health services in the facilities at affordable rate?
19. What did your community do to ensure that drugs were available at the health facilities or replenished as at when due?
20. What did you do to ensure trained health personnel were available at the health facilities?
21. In what ways did the community supervise health facilities to ensure accountability and transparency?
22. What other demands did the community place on the government?

**Section E: Challenges and Threats to local mobilization**

23. What key challenges or threats did you encounter in demanding accountability and transparency?
24. Who were the key actors that resisted your demand for accountability and transparency in healthcare?
25. Do you think your participation/achievements in health management is sustainable in the near future?

## Sandwich Project: Instrument for Primary Health Service Providers/LGA Health Administrators

**Section A. Demographic Data**

1. Category: LGA Health Supervisor ☐ Facility Health Worker
   Others (specify)_____
2. Level/Position/Rank: _____
3. Gender: Male ☐ Female ☐

**Section B: Avenues/Areas of Community Participation in Primary Health Administration**

4. Is there any community involvement in the administration of health facilities?
5. In what specific areas are members of the community involved in administration of the health facilities?
6. What forum was established for interaction between health facilities administrators and members of the communities?

**Section C: DHS/DRF and community participation**

7. What specific systems/channels were established under the DHS and DRF to enable community participation in administration of health facilities?
8. How did community participation under the DHS/DRF enhance drug supplies and availability in the health facilities?
9. How did community participation under the DHS/DRF enhance access to healthcare by members of the community?
10. How did community participation under the DHS/DRF enhance accountability and transparency in the management of health facilities?

**Section D: Challenges and Sustainability**

11. What forms of resistance to change did you experience with the implementation of DHS/DRF?
12. Who were the key antagonist to the DHS/DRF reforms?
13. How was this resistance resolved?
14. How sustainable is the level of citizens' demand for transparency and accountability in health administration in the community?

## Sandwich Project: Instrument for State Actors

**Section A. Demographic Data**

1. Category: a) State Ministry of Health ☐ b) State Primary Health Development Agency ☐
2. c) Others (specify)_____
3. Level/Position/Rank: _____
4. Length of Service: a) 1-5 years ☐ b) 5-10 years ☐ c) over 10 years ☐
5. Gender: a) Male ☐ b) Female ☐

**Section B: State Reforms Enabling Mobilization from Below**

6. How did the state enable community participation in health through the District Health System (DHS) and Drug Revolving Fund?
7. Which key state actors/personalities/ministries initiated and drove the reform?
8. What form of resources/empowerment were given to the communities to enable their participation?
9. What forum or channels were established for community participation in health administration?
10. In what specific areas were the communities enabled to participate most?

a) Decision making ☐ b) Fund raising ☐ c) community service ☐

e) Supervision & Monitoring ☐ e) Health awareness ☐

g) Others (specify) _____

**Section C: Triggers of Opening from Above**

11. What national or state reforms led to initiation & implementation the DHS and DRF?
12. What key objectives/goals did the state intend to actualize through the DHS and DRF?
13. Which international partners supported the DHS and DRF, how and why?

**Section D: Outcome of Collective Action**

14. How did community actions engender accountability and transparency in primary health administration?
15. 1How did community actions impact on sustainable drug supplies/availability in the health facilities?
16. How did community actions impact on health service delivery and access by members of the communities?

**Section E: Challenges encountered in opening the space from above**

17. What resistance were encountered in trying to encourage community participation?
18. Which power holders resisted the reform most?

19. How was the resistance addressed?
20. What is the sustainability of the achievements under the DHS and DRF?

## Enugu State 7 Health Districts across the 17 LGAs

| Health District | LGAs |
|---|---|
| **Enugu Ezike** | Udenu |
| | Igbo-eze North |
| | Igbo-Eze South |
| **Nsukka** | Nsukka |
| | Igbo-Etiti |
| | Uzo-Uwani |
| **Udi** | Udi |
| | Ezeagu |
| **Agwu** | Orji River |
| | Aniri |
| | Agwu |
| **Ikem** | Isi-Uzo |
| **Agbani** | Nkanu East |
| | Nkanu West |
| **Enugu Municipal** | Enugu East |
| | Enugu North |
| | Enugu South |

# Notes

1 Dr. Chimaroke Nnamani is a medical doctor and was the executive governor of Enugu state between 1999 and 2007.

2 The law establishing the DHS in Enugu State was repealed by the Enugu State Health Sector Reform Law 2017. The new state health system called Ward Health System established Local Government Health Authorities in line with Enugu State Local Government System.

3 PDPD – Policy Development and Planning Directorate, SHB—State Health Board, DHB—District Health Board, and LHA – Local Health Authority.

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