The Independent Monitoring and Evaluation Project for the State Level Programmes (IMEP)

Study on PATHS2 Capacity Development: Final Report

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Executive summary

Overview

This report outlines the findings of a study of PATHS2's support to capacity development in health in Nigeria. PATHS2 is a DFID-funded development initiative that aims to support Nigeria in achieving the health related Millennium Development Goals, with particular emphasis on maternal and child health. The purpose is to improve the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems.

The PATHS 2 programme has established five key outputs or deliverables, each supporting a different aspect of the health sector:

1. Strengthened stewardship role for health at the National level,
2. Improved stewardship and management systems at State/Local Government Authority (LGA) level to support appropriate health services,
3. Improved Service Delivery and access to health services and supplies,
4. Strengthened ability of citizens and civil society to hold local health authorities and service providers to account and increase the responsiveness of the health system,
5. Strengthened capacity of citizens to make informed choices about prevention, treatment and care.

The study has sought to answer the following question:

> "How effective has PATHS2 support to the federal level, to states and to LGAs been in developing capacity to perform their key functions, i.e. to develop health policies and legislation; to plan, finance, and manage health services, including adequate staffing and logistics; to set up and use reporting systems with high quality data; and to improve access to and utilisation of basic health services?"

Federal level

PATHS2 has played an important role in developing capacity at Federal level in all three dimensions of institutional, organisational and individual capacity for each of the areas of activity studied - policy and planning, Health Management Information System (HMIS) development, Human Resources for Health (HRH), and the National Primary Health Care Development Agency (NPHCDA). Much of the capacity development remains relevant and useful although concerns were expressed about meeting expectations placed on Planning, Policy and Research and about the insecurity of funding for HRH development. The capacity development achieved has not been consolidated by the provision of adequate federal government funding for implementation and maintenance of the systems that have been built and so there are significant concerns about sustainability. PATHS2 contributed to the eventual passage of the National Heath Act which should provide an improved national framework for health policy.

State level

There have been significant improvements in capacity at state level to govern, plan and budget for health services, although continuing investment needs to be assured in order to sustain these improvements. In each of the States arrangements for the procurement, supply and affordable availability of drugs have been radically improved. Capacity has been developed to capture health related information and to transmit, summarise and use it for planning and evaluation purposes.

However, there is evidence that the system does not work entirely as intended in that data capture remains incomplete and the benefits of the investment made by PATHS2 will be lost unless there is an ongoing budget to support the maintenance of the system at all levels.

The arrangements for staffing the health system effectively remain inadequate with responsibilities continuing to be diffuse and poorly defined in each of the focal states except Jigawa, The consolidation of primary health care (PHC) functions under State Primary Health Care Development Agencies (SPHCDAs) has the potential to unify the planning and provision of health care and leadership of all aspects of human resource management, but this has not taken place in the states in which PATHS2 has worked.

LGA level

The findings at LGA level in Enugu, Kano and Jigawa reflect the findings for state level capacity building in that PATHS2 was extremely successful in building capacity in planning and budgeting, HMIS management and drugs supply, however the sustainability of the gains made in planning and budgeting and the HMIS system are fragile due to lack of funding to maintain the systems whereas the drug supply system is fully self-sustaining. Only in Jigawa with the Gunduma Health System is there a robust link between State level and LGA level, which enables state wide plans to be operationalised effectively at LGA level and the implementing officials to be held to account for their performance by the Gunduma Board senior management.

Facility level

The research undertaken at facility level with staff, facility health committees and communities indicates that all these groups in each of the three States report significant gains as a result of PATHS2's activities relating to service availability and uptake, health improvement in terms of reduced mortality, staff competence in key, especially life-saving, skills, improved efficiency and morale through better managerial support and community engagement, improved physical environments, drug availability and referral arrangements. It is also true that the gains are not universally available and it is difficult to measure the level of coverage achieved. There is a lack of on-going investment and unless this can be made good the system will at best remain at its current level of performance and might even in time revert to pre-PATHS2 levels of performance.

Sustainability

While PATHS2's interventions have been effective in developing capacity almost whenever they have intervened, some of the capacity gains are in danger of being short-lived as result of lack of continuing investment. This problem has been intensified by the severe fiscal pressures that have resulted from the collapse of oil prices from late 2014.

Impact on utilisation of health services and health outcomes

There is evidence of improved health outcomes in the PATHS2 states though the extent to which these improvements can be attributed to PATHS2 interventions is difficult to establish.

Implications for DFID

PATHS2 has demonstrated that a focus on health systems strengthening can yield results in terms of improved sector management and health outcomes, though this requires long-term commitment and engagement. Ongoing DFID support through the MNCH2 project provides a mechanism for

some continuation and extension of training support, but sustainability will fundamentally depend on the extent to which political commitment to higher levels of spending on primary health, and to improving its management, has strengthened.

This will be determined in part by the extent to which electoral benefits are seen by politicians as accruing to demonstrated success in strengthening service delivery, rather than just investing in visible physical infrastructure, or implementing high profile but often unsustainable policies of free drug provision. The major challenge for consolidating the capacity development achieved will be to secure recognition and encourage leadership from Federal and State level of the need for continued funding to implement reforms and roll out improved practice. The National Health Act provides a framework for this, but the approach of the new Federal government will be of key importance for providing policy direction.

PATHS2's experience has also highlighted the continuing need for integration and strengthening of PHC system management, and the need for greater attention to be paid to workforce planning and human resource management. Only limited progress has been made in implementing integrated PHC management through SPHCDAs, and while the Gunduma model in Jigawa has had some success, it also has not been replicated elsewhere.

These conclusions have the following implications for DFID's continued and future programming:

- DFID should continue to advocate, and to promote through its interventions and projects, a systemwide approach to strengthening PHC management and service delivery, in line with Nigeria's health policies and objectives.

- Greater attention should be paid to understanding political incentives and determinants of political commitment for DFID's health sector interventions, with lessons potentially to be learned for the health sector from DFID's parallel education sector project, ESSPIN.

- A clearer position should be developed (working in particular with NPHCDA and the Federal Ministry of Health) about the SPHCDA model and how integration and strengthening of management of PHC can in practice be achieved,

- Greater attention should be paid to human resource management issues for the health sector since this appears to be a critical bottleneck to improved systems performance. Again, consolidating the management of PHC staff under an SPHCDA has potential and effective ways of implementing this need to established.

- It is notable that PATHS2 has focused largely on the public sector, although the private sector plays an important (and in some cases dominant) role in service provision in many parts of Nigeria, particularly in urban areas and the South. DFID's future interventions should reflect more systematically the role of the private sector, and issues of regulation and synergies with the public sector as part of an overall PHC strategy.

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List of abbreviations

ANC	Ante-natal care
AOP	Annual operating plan
CHC	Community health committee
CSO	Civil society organisation
DFID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey
DRF	Drug Revolving Fund
EOC	Emergency Obstetric Care
ESSPIN	Education Sector Support Programme in Nigeria
FHC	Facility health committee
FMoH	Federal Ministry of Health
FP	Family planning
GEMS	Growth and Employment in States
GHSB	Gunduma Health System Board
GHSC	Gunduma Health System Council
HMIS	Health management information system
HRH	Human resources for health
HRHIS	Human resources for health information system
HRIS	Human resource information system
IMEP	Independent Monitoring and Evaluation Project
IMCI	Integrated management of childhood illnesses
IMR	Infant mortality rate
LGA	Local government authority
LGSC	Local government service commission
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MMR	Maternal mortality rate

MNCH	Maternal, neonatal and child health
MTR	Mid Term Review
NAFDAC	National Agency for Drugs and Administration Control
NHA	National Health Act
NPHCDA	National Primary Health Care Development Authority
NSHDP	National Strategic Health Development Plan
PATHS	Partnership for Transforming Health Systems
PCR	Project Completion Report
PHC	Primary health care
PHCUOR	Primary health care under one roof
PRRINN	Partnership for Reviving Routine Immunisation in Northern Nigeria
SAVI	State Accountability and Voice Initiative
SDS	Service Development Strategy
SDSS	Sustainable Drug Supply System
SLPs	State level programmes
SMoH	State Ministry of Health
SPARC	State Programme for Accountability, Responsiveness and Capability
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
TOR	Terms of reference
WHO	World Health Organisation

1 Introduction

This Report presents the findings of a study of the capacity development achievements of the "Partnership for Transforming Health Systems Phase Two Programme" (PATHS2) project. PATHS2 is a six year (2008 to 2014) Department for international Development (DFID) funded programme implemented at federal level and in five focal states in Nigeria. PATHS2 aims to improve governance and service delivery in health, working with key institutions to develop their capacity to plan and manage the delivery of healthcare with an emphasis on better use of Nigeria's own resources. Although PATHS2 implementation has now ceased in three States (Jigawa, Enugu and Kano), there is a two year extension to the programme in Lagos and Enugu until 2016. Additionally the DFID funded Maternal Neonatal and Child Health Project Phase 2 (MNCH2) is taking forward some of the PATHS2 interventions.

This study assesses:

- The extent to which PATHS2 has been successful in increasing the capacity of the health system so as to bring about demonstrable and sustainable improvements in the health of the population and the efficient provision of effective and accessible healthcare;
- To the extent that the programme has been successful in building capacity that leads to improved performance, which PATHS2 interventions led to this success; and
- What were the mechanisms by which improved capacity at one level of government led to improved capacity at other levels.

The study was informed by the perspective that capacity development occurs at individual, organisational and institutional levels. It focused particularly on the development of organisational capacity at each level of government and service provision (Federal, State, Local Government, facility/community). It examined the structures, processes and resource flows that are key to the continuing effective operation of the health system, as well as the influence of the institutional context within which organisations operate, and the role of other actors. The study was informed by a parallel study of capacity development achievements by DFID's Education Sector Support Programme in Nigeria (ESSPIN).

The Report starts with an Introduction. Chapter 2 sets out the objectives, research questions and approach to the study; Chapter 3 outlines the methodology; Chapter 4 summarises PATHS2's capacity building interventions; Chapters 5 to 8 set out respectively, findings about capacity development achievements at Federal, State, LGA and facility levels whilst conclusions and implications are given in Chapter 9. Annex A provides the Terms of Reference (TOR), and Annex B the instruments used for interviews. A list of key informants is not provided for confidentiality reasons but is available in case more information on sources is required to check information. A summary of capacity building activities by state and output area is also available but not included in the report for space and presentational reasons.

2 Objectives, Research Questions and Approach

2.1 Objectives

The TOR define the objectives of the study as being to: “assess PATHS2’s contribution to building capacity in the five states in which it has worked in the following areas:

- Developing systems and capacity in health policy, strategy and financing,
- Improving the Human Resources for Health system’s capacity to plan, manage and develop the health workforce,
- Improving logistics systems to procure and supply drugs and equipment,
- Improving capacity to develop and maintain monitoring and evaluation (M&E) and reporting standards through the Health Management Information Systems,
- Improving capacity of health facilities and providers to deliver quality maternal and child health services, improve access to services and enhance uptake of primary health care services.”

The study explored the conditions under which PATHS2’s activities have made contributions to improving performance in these areas, the likely sustainability of the capacity developed including the routes through which its activities at each level of the health system have affected other levels. The robustness of systems to govern, plan, budget and supervise the organisation and delivery of healthcare from one level to the next with appropriate accountability is essential to ensuring provision of quality primary healthcare to the communities who are dependent on these services.

The study has focused on the following organisations:

- The Federal Ministry of Health (FMoH) and the National Primary Health Care Development Agency (NPHCDA), at the federal level;
- The State Ministries of Health (SMoHs) and the State Primary Health Care Development Agency at the state level;
- Local government Authority (LGA) Primary Health Care (PHC) Departments;
- Health facilities (primary health care and comprehensive health care centres); facility health committees (FHCs);
- Civil Society Organisations (CSOs).

The study focused on the following dimensions of capacity which relaed to major areas of PATHS2’s activities:

- Capacity to govern including policy making, manage and supervise the system effectively at each level including planning and budgeting (federal, state, local government area, facility and community) and to develop and maintain effective governance linkages between the levels,

- Capacity to use the Human Resources for Health system to plan, recruit, train, deploy and develop the health workforce, again at all five levels at which the health system is governed, managed and delivered,

- Capacity to operate the logistics systems to procure and supply drugs and equipment, from federal to facility level,

- Capacity to develop and maintain M&E and reporting standards through the Health Management Information Systems at all levels.

2.2 Research questions

As suggested in ToR the research questions were reviewed during the preparation of the Inception Report. The headline research question remained as in the terms of reference:

> "How effective has PATHS2 support to the federal level, to states and to LGAs been in developing capacity to perform their key functions, i.e. to develop health policies and legislation; to plan, finance, and manage health services, including adequate staffing and logistics; to set up and use reporting systems with high quality data; and to improve access to and utilisation of basic health services?"

The specific research questions were modified from those set out in the ToRs in order to:

- Link them closely to each level at which health services are planned, managed and used,

- Make them specific to the objectives of the study,

- Take into account the suggestion given in the summary of the 2015 Annual Review that some PATHS2 interventions have been more successful than others and,

- Stress the importance for the successful functioning of the health system of having robust mechanisms of governance, management, planning, budgeting and supervision that link one level to the next.

The following research questions were addressed:

1. Have there been improvements in capacity to govern, plan, budget and supervise the health system effectively, to plan, manage and develop the health workforce, to procure and supply drugs and equipment and to develop and maintain M&E and reporting systems?

2. Have changes in capacity at federal level translated into improved performance of the health system at State level and if so, what have the transmission processes been?

3. Have changes in capacity at state level translated into improved performance of the health system at LGA level and if so what have the transmission mechanisms been?

4. Have changes in capacity at LGA level translated into improved performance of the health system at facility level and if so what have the transmission mechanisms been?

5. Have there been improvements in capacity at facility level to deliver effective healthcare services, in the quality and availability of health workers, in the availability of essential medicines and in the reporting and use of information for monitoring and evaluation?

6. Have there been resulting changes in utilisation of health services and health outcomes?
7. To what extent can improvements in effectiveness at federal level be attributed to PATHS2 interventions?
8. Is there evidence that capacity has been built at institutional, organisational and/or individual level even where capacity development has not yet led to improvements in outputs and outcomes?
9. To what extent have synergies with other initiatives (e.g. other DFID programmes including the other State-level programmes, other donor programmes, Federal or State initiatives) contributed to the capacity development observed at each level?
10. How have the interests and influence of different stakeholders contributed to the capacity development observed at each level?

2.3 Methodology

A starting point for the study was a desk review of literature which included:

- Annual Reports of the programme;
- State Annual Reports;
- Log-frames;
- Reports of Annual and Mid-term Reviews;
- Reports of the PATHS2 Household Surveys;
- PATHS2 Policy Briefs;
- Reports produced by PATHS2 on various aspects of planning and implementation;
- The ESSPIN capacity development study (Allsop et al,, 2016).

This review was intended to enable an understanding to be formed of PATHS2's capacity enhancement intentions, strategies and activities and to form the basis of a judgement on the extent to which PATHS2 has articulated coherent capacity building strategies and implemented them successfully in line with the plan. It included quantitative analysis of available data especially related to programme performance. The results of the review have been articulated in a set of summaries of state level information on PATHS2 activities, outputs and outcomes (available on request).

The information summary was also used to inform the process of developing instruments/questionnaires for use in key informant interviews and focus group discussions. The questionnaires were designed according to the individual or group to be approached and their role in the health system. They related to capacity - building activities and players at federal, state, LGA, facility and community levels. These are attached as Annex B.

Three research teams were formed to undertake field research in Jigawa, Kano and Enugu. There were two national lead researchers and an international team leader each of whom led a state team of two researchers at least one of whom was female in two out of the three teams. The national team members in Jigawa and Kano were all speakers of Hausa, and were chosen for their

interviewing and quantitative analysis skills as well as their ability to empathise and engage effectively with local communities.

In each state four LGAs were selected for study together with two primary healthcare facilities and their associated communities in each of the LGAs. Selection of the four LGAs in each state initially aimed to ensure the selection of a representative group of focal and non-focal LGAs with an urban and rural mix, however on further discussion in Abuja it was clear that little would be learned from visits to non-focal LGAs and that in the north, that for security and travel distance reasons some LGAs should be excluded from the selection and that the demonstration LGA in each State should be included. In the event therefore LGAs were selected not at random but so as to get the best possible mix of LGAs using these criteria. Two primary health care facilities were chosen where possible at random from the total list of facilities in each of the four selected LGAs but with consideration of accessibility as a factor in the northern States.

The team leader and the two lead researchers met in Abuja to:

- Review the summary of PATHS2 activities, outcomes and outputs and the messages it contained on the success of the capacity enhancement activities undertaken by PATHS2;
- Review the research questions and templates;
- Meet PATHS2 staff to gain their perspective on the capacity building processes used during the lifetime of the programme and their effectiveness;
- Meet federal level actors in health system development to understand the contribution to enhanced effectiveness of the FMoH and the National Primary Health Care Development Authority (NPHCDA) made by PATHS2's technical assistance,;
- Plan access to key informants in the states that no longer have PATHS2 offices;
- Train the field researchers in use of the research question templates and analysis of results.

It was also hoped to meet with team members from other programmes e.g. State Programme for Accountability Responsiveness and Capability (SPARC) to understand their joint contribution to capacity building for instance in budgeting and planning, however because of time constraints this was not possible.

It was also not possible to gain access to Federal level key informants during this week because they were not available for discussions and the team planned to reconvene in Abuja at the end of the State level work by which time it was hoped that interviews could have been set up with appropriate key informants. In the event there were again difficulties in accessing some key informants at the Federal Ministry and NPHCDA, consequently a third and more successful attempt to meet key informants was made again with the assistance of PATHS2 and the Independent Monitoring and Evaluation Project (IMEP) early in 2016

The teams then moved to Jigawa, Kano and Enugu States respectively and undertook key informant interviews based on the research question templates at SMoHs, at LGAs with primary healthcare management teams and finance leads and then with in-charges and staff members at primary health care facilities, with Facility Health Committees and with community leaders. Time in the field was at a premium and did not allow for discussions with State based MNCH2 teams.

At the conclusion of the data gathering process the national lead researchers met the teams to ensure data had been captured effectively and that the results were written up in an appropriate format. The two national lead researchers then visited Kaduna and Lagos to undertake discussions based on the state level research questions with SMoH and SPHCDA key informants. At the conclusion of the data gathering process the team leader, lead researchers and researchers met over a two day period to synthesise the study results.

Evidence was collated in relation to each of the research questions and summary statements produced that reflected the findings of the teams in each state. From this a summated response to the research questions was derived as the basis for the preparation of this report. In order to preserve confidentiality, a list of key informants is not presented in the report.

3 Overview of PATHS2 Implementation

3.1 PATHS2 within the DFID Nigeria programme

PATHS2 is a DFID-funded development initiative that aims to support Nigeria in achieving the health related Millennium Development Goals, with particular emphasis on maternal and child health. It succeeded an earlier project (PATHS1) which operated from 2002 until 2008.

PATHS1 supported local initiatives to strengthen government stewardship in health policy, planning and financing; improve management in public health, particularly at local level; raise quality standards of preventative and curative services, particularly in the areas of malaria, TB, reproductive health and sexually transmitted infections, safe motherhood and childhood illnesses;and raise awareness of people's entitlement to good quality, affordable care and increase their ability to prevent and manage certain health conditions. It operated in four states (Enugu, Jigawa, Kaduna and Kano).

PATHS2 commenced in 2008 with implementation in five States, three in Northern Nigeria (Kano, Kaduna, Jigawa) and two in the south (Enugu and Lagos). Work in the Northern states was completed in January 2015, following an extension from the original end-date of July 2014. A two year extension for work in the southern states to mid-2016 has been agreed and is in progress. The coalition government in the UK came into power at the time of the Mid-Term Review and pressed for more tangible results to be evident from PATHS2; this led to the development of the service delivery strategy with its eight pillars that it was hoped would be widely replicable.

The goal of PATHS 2 is to support Nigeria in using its own resources efficiently and effectively to achieve the Millennium Development Goals (MDGs) set for the country. The purpose is to improve the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems.

The PATHS 2 programme has established five key outputs or deliverables, each supporting a different aspect of the health sector:

1. Strengthened stewardship role for health at the National level,
2. Improved stewardship and management systems at State/LGA level to support appropriate health services,
3. Improved Service Delivery and access to health services and supplies,
4. Strengthened ability of citizens and civil society to hold local health authorities and service providers to account and increase the responsiveness of the health system,
5. Strengthened capacity of citizens to make informed choices about prevention, treatment and care.

No complete Theory of Change for PATHS2 was articulated before or during its implementation. The PATHS2 Project Completion Report (PCR) of 2015 sets out an inferred theory based on the Extension Business Case:

- Problems to be addressed are the high rates of maternal mortality (MMR) and infant mortality (IMR) particularly amongst poorest;
- Causes – poor public and private health services and various barriers to access;
- Interventions – health systems development; training, equipment, and commodities; communication and accountability, improving healthcare financing,

- Outputs – better systems; improved capacity of providers; improved health seeking behaviour; providers and policy makers more accountable

- Outcomes – funding and management of health services improves; providers more responsive; capacity to provide quality services improves; people understands determinants of their own health and act accordingly; accountability improves; more people access quality services

- Impact – MMR and IMR improves and greater satisfaction with service.

However, the critical assumptions underlying the interventions that PATHS2 has undertaken have not been articulated.

Work in the southern states which is continuing has also included a focus on improving the state regulatory framework for private health provision and support for private-public partnership strategies for expanding coverage, improving access and quality of healthcare delivery, with emphasis on maternal and child health care.

PATHS2 is one of the five DFID State Level Programmes (SLPs). The SLPs are a set of interlocking sectoral and governance reform programmes, focusing initially on five States (Enugu, Jigawa, Kaduna, Kano and Lagos) and with an expanding role in other states. The SLPs are intended to provide a complementary approach, with PATHS2 and ESSPIN focusing on health and education services respectively, while SPARC and SAVI seek to strengthen the public sector governance and accountability context.

A new DFID-funded programme, Maternal, Newborn and Child Health 2 (MNCH2), has succeeded PATHS2's work in Kano, Kaduna and Jigawa. The programme started in mid - 2014, with a six month transition from PATHS 2 in the three Northern State. MNCH2's lesser emphasis on HRH development has been compensated for by the DFID supported W4H programme.

The objective of MNCH2 is to achieve effective and efficient delivery of essential health care for pregnant women, newborns and children, alongside routine immunisation. The programme aims to strengthen health system coordination through improved health sector planning and financing, and increase demand for and access to high quality health services. The programme works with government to build capacity within the public health system to enable sustainability beyond the immediate lifetime of the programme. Sustainable solutions will be sought for every output and outcome of this programme intervention. The MNCH2 programme delivers across the six DFID Northern Nigeria focus States (Kano, Kaduna, Katsina, Jigawa, Zamfara and Yobe). A major focus of MNCH2, as indicated by Output 2 in its logframe is to ensure that federal, state, LGA/District health sector governance and management systems support health services. In this sense it is a continuation of PATHS2, at least in the northern states. Additionally, as indicated above, sustainability is a key feature of the programme.

3.2 Evidence on results achieved

Table 1 and Table 2 provide information on performance against milestones and baseline estimated for PATHS2 outcomes related to maternal health, child health, client satisfaction with health services, and per capita spending on health services. These figures suggest there have been substantial increases in public spending on health (for those states for which comparative information is available), particularly in Kano. There has been significant improvements in the maternal health service indicators in most states, especially for the provision and uptake of ANC. Jigawa made particular progress from a very low base in 2008 on these indicators. There have

also been substantial improvements in the proportion of children receiving recommended treatment for diarrhoea. However, some caution should be used in interpreting the results because of weaknesses in the underlying data, including from the Demographic and Health Surveys (DHS) which provide baseline data (Omoluabi, Megill and Ward, 2014).

Table 1 PATHS2 Outcomes 1 and 2: Maternal health

	Baseline (2008)	Milestone (2015)	Progress (re-weighted survey data)	Confidence limits
1. Proportion of pregnant women making at least 4 ANC visits				
Jigawa	8%	43%	49.2%	48.1 - 56.2
Kaduna	26%	46%	55.6%	54.5 - 61.5
Kano	17%	39%	66.9%	65.7 - 70.7
Enugu	36%	68%	64.9%	60.4 - 69.1
Lagos	34%	66%	69.3%	67.0 - 71.6
2. Proportion of births attended by skilled birth attendants				
Jigawa	5%	20%	20.1%	17.5 - 22.8
Kaduna	22%	30%	29.5%	26.5 - 32.5
Kano	13%	25%	24.7%	22.7 - 26.8
Enugu	65%	90%	88.5%	85.6 - 91.0
Lagos	83%	87%	81.3%	79.6 - 83.1

Source: PATHS2 Annual Review 2015/PATHS2 Provisional Project Completion Review.

Table 2 PATHS2 Outcome 4, 6 and 7: Child health, satisfaction with health service and annual per capita expenditure on health

	Baseline	Milestone (2015)	Achieved
4. Proportion of children under five with diarrhoea that received recommended treatment (ORT, ORT/zinc)			
Jigawa	25.0%	25%	80%
Kaduna	34.0%	44%	78%
Kano	56.9%	61%	88%
Enugu	Not available	84%	85%
Lagos	Not available	60%	93%
6. Proportion of clients reporting satisfaction with health service			
Jigawa	31%	53%	80%
Kaduna	34%	79%	72%
Kano	24%	72%	80%
Enugu	Not available	69%	76%
Lagos	Not available	65%	71%
7. Annual per capita public expenditure on health USD			
Jigawa	$9.1	$14.80	$12.76
Kaduna	$6.4	$11.30	$10.78
Kano	$3.0	$17.80	$16.98
Enugu	Not available	$18.40	$16.00
Lagos	Not available	$14.80	$15.99

Source: PATHS2 Annual Review 2015/PATHS2 Provisional Project Completion Review.

Note: The baseline values for outcome 4 have been derived from NDHS 2008, and the baseline values for outcome 6 derived from the PATHS Baseline (2010) survey data.

3.3 Health policy context in Nigeria

The health policy context in which PATHS2 was implemented has been characterised by overlapping responsibilities for the provision of Primary Health Care (PHC) with each of the three levels of government, Federal, State and LGA having some role in PHC provision, financing, human and other resources and supervision. There are no constitutional restrictions on the role each level of government may play in health care provision, though it has been envisaged that LGAs would have principal responsibility for PHC service delivery. State Governors have exercised dominant authority over all major policy and financing decisions through direct or indirect control of resource allocation and other decision making processes with the State Houses of Assembly playing no role in policy formulation.

Whilst the LGA level in principle has had autonomy over the use of funds for PHC provision, in practice, control over the release of budgeted funds and major HR functions has been exercised at the State level. PHC facilities were managed through the LGA PHC Departments and the PHC Department of the Ministry of Local Government with HR issues for trained staff being managed through the Local Government Service Commission. State Ministries of Health have had no direct mechanism for exercising effective control over any of these systems.

One outcome of this system has been bottle necks in the flow of funds to PHC facilities. This has resulted from the provision of funds from Federal level to LGA joint accounts being dependent ultimately on the reducing flow of oil revenues, release of funds from the State to LGAs being in practice subject to the direct influence of the Governor, and decisions on the allocation between sectors of funds received by LGAs being subject to direct influence from the LGA Chair, in the context of extremely weak LGA budget systems.

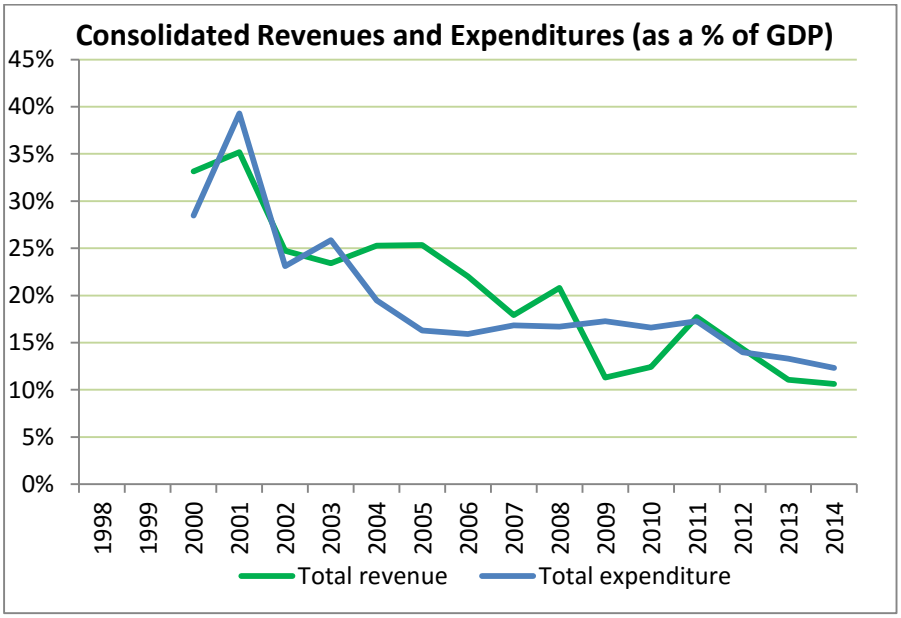
The National Health Bill first mooted in 2004 was in process of development and was finally signed into an Act by the President in December 2014. The Act provides a platform for the efficient coordination of the health system and delivery of a minimum package of essential health services, making provision for social inclusion, addressing the issue of equity in health and seeking to protect families from catastrophic health expenditure and impoverishment due to high cost of healthcare accelerating Nigeria's progress towards Universal Health Care. A core part of the approach envisaged has been the concept of "Primary Health Care Under One Roof" (PHCUOR), aimed at strengthening and centralising the management of PHC services.

The approach envisaged for achieving PHCUOR is through the establishment of State Primary Health Care Development Agencies (SPHCDAs), which has been promoted by the National Primary Health Care Development Agency (NPHCDA). These are envisaged as taking over responsibility for coordinating the provision, supervision, and monitoring, management, maintenance of facilities and human resource functions – recruitment, discipline, deployment and training from LGAs and other state bodies, but under the supervision of SMoHs. The Act promotes the development of SPHCDAs and guarantees the availability of 1% of the national budget for the development of health services by SPHCDAs. However, progress in the establishment and assumption of functions by SPHCDAs has been relatively limited to date – in none of the PATHS2 states has this process taken place, though the Gunduma system developed in Jigawa provides an alternative model for PHCUOR.

The wider macroeconomic environment over the period of the implementation of PATHS2 is also relevant. Most of the period has been one of high oil prices and revenues, until oil prices fell sharply from the last quarter of 2014, leading to severe fiscal pressures at each level of government. This has meant that the last year of operation of PATHS2 in the three Northern states in particular (Lagos is less dependent on oil revenue) was one of great fiscal stress where it was

difficult to implement planned budgets. Assessment of the wider fiscal context, however, suggests that a fundamental problem for social expenditure in Nigeria is the low (and declining) level of tax effort, which is now far below the average for countries of equivalent levels of per capita GDP. As Figure 1 shows, the share of GDP taken as revenue has approximately halved between 2008 and 2014. Improved tax effort could in principle sustain much higher levels of social spending, even during a period of low oil prices.

Figure 1 Consolidated Revenue and Expenditures as a share of GDP 1999-2014



Source: International Monetary Fund (IMF) quoted in Jones, Nwachukwu, Ojegbile and Williams (2015)

3.4 PATHS2 objectives and achievements

Output 1 - National stewardship of health

PATHS2 initially advocated with FMoH to address what were perceived as major issues of governance relating to fragmented responsibility for health between the three levels of government established by the Constitution, low overall expenditure on health and high levels of out of pocket expenditure by patients for often low quality care. Fragmentation was not only between the three tiers of government but at each level there was poor coordination of activities of different actors including development partners. As an approach for building capacity, PATHS2 technical staff were embedded in the Federal Ministry of Health to work with their counterparts in the first two years of implementation.

One outcome to which PATHS2 contributed was the adoption of a National Strategic Health Development Plan (NSHDP) and Results Framework with broad consensus support. PATHS2 also worked to support and strengthen the functioning of the National Council for Health. Interventions largely related to provision of technical assistance and support for reform such as by assisting the passage of the National Health Act. Some personal development training was also funded for key officers.

In addition to supporting the development and use of the same framework for the National Strategic Health Development Plan (NSHDP) and State Strategic Health Development Plans

(SSHDPs), PATHS2 also supported the development of a framework and mechanism for effective coordination of the health sector.

The 2014 Annual Review argued that PATHS 2 played a pivotal role in coalition building in support of the Health Bill. Activities included advocacy visits to former President Olusegun Obasanjo and support to key members of Senate and House Health Committees, a media campaign, and retreats with stakeholder groups to discuss the Bill's key provisions. These efforts are generally regarded to have been major contributors to the eventual passage of the 2014 version of the Bill by both houses of the National Assembly.

PATHS2 worked to improve systems and capacity in health policy and strategy, monitoring and evaluation, human resources, and health management information systems. PATHS 2 gave early support in the development of the National Strategic Health Development Plan and participated in and supported the work to prepare the second strategic plan. Support to the Family Health Department focussed on skills-based in-service training curricula for Emergency Obstetric Care (EOC), Family Planning (FP), and Integrated Management of Childhood Illnesses (IMCI), and continuing to build the capacity of a cadre of national and state-level master trainers to deliver the trainings.

PATHS 2 supported systems and capacity development to strengthen the NPHCDA's leadership of Primary Health Care Under One Roof (PHCUOR).

Output 2 - State level interventions

PATHS2 worked to ensure the development of State Strategic Health Development Plans in each state in line with the National Plan as well as supporting the systematic development and operationalisation of a range of relevant policies, plans and guidelines including Mid-Term Sector Strategies that set out five year plans for development of health services and Annual Operational Plans. PATHS2 attempted to support "PHC under one roof" in a variety of ways depending on the setting including by encouraging the development of SPHC Management Boards in Kano and Kaduna (as a step in the journey towards the establishment of SPHCDAs) and by continuing to support the development and operation of the Gunduma health system in Jigawa.

Table 3 reports on progress in strengthening planning and budgeting systems, and implementation of LGA annual operations plans, as well as the provision of timely data from health facilities. This suggests that strengthened planning and budgeting processes have been established in all states.

Table 3 Output 2 results

	Baseline (2009)	Milestone (2015)	Achieved (2015)
2.1. Proportion of elements of a best practice planning and budgetary system implemented at State level			
Jigawa	0%	80%	100%
Kaduna	0%	80%	100%
Kano	0%	80%	100%
Enugu	0%	90%	100%
Lagos	0%	90%	100%
2.3. Number of new and revised state policies, plans, and legislation developed, and reforms initiated with PATHS2 support			
All 5 states	3	67	96
2.5. Proportion of LGAs implementing LGA Specific Annual Operational Plans			
Jigawa	0%	100%	100%
Kaduna	0%	100%	100%
Kano	0%	90%	100%
Enugu	0%	100%	100%
Lagos	0%	70%	100%
2.6. Proportion of health facilities submitting timely data			
Jigawa	0%	97%	92%
Kaduna	0%	75%	80%
Kano	0%	72%	82%
Enugu	0%	Public: 95.0% Private: 53.5%	Public: 79.0% Private: 61.6%
Lagos	0%	Public: 72.0% Private: 62.9%	Public: 86.0% Private: 75.5%

Source: PATHS2 Annual Review 2015/PATHS2 Provisional Project Completion Review.

In all states as a result of PATHS2's work the MTSS system is embedded in the SMOH. Supporting Human Resources for Health (HRH) systems and capacity building was the subject of attention with the focus on health workforce planning, management and development. Each state now has an HRH policy and strategic plan; HRH structures established include HRH units in SMOHs and HRH working groups; and HRH systems developed include the human resources for health system (HRHIS) and job descriptions for frontline workers.

The focus of PATHS 2 support for drug logistic systems was directed to strengthening the capacity of State Drug Revolving Fund (DRF) committees, Central Medical Stores, LGA Medical Stores, and LGA PHC departments. The strengthened logistics systems have resulted in increased CMS procurement levels year on year and a significant reduction in expiry to low levels.

The main focus of output 2 is support to State and LGA/District Health Sector Governance and Management Systems to improve the provision of health services**.** Output 2 links the implementation of national-level policy (Output 1) in project states with improvements in service delivery at the state, LGA and facility level (Output 3), and with awareness-raising and communication efforts at the community level (Outputs 4 and 5).

In all states the MTSS process has been embedded in the State Ministry of Health (SMOH). Support to HRH systems, including capacity building has been given continued attention with PATHS2 with the focus on health workforce planning, management and development with SMoHs encouraged to ensure annual recruitment of health workers. Each state now has an HRH policy and strategic plan; HRH structures established include HRH units in SMOHs and HRH working groups; and HRH systems developed include HRHIS and job descriptions for frontline workers.

The focus of PATHS2 support for drug logistic systems was directed to strengthening the capacity of the SDSS/state DRF committees, Central Medical Stores (CMS), LGA Medical Stores, and LGA PHC departments. The strengthened logistics systems have resulted in increased CMS procurement levels year on year and a significant reduction in expiry levels. However, the capacity of CMS does vary; concerns relating to the CMS in Enugu are discussed later

At this level interventions related to training, support for personal development, and provision of technical assistance.

Output 3 – Service delivery

In addition to supporting the establishment of clusters of PHC facilities PATHS2 worked to support the operationalisation of eight service delivery pillars in PHC relating to: improving commodity supply, renovating physical infrastructure, improving HR capacity through training front line staff in a range of life-saving interventions, establishing two-way referral systems with secondary health services, implementing integrated supportive supervision, developing the HMIS system, building accountability to communities through Facility Health Committees and improving health communications and community mobilisation.

Table 4 shows that substantial progress has been made in strengthening the provision of emergency obstetric care and child health servces, as well as in improving the availability of drugs in health facilties.

Table 4 Output 3 results

	Baseline	Milestone	Achieved
3.1 Proportion of cluster health facilities (BEOCs and CEOCs) providing Emergency Obstetric Care (EmOC) services			
All 5 states	0%	100%	100%
3.2 Proportion of cluster health facilities (PHCs, BEOCs and CEOCs) providing a defined package of child health services			
All 5 states	0%	97%	100%
3.3 Number of health facilities capitalised with drugs			
All 5 states	795	2,000	2,311
3.4 Cumulative number of health facilities renovated by PATHS2			
Jigawa	0	69	70
Kaduna	0	62	62
Kano	0	75	75
Enugu	0	23	23
Lagos	0	21	21
3.5 Proportion of public health facilities with a defined list of essential drugs in stock at the time of the visit			
All 5 states	SHCs: 7% PHCs: 4%	SHCs: 85% PHCs: 70%	SHCs: 88% PHCs: 81%
3.6 Cumulative number of health workers trained to provide maternal, new-born and child health services in public and private facilities			
All 5 states	195	4,602	6,925
Source: PATHS2 Annual Review 2015/PATHS2 Provisional Project Completion Review.			

This output is concerned with developing and demonstrating a replicable model to deliver quality maternal and child health services in selected LGAs and by year three it had become the central focus of the programme, concerned with implementing the Service Delivery Strategy (SDS) in the five programme states. The SDS emphasises ‘making MNCH work’ through ‘a replicable (cluster) model to deliver quality maternal and child health services in selected (focal) LGAs’.

The PATHS2 cluster model has three levels of facilities and each facility within every cluster is strengthened by inputs – appropriate to the level of facility – from eight implementation pillars, namely: health commodities, basic infrastructure improvements, human resources, two-way referral, integrated supportive supervision, HMIS, service accountability to communities and finally health communication and community mobilisation. Outputs 4 and 5 are concerned with pillars seven and eight respectively.

At this level interventions comprised training, technical assistance and funding and supervision of infrastructure improvement together with development and successful adoption of PATHS2's innovative Service Delivery Concentric Model.

Output 4 – Accountability to communities

PATHS2 worked to establish functioning Facility Health Committees related to as many PHC units as possible and also to introduce a Community Scorecard by means of which communities could rate and give feedback on the acceptability of the services the PHC facilities were providing, service charters were also developed. These results were largely achieved by technical assistance provision and training events. Progress achieved is reported in Table 5.

Table 5 Output 4 results

	Baseline	Milestone	Achieved
4.1 Cumulative number of facility and non-facility based health committees established and operational in public and private facilities in supported clusters			
All 5 states	0	2,185	3,025
4.4 Proportion of people in PATHS2 cluster areas who indicate that FHCs have contributed to improvements in health facility services in the previous two years			
Jigawa	39%	55%	88.9%
Kaduna	45%	60%	81.3%
Kano	29%	45%	91.3%
Enugu	34%	50%	84.2%
Lagos	14%	27%	66.2%
Source: PATHS2 Annual Review 2015/PATHS2 Provisional Project Completion Review.			

Output 4 is concerned with strengthening the ability of citizens and civil society to hold local health services to account, thereby improving the responsiveness of the health system to citizens and service users, especially women and children. There was good progress with establishing facility health committees (FHCs) as part of the roll out of the final clusters. Efforts to enhance the sustainability of FHCs included training on resource mobilisation; developing state-level frameworks that provide for formal recognition of citizen participation in improving health; and identification of institutional homes for ongoing FHC engagement and support.

PATHS2 continued to support the establishment and functioning of FHC Alliances at the LGA level, as well as community support organisation (CSO) Advocacy Partnerships and the introduction of a Community Score Card charters were introduced; appropriately used these could further enhance accountability.

Output 5 – Community mobilisation

Work focused on training community volunteers, organising community events and using techniques such as rapid awareness raising to reach out to communities. Public service announcements were a further major part of the strategy together with the development of support groups for pregnant women to help create and reinforce social norms in support of the use of MCH services. As indicated, these results were achieved through training and technical assistance.

Table 6 Output 5 results

	Baseline	Milestone	Achieved
5.3 Proportion of women aged 15-49 years who intend to deliver in a facility in the cluster area for their next delivery			
Jigawa	28%	40%	48.3%
Kaduna	51%	63%	63.2%
Kano	37%	50%	54.6%
Enugu	95%	95%	94.9%
Lagos	92%	92%	82.6%
Source: PATHS2 Annual Review 2015/PATHS2 Provisional Project Completion Review.			

Output 5 is concerned with strengthening the capacity of citizens to make informed choices about treatment, prevention and care for priority health conditions involving community events and training volunteers, and public service announcements. PATHS2's "Mega Mobilisation" process was instrumental in ensuring key messages were heard and absorbed by mass audiences.

Progress in increasing the reported intention of women to deliver in a health facility (a key focus of mobilisation efforts) is reported in Table 6.

4 Capacity Development at Federal Level

4.1 Overview

PATHS2 initially advocated with FMoH to address what were perceived as major issues of governance relating to fragmented responsibility for health between the three levels of government established by the Constitution, low overall expenditure on health and high levels of out of pocket expenditure by patients for often low quality care. One outcome was the adoption of a National Strategic Health Development Plan and Results Framework with broad consensus support. PATHS2 also worked to support and strengthen the functioning of the National Council for Health.

Support was given to develop the role and functions of the Department of Planning and Statistics in the FMoH including strengthening the leadership of the national M&E system. PATHS2 also supported planning and organisational development in three key national agencies related to drugs administration, primary health care development and the national health insurance scheme.

Latterly, in addition to giving technical assistance to a large number of FMoH activities and initiatives, as evidenced by for example the 2014 and 2015 Annual Reports, PATHS2 worked to develop and gain support for the National Health Act of 2014 that ensured the availability of ring-fenced funding for PHC and required the development of “Primary Health Care Under One Roof” with the establishment of SPHCDAs in each State supported by the NPHCDA.

Support to the Family Health Department focused on skills-based in-service training curricula for key MNCH services, and continuing to build the capacity of a cadre of national and state-level master trainers to deliver the MNCH training. Work with WHO and NAFDAC has begun to achieve pre-qualification of NAFDAC’s Central Drug Control Laboratory.

4.2 Department for Planning, Research and Statistics

PATHS2 had worked to develop the capacity of the Department of Planning, Research and Statistics at the Ministry through a programme individual development for key officers, by supporting the introduction of improved planning policies and procedures, by providing substantial technical assistance across many aspects of the Department’s work over the lifetime of the project and by advising on restructuring the Department so as, for example, to merge M&E with research and statistics. One outcome to which PATHS2 contributed was the adoption of a National Strategic Health Development Plan and Results Framework with broad consensus support. PATHS2 also worked to support and strengthen the functioning of the National Council for Health. Interventions largely related to provision of technical assistance and support for reform such as by assisting the passage of the National Health Act. A significant innovation that was introduced as a result of PATHS2’s work was the process of joint annual reviews of progress against plan.

The capacity enhancement activities of PATHS2 were considered by key informants to have been effective and appropriate however difficulties remained relating to the demands made on the Department outstripping the resources available. As the fiscal space was shrinking so the Department was required to work more intensively so as to use more limited national resources to best effect. There were gaps in the available human resource and skills in the Department with few doing the work. New issues such as the Ebola crisis needed to be addressed by the hard pressed Department at the same time as the National Health Act was to be implemented and there were international commitments. Thus, whilst the capacity building that PATHS2 had undertaken was significant, the gap between expectations and ability to deliver was increasing.

Various structural factors limited the ability of the Federal Ministry to influence the uptake of national policies by the States. The Constitution does not clearly define or restrict the responsibilities of different levels of government for health, although this is addressed to some extent by the proposed establishment of SPHCDAs following the passing into law of the National Health Act. The National Council on Health was the highest coordinating body comprising the Federal Minister for Health and the States' Health Commissioners and was the main policy forum, supported by the Technical Committee, but whilst its agreements were binding by agreement of the members, there were no sanctions. Similarly, the National Economic Council that comprised all the State Governors gained compliance through peer pressure. The development of the National Strategic Plan for Health had been a major unifying factor and the States were intended to devise their plans in light of it but the national plan was not fully funded and so there were difficulties. It was hoped that the National Health Act would strengthen compliance with national health policy because of the ground-breaking provision that gave the Federal Ministry discretion over allocating 1% of the national consolidated revenue budget to the States for SPHCDA development and related activities.

4.3 Health Management Information

PATHS2 sought to improve the capacity of the HMIS section at Federal level by restructuring, by supporting training, by reviewing HMIS policy and the strategic plan and also to strengthen the HMIS capacity of the States and better integrate the work at State level with the work at Federal level.

Results of this activity included helping to re-organise the Planning Department which included the HMIS section to be better able to deliver its mandate; this has been key to improving productivity because the Department now utilised its staff more effectively. An example of this reorganisation was the merger of M&E unit with research and statistics. PATHS2 had also supported HMIS training at the central level and the review of the HMIS policy and strategic plan including facilitating quarterly M&E meetings at the national level.

PATHS 2 had built the capacity of the States they supported in HMIS and these States had better reporting than the national average. Based on PATHS 2's request, the PATHS2 states were invited to the national Health Data Producers and Users Meetings at the national level. The meeting was initially only attended by FMoH agencies, departments and development partners. HMIS improvement built on the work completed by PATHS1 who had introduced the District Health Information System (DHIS) to Nigeria. PATHS2 supported the implementation of the DHIS upgrade to the more robust and modular version of DHIS2 at the federal level and in the supported states. With the improved capacity at FMoH, adoption of the DHIS2 was extended to all the other non-PATHS2 states and the FCT country wide.

Factors influencing sustaining what was achieved relate to continuing challenges including funding. There has been no funding for HMIS at the federal level for the last 3 years apart from salaries and the N50 million allocated in 2014 to print tools. The HMIS division is mostly funded by donors and partners including PATHS2. There were concerns about what would happen to programmes supported by PATHS2 when it ended.

4.4 Human Resources for Health

PATHS2 had sought to support the re-structuring of the planning, research and statistics department which led to expansion of the HRH unit and had also anchored a retreat to review the current structure of HRH nationally.

PATHS2's input also included support for the development of the first draft of the HRH training manual with WHO was supporting the finalisation. PATHS 2 helped develop Nigeria's health workforce profile in 2012 and WHO had undertaken to help update it this year. PATHS2 also supported the development of Project Implementation Manual for the Nigerian Public Training Initiative that aimed to enhance the capacity of community health tutors, nurses and midwives. PATHS 2 had supported the development of the HRH observatory although it was currently moribund; the HRH branch hoped to resuscitate it. Paths2 also supported National HRH conferences which had done valuable work.

Key informants' assessments of the results of PATHS2's interventions in HRH development was positive although they said that they do not have adequate capacity currently in terms of trained workforce and need more staff, training for them and more exposure on HRH through meetings and conferences with HRH experts. The need for training on specific areas such as workforce registry development was highlighted. Training should also be provided for HRH desk officers on the HRH manual and policy development.

The input of other development partners was a feature of the history of HRH capacity development in the Ministry; for example the development of the workforce registry was supported by PATHS2, Capacity Plus, WHO and PRRINN-MNCH. Phase 1 of the registry had been completed and was gathering currently getting data from the five major health care regulatory agencies as well as from partners and some of the states. Phase 2 of the registry development would involve acquiring data from the other nine regulatory agencies, training institutions, remaining states, private health facilities and diaspora.

Other partners remained active in support of the HRH department; the World Health Organisation (WHO) had initiated the use of Workload Indicator of Staffing Needs for workload analysis to improve HRH planning, recruitment and deployment and the revision of HRH policies and was now mapping the movement of migrant health workers; USAID's Capacity Plus Project was supporting the revision of the HRH strategic plan; Capacity Plus conducted a mapping of HRH partners and what each is doing, to avoid duplication; JHPIEGO led other partners to work with the FMOH to develop the task shifting policy.

The key informants stressed the involvement of States in HRH policy development; with the aid of development partners some States, including PATHS2 for Jigawa, had started revising their HRH policies, following the federal level revision with the work being coordinated in FMOH led workshops following which there was a process of validation that concluded with sign off by the National Council of Health with all the state commissioners.

In terms of factors influencing the continuation of what was achieved funding was identified as the greatest challenge. HRH does not have a budget line and is fully donor funded and used the HRH partners' forum to leverage resources for their work. The lack of funds impacts negatively on policy and strategy implementation. Other key challenges remained inadequate staffing and office space.

4.5 National Primary Health Care Development Agency (NPHCDA)

PATHS 2's played a key role in advocating for the passage of the National Health Bill to become an Act and continue to participate in developing an implementation framework.

Key informants indicated that they understood their role and functions and have been supported by several partners over the years including PATHS 2, Gates Foundation and UN Agencies. NPHCDA is responsible for the stewardship of the primary level health care in Nigeria, with a focus on policy development, partner coordination and international resource mobilisation but also

sometimes intervene directly in providing infrastructure, human resources and health commodities. Key informants believed their capacity to function appropriately had been adequately developed with the right number and mix of staff but their staff will benefit from more trainings to update their skills.

PATHS2 supported the training of NPHCDA staff in areas including M&E/HMIS, supply chain management, policy development and health financing and also support for the development of the PHCUOR concept, including by assisting the development of a common framework for State Primary Health Care Development Agencies (SPHCDAs). PATHS2 has also supported better coordination of state primary health care efforts by facilitating the participation of the states they support in NPHCDA activities.

In assessing the results of these interventions key informants indicated that PATHS 2 was perceived as a very reliable partner especially in the areas of policy development and systems strengthening and in particular had worked on improving access to medicines at the primary care level including revision of the essential medicines list and strengthening of supply chain systems for primary health care commodities. The DRF system which they introduced at the state had improved commodities security and sustainability of supplies.

NPHCDA claimed to possess the resources necessary to implement their plans if and the departments/units are funded to implement their planned activities. NPHCDA receives government budget for its operations and also partner support for most of its work with key partners including GAVI, Gates Foundation, MDG grants and UNICEF.

4.6 Conclusions

PATHS2 has played an appreciated supportive role in strengthening federal level capacity for planning, HMIS and HRH. However, this capacity development has not been consolidated by the provision of adequate federal government funding for implementation and maintenance of the systems that have been built and so there are significant concerns about sustainability. NPHCDA considers that is has sufficient resources to take forward the results of the support provided through PATHS2. PATHS2 contributed to the eventual passage of the National Heath Act which should provide an improved national framework for health policy. However much will depend on the level of commitment and effectiveness of the new Presidential administration elected in 2015 in taking forward a coherent and adequately funded federal policy that will provide effective leadership and direction for states.

5 Capacity Development at State Level

5.1 Policy formulation, planning and budgeting

5.1.1 Overview of capacity development

PATHS2 has supported the development of policies, with a total of 96 new policies, plans and laws developed with PATHS2 input according to the logframe for the northern States of Jigawa, Kaduna and Kano. State officials have been supported with training events, continuous provision of technical assistance and individual personal development activities including mentoring so as to develop expertise in formulating Strategic Health Development Plans (SSHDP), Medium Term Sector Strategies (MTSS) and Annual Operational Plans (AOP) this last named for the LGAs as well as the States. Output 2 of the logframe indicates that 100% of the elements of best practices are being applied in the of planning and budgetary systems have been implemented in the northern States. In each case the plans are linked to budgets, although this report demonstrates, the budgets remain at best partially funded resulting in vital programmatic activity not taking place at the point of health care delivery by the LGAs or Gunduma Councils.

It is clear from the relevant key informant interviews and PATHS2's results reporting that there has been a successful process of capacity development by PATHS2 in all five States in policy formulation, planning and financial management including budgeting. This process related to both enhancing the capacity of individuals in the State planning teams and also developing organisational capacity by incorporating key planning processes into routine activity. Key informants were able to articulate their roles clearly and all were confident that currently they had sufficient capacity in terms of trained staff and embedded processes to fulfil their roles. However, in some States there were impediments to completing annual planning cycles due to lack of funding for planning activities. For example it was not possible to bring key staff together for planning activities because of the cost.

Specific initiatives that were noted by key informants included the following:

- In Enugu, PATHS2 facilitated the expansion of inputs into the planning and budgeting process through a multi-stakeholder workshop that included members of the State House of Assembly's Committee on Health. This has made it easier for the officials to defend their budget. In 2015 they developed their MTSS without support from PATHS2.

- In Lagos, PATHS2 provided technical assistance for development of the State's health financing plan including a new mandatory health insurance act which has been approved by both the legislature and the Governor.

- In Kano and Kaduna whilst PATHS2 provided significant support to develop planning capacity, since PATHS2 funding ended the workshops needed to develop plans have not taken place as local officials would wish due to lack of funds, although MNCH2 is providing some support in this area.

- In Jigawa reference was also made to the need for on-going input by development partners to support the planning process. The planning staff also discussed the difficulty traditionally experienced of attracting competent staff to work in this Directorate that was seen as a place where, because of staff shortages, the officials were overworked. PATHS2 had made the Directorate a more attractive proposition because of the access provided to group and individual development, however this was no longer available and it was feared it would again become difficult to attract effective staff.

Although the planning and budgeting capacity of relevant officers had improved, doubt remains about political commitment to implement the plans in Enugu, Kano, Kaduna and Lagos. In Jigawa by contrast the Gunduma system does link effectively State planning to operational delivery of PHC, although the extent to which planned budgets are funded also depends ultimately on the approach taken to distribution of funds by the Governor and whilst this is a drawback, at least the Gunduma system incorporates effective linking of planning and delivery of health care in a way that the other States have yet to achieve.

5.1.2 Strengthening State management of PHC

Summary of the situation

In Kano and Kaduna some progress has been made in effectively transmitting State level policies, plans and budgets for PHC to LGAs through the PHC Management Boards that had been established, although responsibility for the provision of PHC remained with the LGAs. In Jigawa the Gunduma Health Board and Councils effectively linked State level planning with direct provision of PHC whilst retaining LGA participation in PHC provision through their representation on the Gunduma Councils. Lagos and Enugu continued to be characterised by State and LGAs acting independently without effective transmission arrangements. Of the five focal States none had introduced a SPHCDA (as opposed to a State Primary Health Care Board – with similar functions to an SPHCDA) although all except Enugu had enacted laws to establish an SPHCDA and Kano was in process of establishing one.

Kaduna and Kano

Kaduna introduced a State Primary Health Care Management Board with support from PATHS2 in 2014. It was fully functional, had been set up with support from PATHS2 and was supervised by the SMOH. Kano had a PHC Management Board that worked through six zones. It was charged with the delivery of PHC and was accountable to SMOH. Each Zone had a Director accountable to the Management Board who worked with eight heads of department to coordinate with LGA counterparts.

In both these States key informants stressed that there was good liaison in planning and budgeting between SMOHs and LGAs, with the LGAs fully integrated into the process of preparing their annual operational plans (AOPs) in light of the States' MTSSs and readily adopting policies and plans drawn up by the SMOHs. LGAs did not consider themselves to be autonomous in planning and budgeting and were guided by the relevant Ministries and Departments. Failure to fully implement SMOH policies and plans related either to lack of capacity in the LGA or to their lack of success in persuading the LGA Chairman to include the AOP in the budget and ensure adequate release of funds. This demonstrated a fundamental weakness in the health system because planning was not linked to funding; the size of the budget necessary to implement the AOPs was known, but actually funding the budget was a separate process at LGA, not State, level and consistently resulted in key elements of the budget remaining unfunded.

Lagos and Enugu

In Lagos and Enugu relationships between the SMOHs and the LGAs were reported by key informants to be less close than in the other States.

In Lagos the LGAs were reported to be de-linked from the State and operate more autonomously than in the north making implementation of State plans and policies a challenge. Lagos had moved from the LGA Service Commission being responsible for PHC to establishment of a PHC Board, which is better able to influence LGAs than the SMOH, as an interim step towards setting up an

SPHCDA although there was significant reluctance on the part of some LGAs to recognise the Board and it was not functioning effectively. The State budget for health was normally only partly funded (around 50% was reported).

In Enugu it had been intended that PHC would be managed under the District Health System that had been proposed as means of unifying the delivery of primary and secondary health care but LGAs had not recognised the District Health System's authority for PHC and it was only involved with secondary care. It was reported that in this State there was often resistance on the part of the LGAs to implementing SMOH policies with the LGAs currently controlling expenditure on PHC. It was also reported that release of budgeted funds to LGAs was consistently challenging, with only 30% of the annual budget for 2015/16 released by mid-year. Enugu planned to introduce an SPHCDA to overcome the current lack of consensus on PHC between the SMOH and the LGAs, address the difficulties that became apparent when attempting to introduce the District Health System in the State and to access National Health Act funding for PHC. PATHS2 had been advocating through the state house of assembly and the executive, for the passage of the health sector bill into law that provides for the establishment of the SPHCDA or State PHC Board.

The Gunduma system in Jigawa

In Jigawa similarly there were strong and effective transmission arrangements between the SMOH and the LGAs due to the development (under the preceding PATHS1 project) of the Gunduma (District) health system in this State enabling the concept of "primary healthcare under one roof" to be demonstrated in this State in what the NPHCDA plans should be the norm across Nigeria as the National Health Act of 2014 is implemented. The Gunduma Board in Jigawa ensures that PHC is planned and delivered "under one roof" and integrated with secondary health care in the sense that the roof is the Gunduma Board, however, clearly it is appropriate and desirable that the roof should be the SMOH implying the need for the accountability of the Gunduma Board currently direct to the Governor to be switched to SMOH. Moreover, the integration of PHC and SHC achieved by the Gunduma Board and Councils would be lost on introduction of an SPHCDA.

The Gunduma system comprise a State-wide Gunduma Health Service Board and nine Gunduma Health Service Councils. The Councils provide primary and secondary health care on behalf of their constituent LGAs. There are nine Gunduma Councils for 27 LGAs. The Gunduma Board has a Chairperson appointed by the Governor, to whom he/she is accountable, a membership that is representative of each of the five Zones in the State together with a range of ex-officio members including the Permanent Secretaries of the SMOH and other relevant Ministries. It has an executive team led by the Director. The Gunduma Councils comprise the LGA Chairs, representatives of traditional institutions, the the Chief Imam, and all members of the State Houses of Assembly and Representatives related to the constituent LGAs. The Councils are accountable to the Gunduma Health Service Board and also have a team of officials under a Director to manage health services on a day to day basis and implement decisions of the Councils.

Whilst key informants were all clear that the role of the SMOH was to formulate health policy and the Gunduma Health System Board (GHSB) existed to manage the provision of health services across the State, there was evidence of tension between the GHSB and SMOH. SMOH was unhappy that the GHSB reported directly to the Governor and not to the SMOH, thus, in their view, unhelpfully separating policy formulation from the delivery of health care. Although there was a monthly liaison meeting between them, it was reported to be impossible for SMOH to assess the performance of the GHSB as required in law because of the absence of reporting processes, with the GHSB believing itself to be independent of SMOH. The lack of counterpart officials and one-to-one relationships created a divide between the two bodies.

However, no such difficulties were apparent between the GHSB and the Gunduma Health System Councils (GHSCs) where lines of accountability were clear and direct. This enabled an effective ground-up planning and budgeting process to continue to take place annually with SMART targets and budgets devised in line with a previously declared budget envelope, negotiated in an annual cycle between GHSB and GHSCs and discussed and approved by the Councils where they remained functional. Unfortunately it was proving impossible for the GHSB to release funds in full, in line with the approved AOP and budget. Typically GHSCs were receiving only around 85% of the approved budget each year. This meant that whilst salary costs (by far the biggest line item at around 75% of the total) and overhead costs for the GHSC office were funded, there had been no programmatic expenditure for the last two years. This had the effect of making it impossible to implement the AOP in full with many vital activities such as health promotion, disease surveillance and control, routine immunisation (apart from that funded by vertical programmes), refresher training, monthly management meetings, staff motivation and equipment repair and replacement simply not taking place. In both GHSCs visited however, it had fortunately proved possible to continue supporting from the overhead budget regular visits by the Reproductive Health Supervisor to PHC facilities and modem costs for HMIS thus ensuring that the capacity development achieved by the successful implementation of improved supportive supervision and data capture and transmission could be continued.

5.1.3 Conclusion

PATHS2 successfully contributed to developing policy formulation, planning and financial management capacity at State level in each of the States. Key informants believed however that the gains were potentially fragile and would not be sustained in the long-run because the significant investment in developing group and individual competencies was no longer available and as key officials moved on to other positions or retired their inputs would be lost to the SMOHs This implies that PATHS2 has not been successful in building high-level political commitment to this model of reform which would see on-going funding being reserved for capacity development of key officers in perpetuity.

It was likely that some of the key officials who reported directly to the heads of departments would, in the immediate future assimilate some of their principals' skills and understandings but this would at best be partial and in the absence of strong continuing leadership at the top that was committed to managing the planning cycle conscientiously the process would atrophy over time. States were already reporting difficulties in operating the planning system as defined due to lack of funding for travelling to meetings to discuss plans and budgets, although the Gunduma system in Jigawa appeared to be better placed to sustain the planning cycle.

In Kano and Kaduna some progress had been made in effectively transmitting State level policies, plans and budgets for PHC to LGAs through the PHC Management Boards that had been established, although provision of PHC remained with the LGAs. In Jigawa the ÃHealth Board and Councils effectively linked State level planning with direct provision of PHC whilst retaining LGA participation in PHC provision through their representation on the Gunduma Councils. Lagos and Enugu were characterised by State and LGAs acting independently without effective transmission arrangements.

5.2 Health Management Information System

5.2.1 Overview

PATHS2 capacity development in relation to HMIS aimed to enable the States to implement locally the National Health Management Information System. Support included strengthening capacity for data collection and reporting in the State under using DHIS2 software, strengthening capacity for continuous data quality improvement including developing Monitoring and Evaluation capacity and on strengthening capacity for using data for decision making.

Capacity development activities at State level included providing support to roll out DHIS2 in LGAs and facilities, training and mentoring in DHIS2 including analysing reporting rates and coverage of indicators, training in data quality assessment, supporting monthly meetings where HMIS/M&E staff could review progress and trouble-shoot with their LGA counterparts, provision of laptops and office equipment and assistance with developing M&E framework documents.

All key informants gave very positive accounts of the capacity building inputs provided by PATHS2 and were eager to assert that PATHS2 had been successful in institutionalising an effective HMIS in the five States, that routinely provided accurate and comprehensive data in a timely manner from facility level to the SMOH (and GHSB in Jigawa) where it could be put to use to plan the provision of health services by competent M&E officers as evidenced by the production of the MTSS and AOPs that were informed by data from the field.

Key informants in Kano and Kaduna recounted the shift under PATHS2 from a paper-based, annual data collection exercise to a system under which State-wide data is available monthly. In Kano there is now a budget line for printing the data collection tools and a “Control Room” function that checks the quality of data received and revalidates it when necessary with LGAs. PATHS2 provided laptops with internet connectivity.

In these States PATHS2 developed capacity for operating a successful HMIS system through training HMIS officers and supporting monthly M&E review meetings, data quality assurance processes and quarterly meetings of the Health Data Consultative Committee. PATHS2 assisted the development of an M&E unit in the Department of Planning, Research and Statistics in Kano’s SMOH and the establishment of a Department of Planning, Research and Statistics in Kaduna. Each State now has trained M&E and HMIS officers.

In Enugu PATHS2 supported data transmission using mobile phones which ensured about 60% of public facilities were routinely reporting activity and around 64% of private facilities. Data from this State is used in the planning process and to inform operational decisions; an example was that ANC data had been used to determine which facilities were busiest and so should have first call on funds to erect boundary fences. Data was also shared routinely with the managers of vertical programmes (HIV, TB, malaria) and was summarised in fact sheets for general distribution.

In Lagos PATHS2 is credited with bringing about significant improvement in levels of reporting and the quality and use of data, with about 80% of private facilities also reporting on the State’s DHIS2 platform. Monthly M&E meetings between State and LGA HMIS officers enable the system to be maintained, data to be discussed and joint solutions to challenges devised. PATHS2 also supports data quality assurance including visits to facilities and the Primary Health Care Board actively participates in the M&E system with monthly reports being made to the Commissioner for Health.

Key informants in Jigawa claimed that under the Gunduma Health Service Board, 93% of facilities were reporting in a timely and complete fashion. PATHS2 had trained staff on how to capture data,

how to operate DHIS2 and the importance of good data collection; 15 laptops had been provided. Basic and advanced M&E training had been provided at both GHSB and GHSC levels and for the LGAs. GHSB key informants reported that the HMIS system was working well from data capture in the facilities, through it being put on-line at the LGAs, sent to the GHSCs for checking of accuracy and completeness together with the PHC Director, then sent on for analysis and use by the GHSB and SMOH by the 14th of each month. They also stated that the State was producing data that was 80% accurate which was in line with the standard. Data informed the strategic and operational plans and enabled quality of provision of health care to be monitored for example by analysing availability of drugs or staff.

However, it is indicated in published Annual Reports and Reviews that in general health data is not being gathered as effectively as is desirable and remains unreliable. This is likely rapidly to deteriorate further with the ending of PATHS2 interventions as commented on in the sustainability section below.

5.2.2 Conclusion

It is apparent that investment in training and re-training HMIS staff is linked to PATHS2 and is as likely to cease with the end of the project in Lagos and Enugu as it already has in the three northern States. This will inevitably mean that the effectiveness of the staff operating the system will degenerate over time. Similarly, without funding for regular meetings of HMIS staff from State and LGA, these invaluable opportunities to ensure the system is working optimally will remain lost.

In Kano it is reported that the main problems facing data reporting quality and timeliness relate to the transfer of trained HMIS staff to other positions and their replacement by untrained new staff. Nor is there any longer routine supervision of LGAs and facilities by SMOH officials. In both Kano and Kaduna the rental fees for the modems at LGA level are not being paid, nor are the monthly M&E meetings taking place any longer. There was some indication that MNCH2 is aware of these difficulties and plans to reinstate support for HMIS, but this just delays the inevitable erosion of the system unless the States commit to providing in perpetuity the kind of support for HMIS enjoyed under PATHS2.

The situation was less bleak under the Gunduma system in Jigawa because funding for office overheads was diverted to support modem charges and the Gunduma Councils were able to supervise the data collection and compilation processes and also to maintain liaison on HMIS data quality with the Gunduma HSB in the regular meetings that still take place at officer level to review the quality of data, problems in its gathering and transmission and the key messages the data was giving on the utilisation of health services that would then be used to inform the MTSS and AOPs.

5.3 Human resources for health

5.3.1 Overview

PATHS2 capacity development support in respect of HRH included strengthening the SMOH and LGSC's ability to plan and manage HRH, enabling SMOHs to implement and deploy effectively an HRIS, develop an HRH policy and create training institutions that were fit for purpose.

HRH capacity development activities undertaken by PATHS2 included training SMOH and LGSC officials in workload analysis, HRH planning, management and development including training in coaching and mentoring, Training of Trainers, training in introducing a performance management

system, and in preparing job descriptions for front-line workers. PATHS2 supported SMOHs to develop an HRIS that would result in a database of health workers and their mix, skills and location and key officials were trained in maintaining the system. Some States were also supported by PATHS2 to develop an HRH strategic plan and set up an Observatory to ensure the plan was implemented. Finally, PATHS2 worked to develop the capacity of the States to train nurses, midwives and health scientists.

5.3.2 State level experience

Kano and Kaduna

In Kano and Kaduna, PATHS2 enabled new HRH units to be established within the Departments of Planning Research and Statistics and provided office equipment and computers. PATHS2 supported an assessment of what human resources were available for health care in the States and also assisted with the development of an HRH strategic plan and an HRH policy. PATHS2 enabled Kano to redistribute the health workforce across the State to be more in line with need which also helped to reduce turnover. In Kano the HRIS was loaded with the data of 10,000 staff members although the license expired and it fell out of use.

Of all five States it appears that Kano most effectively got to grips with the vital issue of strategically planning a health workforce that is fitted to meet the current health needs of the population. This includes identifying what cadres of health workers are needed, how many workers are required in each cadre, how many need to be recruited/trained in order to meet the assessed need on a year by year basis in light of the funding of additional posts and replacing staff lost to the workforce through normal attrition, and how the workforce should be distributed across the State. Both Kano and Kaduna reported that they were undertaking recruitment based on the HRH needs assessment; large numbers of additional staff were apparently being recruited for PHCs in Kano, also pharmacy and nursing numbers in training had been increased. The staffing arrangements are not straightforward with the SPHC Management Board setting the “funded establishment” and recruiting to positions and LGAs funding the salaries. In Kano the HRIS enabled managers to understand how health workers were distributed across the State and to implement a plan to distribute them more in line with need.

Enugu

By contrast it appears that in Enugu the Local Government Service Commission (LGSC) takes the lead on all matters related to recruiting, deploying and performance managing the health workforce at the request of the 17 LGAs with over 400 PHC facilities and the LGAs do not follow any coherent approach when it comes to planning a health workforce that is fitted to the needs of the population. The LGAs do produce AOPs and LGSC contributes to this process, but the plans are normally devised after the budget has been set. There is only one staff member in the LGSC who is focussed on health which is clearly unsatisfactory.

Also in Enugu, PATHS2 trained the Supervisory Councillors for Health in each LGA to be involved in the health planning and monitoring, this made them more effective advocates for health funding with the LGA Chairs, although ideally funding for health would follow the approval of a strategic plan and be in line with it and so remove the element of chance that currently characterises State health expenditure here.

Lagos

In Lagos the State has human resource challenges at the facility level. It has more trained health care workers than other States but a lot are in the private sector and the demand for services is high because of the population.

PATHS2 helped the State conduct an HRH audit which showed an 85% deficit in public health facilities, especially doctors and nurses. PATHS2 also helped the State develop a HRH policy which included strategies such as task shifting, for making the best of the HRH available. The State was operating a paper based HRIS. The HRH unit which was relatively new collected data from the different levels of the health system and hoped shortly to start collating and analysing it as a guide to decision making.

The SMOH does not have responsibility or authority for recruitment, deployment/redeployment and performance management of health care workers in health facilities. The Hospital Management Board is responsible for that at the secondary level while the Primary Health Care Board is responsible for the primary care level. The HRH unit in SMOH is not very clear on how their role will influence the roles of these two boards. The midwifery services scheme (MSS) has been incorporated into the State budget.

Jigawa

In Jigawa, in the SMOH, there is a Director of Human Resource Development who is accountable to the Permanent Secretary. The role appears largely to relate to the development and functioning of the State's two training institutions for nurses and midwives and health technicians respectively and the professional development of nurses, otherwise HRH in the State is managed within the Gunduma health system. PATHS2 was instrumental in gaining provisional accreditation for midwifery training in the State from the Nigeria Nursing Council after the State had apparently established the college without the course being approved.

The GHSB has a Director of Human Resources with a small supporting staff and there is an HR Coordinator in each GHSC. PATHS2 was instrumental in the recruitment and posting to under-served rural communities of 40 midwives and 20 doctors, funding for whom was picked up from PATHS2 by the State on a tapering basis. PATHS2 also ran a series of trainings for Directors on human resource development and management, established HRIS and supplied the job descriptions for a range of staff cadres.

The GHSB in Jigawa seems, as in Kano, to have made some progress in defining the size and composition of the workforce it requires and for example reported having a plan to recruit additional staff in 2016, mostly to fill new positions associated with new PHC facilities. In Jigawa's Gunduma Health System staff members' contracts of employment are held by the GHSB which also recruits health workers and manages them on a day to day basis through the Gunduma Health Service Councils. This creates a seamless and thus effective HRH system that contrasts both with the more complex arrangements for planning and funding the workforce and hiring and managing staff that characterise the other States where the LGSC undertakes staffing functions on behalf of the SMOH or where the LGAs provide health services independently of the SMOH.

It was reported that in Jigawa recruitment of many cadres of specialist health workers was rarely problematic because the training institutions traditionally trained far more health workers (except midwives and doctors) than were needed. Thus the GHSB recruited 15 health information technicians in a year from a pool of 114 trained graduates and 15 medical laboratory technicians from 123 who have qualified in the State but were not employed in that role.

In Jigawa around 12% of total State (and 75% of all health) expenditure is spent on health staffing costs, limiting resources available for other expenditure such as on replacement equipment and infrastructure improvements. This was seen as a significant issue in the SMOH, although it would be roughly in line with the normal pattern for western health systems, so might not in fact be the problem SMOH perceived it to be. In the Planning Department there was talk of the need for task-shifting in respect of doctors, nurses and pharmacists, although it was difficult to understand how SMOH could make this happen unless GHSB also saw it as a priority.

In Jigawa 5700 staff out of a total of 6700 have been enrolled in HRIS, although, significantly, the software has been found to have a number of unresolved glitches and the GHSCs have reverted to monthly reporting on staffing issues using the old paper based system with which they are reported to be happier. The HRIS database had not been updated for ten months, although it is understood that MNCH2 have addressed this issue.

The HRH performance management system on which HRH officials were trained extensively was, in the event, not introduced and the old, “civil service/paper exercise” style appraisal system continued to operate.

It has been reported that PATHS2 supported the state to develop job descriptions for posts throughout the health system. However, whilst a printed manual existed in Jigawa, there was just one copy that was held at the GHSB. Consequently, it had not been possible to discuss job descriptions with staff or to otherwise disseminate them and so that potential benefits had not been realised.

It was readily acknowledged at the GHSB that the implementation of a fully functioning HRH system remained work in progress and the State needed support to continue to develop its effective management of the workforce.

5.3.3 Conclusion

Key informants in each State acknowledged that PATHS2 support for HRH should have been focused on earlier after the PATHS2 Mid Term Review (MTR) and that the States had not so far been effective in delivering on the ground a workforce that was sized, constituted, skilled, deployed and managed in line with the health needs of the population served, and this point was made also forcibly in the draft Project Completion Review.

In two of the States there was no clear-cut answer to the question of who is in charge of planning, funding, developing and managing the workforce, and the role and even influence of the SMOH in this vital area of health service delivery was unclear. PATHS2 has not addressed this gap in institutional capacity.

Even in the northern States where SMOHs and the Gunduma Board/State Primary Health Care Management Boards had a better grip on HRH, the performance management system had not been introduced, job descriptions remained un-disseminated and HRIS had been abandoned for at least ten months. As with planning and budgeting and HMIS, staff need training and re-training in basic functions and if it proves impossible to achieve this then there is a danger that the discipline will disintegrate over time.

5.4 Drug procurement and supply management

5.4.1 Overview of capacity development

PATHS2 sought to develop capacity to make drugs sustainably available by the creation of well governed Sustainable Drug Supply Systems with functioning Central Medical Stores whose officials had the competence to manage effectively procurement, warehousing and distribution, underpinned by a functioning Logistics Management Information System and incorporating capitalised and managed Drug Revolving Funds to ensure right-priced, high quality commodities could be accessed readily by patients when required. A key feature of the system was its financial sustainability funded by modest mark-ups on sales.

5.4.2 State level experience

Development of effective drug supply and management systems in each of the States was a major success of PATHS2; the systems were efficient in the economical purchase, storage and distribution of drugs, effective in that they made available high quality, reliable medicines and accessible in that they enabled patients to purchase drugs at affordable prices from widely dispersed locations.

Kano and Kaduna

In Kano the drug supply system was managed by the Drugs Management Supply Agency and in Kaduna by the Drugs and Medical Commodities Supply Agency both established by PATHS2 and in both cases the management teams were able to articulate their roles clearly which they attributed to the capacity development activities of PATHS2.

In these States PATHS2 was instrumental in developing and institutionalising stock management guidelines, M-supply software for medicines supply management, DRF guidelines, pricing policies, a deferral and exception policy for indigent clients and financial management policies. The State DRF Committees were established to manage the DRFs in the States and took the number of facilities capitalised for DRF to around 700, with more in the pipeline. Community involvement in local management of the DRF has ‘become increasingly common with facility health committees deciding what drugs should be purchased and overseeing arrangements for receiving the supplies and checking receipts.

There have been some instances of DRF de-capitalisation through fraud or the introduction of “para DRFs” whereby the staff member accessed their own supply of medicines and sold them to clients at higher prices. Such actions are dealt with seriously and the costs recovered from the perpetrators’ salaries.

Enugu

In Enugu there has been a consistent increase in availability and quality of drugs at the CMS and the facility level as a result of the strengthened DRF under the Sustainable Drug Supply System. PATHS2 was mostly responsible for strengthening the DRF system. In the past, the DRF management committee was in the SMOH but since 2012, the committee has evolved to a Sustainable Drug Supply System (SDSS) with a management committee that has members outside the SMOH. It includes 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. The DRF money is ring-fenced and so cannot be used for non-DRF related expenditures. This has helped grow the purse and prevent

decapitalisation which was common in the past. They now use a “fixed price framework agreement” procurement system to fix prices for commodities and get better value from suppliers.

Monitoring was difficult because facilities became decapitalised and were not able to procure drugs. In 2010, PATHS2 commissioned a review in Enugu that eventually led to the establishment of “in-state teams” that included LGAs and chairmen of FHCs who monitor health facilities to ensure accountability and that they procure from the CMS. The department also reactivated its M&E team which 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. These changes improved the functioning of the DRF and decapitalisation was no longer a problem. The DRF account has a component for M&E and capacity building so the entire system is self-funding.

PATHS2 pulled back from active support in Enugu two years ago so the SMOH has been in charge. They have been able to utilise the trainings and mentoring from PATHS2 to keep the system running without external support. They have been aided by the improved staff attitude at all levels as a result of PATHS2 training and increased facility buy-in as a result of enlightenment and involvement of FHCs. The CMS is open to the private sector who also engage with the DRF management through the SDSS. Inventory management in the CMS is still a challenge. There was an issue with the M-Supply software because Enugu SMOH was not able to renew its subscription with the providers.

Lagos

In Lagos the DRF operates but it was considered to be much more successful at the secondary care level than at the primary care level. Seventeen of the 24 secondary care hospitals in Lagos are running DRF while the remaining seven are operating the joint venture system. Under the JV arrangement, the hospital pharmacy management is outsourced to a private operator. The JV system was in place before PATHS2 worked with the State to revive the DRF system in 2012, by recapitalising it, developing guidelines and training staff. The DRF is working well in the 17 secondary hospitals while the JV has been having serious challenges because the operators are owing the suppliers.

The DRF was reported to be challenged at the primary care level because of the small scope of the DRF relative to the size of the State, the weak capacity at that level and the challenge of managing the LGAs. At the primary care level, there are just 27 pharmacists for over 200 facilities. DRF operates in only 58 of the primary care facilities. Another challenge is storage at the state, LGA and facility levels and the unwillingness of the LGAs to support the DRF – LGAs in Lagos are very strong so it is very difficult to bypass them.

A mix of the push and pull approaches were reported to be used to get drugs to the facilities because of the logistics difficulties some of the facilities face in trying to pick up their drugs. The State leverages the presence of key pharmaceuticals and their vendors in Lagos to include in their procurement contracts last mile distribution to the recipient facilities. This push system is further necessitated by the storage inadequacies hence the need to often move commodities straight to facilities. The stores are short staffed and the m-supply has not worked in over two years, increasing their workload.

DRF money is ring fenced at the state level. The challenge is with the DRF money at the facility level. Some of the facility managers who are signatories were reported not to be complying with the guidelines.

Jigawa

In Jigawa, the Director of Procurement and Supplies was accountable to the Commissioner with a remit to procure, store and sell medicines and commodities ensuring drugs were available to patients as required. The Jigawa Medical Stores Organisation (JIMSO) supplied 95% of the State's health centres through LGAs whose stores purchased from JIMSO and sold to facilities, also a large number of patent medicine shops, some private clinics and12 hospitals. Items sold under the DRF were 50% cheaper than in the market and attracted only a 5% mark-up as opposed to 20% on the open market.

The refusal of vertical programmes to route their medicines through JIMSO is the only gap. There were reported to be 90 pre-qualified suppliers available to supply JIMSO in line with the Annual Procurement Plan and it was hoped to be able to develop a quality control laboratory.

PATHS2 had made a very significant contribution to this success story by building capacity to manage the Sustainable Drug Supply System, including setting up the main store and the sub-stores, training staff to undertake warehousing successfully and setting up the electronic inventory system. LGA stores staff had been trained by PATHS2 as had facility staff. The Logistics Management Information System had been institutionalised. Staff from SMOH, JIMSO and the Gunduma Health System had been trained in effective procurement so that they could now undertake this independently.

5.4.3 Conclusion

PATHS2 capacity enhancement activities have resulted in remarkable gains in most of the States in terms of successfully establishing apparently flourishing, appropriately governed and managed, and potentially sustainable operations for efficient procurement, storage and distribution of medicines and health related commodities together with functioning DRFs that enabled capitalised facilities to supply as required high quality drugs to clients at affordable prices.

The major strength of the system, and in this it was differentiated from arrangements for planning and budgeting, information management and human resources for health, was that the system was fully self-sustaining through efficient purchasing of large quantities of stock and sale to other parts of the public and private health system at affordable mark-ups that covered all costs associated with operating and sustaining the system.

No additional funding apart from for capitalising additional outlets was required from any source and there was therefore no reason why the system should not operate in perpetuity on the basis that the payments by patients are sufficient to cover all the costs of operating the system, covering as they do the mark-ups incurred in purchasing the medicines from the Supply Agencies provided that the DRFs remain appropriately capitalised and are not weakened by using the funds for other purposes or requiring them to support models of free health care for sections of the community or by the impact of reduced oil revenues.

6 Capacity Development at Local Government Level

6.1 The Role of LGAs

LGAs provide PHC through health centres and health posts staffed by nurses, midwives, community health officers, heath technicians, community health extension workers and by physicians (doctors) where they are employed in the southern part of the country. The services provided at these PHCs include: prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health and the collection of statistical data on health and heath related events.

Health care delivery at the LGA is in some states (where, as in the study states elected local governments are in place) headed politically by a supervisory councillor and technically and administratively by a PHC coordinator and assisted by a deputy coordinator. The PHC co-coordinator reports to the supervisory counsellor who in turn reports to the LGA chairman. In some states however, PHC coordinators are responsible for managing health care services and reports directly to the LGA chairman, while in others they are called HoD Health and especially, in Lagos, they are called Medical Officer of Health (MoH) who also report to their respective LGA chairmen. Supervisory councillors of health in such cases play just supervisory or less visible roles, but may be required to facilitate advocacy activities in response of the health needs of the people in the LGA. PHC Coordinators, MoHs and HoD Health as the case may be have varying professional and training backgrounds.

The team's researcher in Enugu was able to visit a number of LGAs in his home state being less constrained by time and security considerations than in the north. Thus more information was retrieved for Enuguthan in Kano or Jigawa. In Jigawa the study focussed on the work of the staff of the Gunduma Councils as the managers of the primary health system in the state, rather than on the LGAs whose role in health care provision is residual.

6.2 Capacity in the LGAs

6.2.1 Capacity of the Heads of the PHC Departments

In Enugu the Heads of the PHC Departments in the LGAs and their teams were able to articulate their roles and functions as being responsible for coordinating primary health care activities in the LGA, and distribution and performance management of PHC workers within the LGA. Their overarching goal was to ensure that residents of the LGA received quality health care. The HoDs reported that they had adequate capacity to carry out their role and functions although they require more environmental health officers and health facility supervisors.

LGAs in Kano were clear about their roles and responsibiliites. In Jigawa the Gunduma Councils and their officers fulfil the role in delivering primary health services that is undertaken by the LGAs in the other states and both teams visited during the study were very clear about their responsibiliites and were confident and competent managers of health care delivery.

6.2.2 PATHS2's impact on the functionality of the health system

In Enugu PATHS2 has been key to building the LGAs' capacity to perform. They were trained by PATHS2 on developing operational plans, interpersonal communication, HMIS and training and

mentoring FHCs. PATHS2 also trained health facility staff and provided technical assistance and mentoring to both the LGA and facilities.

PATHS2's role in bringing together the Supervisory Councillor for Health and the HOD, Health had a very positive impact on the funding and sustainability of health activities at the LGAs because this close working relationship ensured that the Supervisory Councillors were well briefed on health issues and could advocate effectively for the Departments.

Many PHCs were not functional before PATHS2's intervention but utilisation of those facilities that were upgraded by PATHS2 has increased as a result of upgrading of infrastructure, enhanced availability of drugs because of the DRF, improved health workers' capacity and community awareness.

The HODs are concerned that the LGAs will not be able to sustain PATHS2's achievements. One concern is shared across the States and that is that the LGAs have not taken over the funding of meetings for liaison and training that were initially funded by PATHS2.

In Kano it is also apparent that the LGAs had capacity to perform well in all the areas focussed on by this study.

In Jigawa the Gunduma Councils substitute for the LGAs in the operational delivery of primary health services and were functioning very competently in providing local leadership of the health system and its day to day management.

6.2.3 Operational Planning and funding of the LGA health plan and activities

In Enugu the LGAs have annual operational plans for health. CSOs are involved in the broad stakeholder planning workshops, but the health facilities are not involved. PATHS2 helped to introduce and coordinate the CSO and stakeholder involvement in planning. The LGAs developed a budget every year, but the budget was usually set independently of the LGA's operational plan for health. Crucially the health department was not involved in preparing the LGA budget which was led by the LGA planning officer. In order to try to overcome this dysfunctional situation the health departments have started inviting the LGA planning officer to the operational plan development workshops, to sensitize him on health care needs and to improve chances of the operational plans being incorporated into the LGAs' budgets.

Budget release by the LGAs is very low as a proportion of the proposed budget with the result that most health plans and activities remain unfunded.

There are no formal communication channels for plans and policies to the facilities and communities who only become aware of the contents of plans when the LGA PHC teams work with them to implement relevant components. The LGA team was reluctant to share the operational plan so as to manage expectations in the face of inadequate funding.

In Kano PATHS2 had institutionalised the development of the state strategic health development plans (SSHDP), medium-term sector strategies (MTSS) and annual operational plans (AOP) for the States and LGAs. Unfortunately, these activities stopped when PATHS2 ended funding for these activities although MNCH2 is now trying to take over some of them. The changes are remarkable in the sense that the LGA staff were participating in the development of the state SSHDP, MTSS together with their colleagues from the State and they were able to develop their own AOP. Unfortunately, after PATHS2, the process was suffering, as they needed funds to organise workshops to sustain these processes and these were not forthcoming from the state budget. Moreover, on most occasions the AOP was developed after the budget is passed and

therefore not likely to be included in the LGA budget. Even when they developed the AOP ahead of the budget preparation, the LGA authority tended to ignore it. The LGAs advocated to the LGA chairman and the lawmakers to attempt to ensure that their AOP is included in the budget and the funds are released.

In Jigawa the Gunduma Council officers were clearly skilled in planning and ran the annual planning cycle as a routine part of their work. This involved bottom up assessment of needs as expressed by the facility in-charges, synthesis at Gunduma Council level in a draft operational plan which was endorsed by the Council itself when functional and submitted to the Gunduma Board for approval together with the draft budget.

6.2.4 Facility supervision

In Enugu the HOD drew up the facility supervision plan based on issues raised during the monthly M&E meetings or heads of facilities meetings and visits were undertaken in line with need rather than routinely. There was an integrated supportive supervision (ISS) checklist developed with the support of PATHS2 but supervisory visits have become irregular since PATHS2 and FHI 360 stopped funding them.

Monthly meetings were held with all the section heads of the PHCs to discuss challenges and staff performance which gave a platform for receiving and dealing with staff issues. There was no formal staff performance management system. When a member staff reported having issues, the HODs investigated and had the power to issue a query or even withhold salary as a punishment, if necessary.

In Kano facility supervision was undertaken satisfactorily by the PHC HoD and in Jigawa this was the responsibility of the Gunduma Council officers who made it a priority for the reproductive health coordinator even when lack of resources meant other activiites had to be shelved.

6.2.5 The Monitoring and Evaluation (M&E) System and HMIS

In Enugu monthly M&E meetings were used to collect data from health facilities since their M&E focal persons were asked to bring their data to the meetings. These meetings were initially funded by PATHS 2 but has become irregular since PATHS2 started winding down and stopped funding the meetings. The LGA is yet to fully take over the funding. To remedy the situation, PATHS2 introduced mobile phones for collecting and reporting data and trained facility staff in their use. Reporting rates have increased again with the introduction of the mobile reporting, but is still lower than when the meetings were used. The PHCs complain of connectivity and technical challenges with using the phones.

Data was analysed each month by the PHC department to identify, investigate and resolve issues such as any decrease in the utilisation of services. They also used data to identify communities that merited being targeted with mobile outreach and awareness creation activities. Data from the HMIS was not used for developing LGA budgets.

In Kano PATHS2 had been very successful in helping to establish the Information system in the State. Monthly M & E review meetings were institutionalised as well a support and supervisory visits. DQA was also put in place as well. Reporting timelines were defined and adhered to from the health facilities to the LGA to the state and national levels. Despite lack of funds, the health facilities M & E officers are still reporting M & E data to the LGA M & E officer on a monthly basis. Health facilities' M & E officers collected reports from all units in the health facility and send them to the LGA M & E officer using the monthly summary forms. The LGA M & E officer then consolidated

and looked for gaps in quality and provided feedback to the health facilities' M & E officers. When the LGA M & E officer was happy with the data, he entered it into DHIS. Data submission deadlines ran from 1st to 14th of the current month for the previous month's data and around 80% to 90% of facilities were routinely meeting this timetable. The main problem facing HMIS was conflicting projects like the supplementary immunization days that coincided with the reporting period.

In Jigawa this system was effectively run by the Gunduma Council officers through a dedicated HMIS lead who oversaw the collection of data at facility level and in collaboration with LGA PHC staff summarised it for onward transmission to the Gunduma Board and the SMoH.

6.2.6 DRF and availability of quality drugs

In Enugu the DRF system worked well in the State and most of the facilities did not experience stock-outs. PATHS2 provided extensive support for the establishment and continuous running of the DRF. The supervision by the in-state team had been very helpful in improving DRF management at the facility level.

A few of the facilities had decapitalised and the health department was investigating to find out the causes and work with the State to resolve them.

In Kano most of the health facilities were continuing successfully to run the DRF as designed by the State. The state DRF committees were now in charge of capitalising more health facilities to carry out DRF activities.

In Jigawa, again the Gunduma Council team competently managed the supply of drugs to facilities working in collaboration with LGA staff who managed a sub-store for medicines under JIMSO from which the in-charges ordered their supplies according to funds available in the DRF.

6.2.7 Human resources for health

In Enugu staffing levels were held to be generally inadequate at the facility level with CHEWs, nurses/midwives and laboratory technicians in short supply. There was also the challenge of constant staff redeployment, as staff trained in enhanced clinical skills by PATHS2 were redeployed and replaced by untrained staff although the LGAs supported the step-down ALSS training for those front line staff which had not been included in the initial courses.

In Kano HRH was not well coordinated and systems were not in place. In Jigawa, as commented elsewhere in this study human resource management was managed effectively by the Gunduma Councill officers who were in a clear line relationship with the facility staff, appointed them, supervised them effectively and managed their contracts and performance. This is undoubtedly the model that can be replicated with great advantage in the other states

6.3 Conclusions

The findings at LGA level in Enugu, Kano and Jigawa reflect the findings for state level capacity building in that PATHS2 was extremely successful in building capacity in planning and budgeting, HMIS management and drugs supply, however the sustainability of the gains made in planning and budgeting and the HMIS system are fragile due to lack of funding to maintain the systems whereas the drug supply system is fully self-sustaining. It should be noted however, that the creation of SPHCDAs will end the LGAs responsibility for the provision of healthcare.

Only in Jigawa with the Gunduma Health System is there a robust link between State level and LGA level, which enables state wide plans to be operationalised effectively at LGA level and the implementing officials to be held to account for their performance by the Gunduma Board senior management. A new finding was that linkages between LGAs and facilities were strong and are only jeopardised by lack of programmatic funding to sustain integrated supportive supervision.

7 Capacity Development at Facility Level

7.1 Improvements in capacity due to PATHS2's interventions

This section is based on interviews with facility offices in charge, members of staff, and community memebers. Although the facility in-charges and the members of staff of each facility were interviewed separately, both gave essentially the same responses. Responses were also very similar from each of the total of 24 facilities visited covering the States of Kano, Jigawa and Enugu. Facility staff spontaneously reported successful interventions by PATHS2 relating to the eight service delivery pillars:

1. Improved supply of health commodities. Most facilities reported that drug supplies were coming regularly and there were few stock-outs or expiries. The availability of family planning products was particularly appreciated. The units had good storage facilities. Unlike other donor projects, PATHS2 had not supplied free drugs, but the establishment of the DRFs on a sustainable basis was seen as a major step forward.

2. Improved basic infrastructure. There was great appreciation of the work PATHS2 had done to renovate facilities and supply equipment for laboratories or for power generation. Some units were disappointed that planned renovations did not take place, and some reported that equipment had broken down and that there was no budget to repair it. Moreover, it appeared that many of the generators were out of use because there were no funds to buy fuel. Lack of water remained a problem in most units together with no funding for cleaning staff or disposable items such as gloves or maternity pads. However, the general conclusion was that where PATHS2 had intervened to support infrastructure renovation, the new facilities were substantially more functional than previously.

3. Improved human resource capacity. Facility in-charges and staff greatly valued the training that PATHS2 had provided to increase the clinical skills of front line staff; any increases to the establishment that had been achieved were also valued. However, the clinical training had only reached a proportion of the total staff – it had not been comprehensive which left many health workers lacking adequate skills. The greatest source of continuing concern for the facility staff was the lack of overall numbers of staff, this led to delays in patients being seen on busy days and to the staff being pressurised into providing emergency obstetric care on a 24/7 basis even though they were only staffed for 9 to 5 operation. This is why PATHS2 is supporting PPP initiatives, especially in the Southern States, where there is substantial presence of private providers. With dwindling resources, private provider initiatives can also be encouraged in the northern states. The skill-mix was poor with over-reliance on CHEWs and HCOs for provision of most of the care. It was also reported that the step-down training in clinical skills was largely ineffective apparently due to lack of hands-on training and so the planned roll-out of enhanced skills was not, in reality, taking place.

4. Establishment of two-way referral systems. It was clear that this had been successfully established for many of the facilities and visits to the primary care units by hospital based clinicians were seen to especially be beneficial in making affordable, high quality consultations available locally.

5. Strengthened integrated supportive supervision. All facilities reported that they were visited regularly for supportive supervision by staff from the LGA, Gunduma or even the State. The visits were reported to be regular, monthly or more frequently and 'purposeful, enabling the

officers in charge to discuss problems and obtain feedback as well as often sending monthly data back with the supervisor.

6. Strengthened HMIS. Again, almost all units reported that the system as designed was working well for them with even those units that lacked a dedicated M&E officer being able to return data on a monthly basis, in Enugu via mobiles.

7. Increased accountability to communities. Many OICs were highly appreciative of the existence and active work of the FHCs and could give examples of ways in which the FHCs were proving invaluable inputs and supports to the units.

8. Strengthened health communication and community mobilisation. Whilst this was mentioned less frequently than some of the other pillars, staff indicated that they now had means of knowing the level of patient satisfaction with the services their unit provided which they valued and that uptake of services had increased in part because of the messages being transmitted about the need to seek health care.

7.2 Improvements in utilisation and outcome

Facility staff were universally and uniformly positive about the beneficial impact of PATHS2's interventions on the utilisation of health services and health outcomes.

Although the reports from the facilities were anecdotal and unquantified, staff firmly believed that maternal and child mortality rates had declined since PATHS2 started working and that child illnesses were less prevalent, that immunisation rates had increased and that there was less reliance on traditional birth attendants and healers.

Numbers of patients attending for ANC, safe delivery and routine treatment had increased due to a range of factors including simply knowing that the facility was open and functioning, the known and reliable availability of good quality, low cost medicines, the increasing knowledge in communities that their health workers had enhanced skills and that outcomes were improving accordingly, as patients' satisfaction with services increased so they "spread the word", FHCs' outreach activities were helping more people to know of the availability of services and of the need to access care and the enhanced availability of specific services such as family planning also helped to increase the number of people accessing care from the PHCs.

7.3 Attribution of the improvements to PATHS2

The reports from the facilities indicated that whilst a large number of other development partners and NGOs and volunteers contributed to the development of the facilities and their services, the vast majority of these interventions related to supporting vertical programmes for such communicable diseases as malaria and HIV, in the main by donating supplies of drugs, commodities and specialised equipment. A very few were reported to have made programmatic inputs such as supervising their vertical programme.

The only area of "cross-over" of any significance was in relation to the construction activities of the Office of the Senior Special Assistant to the President on the Nigeria Millennium Development Goals (OSSAP-MDG), typically building staff residences or sinking boreholes, which were highly complementary to PATHS2's objectives. None of the other agencies adopted anything remotely resembling PATHS2's comprehensive approach to facility and community development.

7.4 Community views on PATHS2's effectiveness

Comments by members of the community interviewed by the research teams reflected those of the facility staff with little variation across the three States. In particular, there was great awareness of the step change in the performance of the units that was attributable to PATHS2's capacity enhancement work with patients being content to attend for a broad range of conditions in much increased numbers, improvements in staff competence, attendance and their respect for patients, in the range of services available, the cleanliness of some of the facilities and the consistent availability of drugs at affordable prices.

Community members were also aware of some difficulties remaining such as lack of electricity and water, absence of fuel for generators, limited service availability at night, lack of consumables such as laboratory reagents and inability to fund repairs of any kind.

When asked about arrangements for transporting critical patients to secondary care, all community groups responded that ambulance provision was not available and the community had to take responsibility for transporting the patient with out of pocket payments covering costs.

It was apparent that at least among the engaged members of the community who took part in the FGDs, there was good awareness of the health messages that were being communicated as a result of PATHS2 and other initiatives such as SAVI; messages were heard on the radio, given out by the chief imam, communicated by the town announcer or by volunteers going house to house.

Community members were universally confident that they could give feedback to the health system through accessing their FHC or by approaching the OIC directly, who was often a member of the FHC and the FHCs were perceived to be effective groups with a remit to support the facility in any way possible, including by supporting up-gradings, and also by advocating for the community's need to the Commissioner and even the Governor.

7.5 Conclusions

Feedback from both facility staff and community members confirmed that PATHS2's capacity building activities had contributed substantially to the creation of primary health care units that were able to instil confidence in the communities they served and that offered consistently an accessible and appropriate package of effective care. It is clear that the functionality of the units targeted by PATHS2 has been substantially increased and that there is accountability to local communities through effective FHCs with a population that is increasingly able to appreciate when to seek health care and to hold the providers to account.

However, despite PATHS2's substantial achievements, significant problems remain. For lack of essentially small amounts of impress cash, the day to operation of the units in such areas as security, availability of functioning equipment and cleanliness is severely compromised. Facility OICs, staff members and community groups all indicate that the absolute staff numbers are inadequate and the skill-mix too low. Whilst the staff who have had access to training in enhanced clinical skills are providing first-rate care, many front line staff did not get access to the training and it is reported universally from the facilities that the step-down training is ineffective in transferring skills. With substantial workforce attrition reported by the States there is a real danger that unless action is taken, the staff competence that is as at the heart of the communities' confidence in the units and willingness to use their services will be lost and the units will return to their previous unused and moribund state. Health care delivery requires well-trained staff available at the front line and without this other inputs lose their value being necessary but not sufficient.

8 Conclusions and Implications

8.1 Conclusions

The headline research question for the study is:

> "How effective has PATHS2 support to the federal level, to states and to LGAs been in developing capacity to perform their key functions, i.e. to develop health policies and legislation; to plan, finance, and manage health services, including adequate staffing and logistics; to set up and use reporting systems with high quality data; and to improve access to and utilisation of basic health services?"

The main conclusions are summarised below.

8.1.1 Federal level conclusions

PATHS2 has played an important role in developing capacity at Federal level in all three dimensions of institutional, organisational and individual capacity for each of the areas of activity studied - policy and planning, HMIS development, HRH, and the NPHCDA. Much of the capacity development remains relevant and useful although concerns were expressed about meeting expectations placed on Planning, Policy and Research and about the insecurity of funding for HRH development. The capacity development achieved has not been consolidated by the provision of adequate federal government funding for implementation and maintenance of the systems that have been built and so there are significant concerns about sustainability. PATHS2 contributed to the eventual passage of the National Heath Act which should provide an improved national framework for health policy. However much will depend on the level of commitment and effectiveness of the new Presidential administration elected in 2015 in taking forward a coherent and adequately funded federal policy that will provide effective leadership and direction for states.

8.1.2 State level conclusions

There have been significant improvements in capacity at this level to govern, plan and budget for health services, although continuing investment needs to be assured in order to sustain these improvements. In each of the States arrangements for the procurement, supply and affordable availability of drugs have been radically improved. Capacity has been developed to capture health related information and to transmit, summarise and use it for planning and evaluation purposes. However, there is evidence that the system does not work entirely as intended in that data capture remains incomplete and - a theme of this report – the benefits of the investment made by PATHS2 will be lost unless there is an ongoing budget to support the maintenance of the system at all levels.

The arrangements for staffing the health system effectively remain inadequate with responsibilities continuing to be diffuse and poorly defined in each of the focal states except Jigawa, where the Gunduma system manages human resource issues in an integrated manner and with roles and responsibilities for HRH defined among the contributing agencies. Whilst there have been improvements in the supply of trained health personnel as a result of PATHS2's interventions, it would have been advantageous if PATHS2 had been able to focus on rationalising the arrangements for planning, funding, developing and deploying the health workforce and in this sense building institutional capacity. The consolidation of PHC functions under the SPHCDAs has the potential to unify the planning and provision of health care and leadership of all aspects of

human resource management, but this has not taken place in the states in which PATHS2 has worked.

It is in terms of supervising the health system adequately and in linking State policy making, planning and budgeting to LGAs that the differences between the States is most marked.

In Jigawa the Gunduma Health System Board and Councils appears to provide a reasonably effective model for the provision of “PHC under one roof” by integrating the planning and delivery of PHC within the Gunduma system and taking control of these functions out of the hands of both the SMOH and the LGAS. Whilst effective means of engaging the LGAs in PHC planning and delivery are available through the Gunduma system, the relationship of the Gunduma Board with SMOH requires strengthening to improve coordination and accountability.

In Kano and Kaduna the SPHC Management Boards have gone a long way to integrating the planning and provision of PHC although without the full integration of functions that the SPHCDAs could bring, if implemented as envisaged in the NHAct 2014. The close working relationship between States and LGAs described here indicates that, because of the perceived mutual dependence of State and LGA, changes in capacity at State level have translated into improved capacity at LGA level with the main transmission mechanism being the SPHCMBs.

In Lagos and Enugu the separation of States and LGAs in provision of PHC is most pronounced and most damaging and it is not possible to say for these States that changes in capacity at State level have translated into improved performance of the public health system at LGA level because the necessary transmission mechanisms do not exist. An additional consideration is that in Lagos the health system essentially depends on the private sector, which makes LGAs less relevant unless they are able to develop an effective system of regulating private health care provision.

8.1.3 LGA level conclusions

The findings at LGA level in Enugu, Kano and Jigawa reflect the findings for state level capacity building in that PATHS2 was extremely successful in building capacity in planning and budgeting, HMIS management and drugs supply, however the sustainability of the gains made in planning and budgeting and the HMIS system are fragile due to lack of funding to maintain the systems whereas the drug supply system is fully self-sustaining. It should be noted however, that the creation of SPHCDAs will end the LGAs responsibility for the provision of healthcare.

Only in Jigawa with the Gunduma Health System is there a robust link between State level and LGA level, which enables state wide plans to be operationalised effectively at LGA level and the implementing officials to be held to account for their performance by the Gunduma Board senior management. Linkages between LGAs and facilities were strong and are only jeopardised by lack of programmatic funding to sustain integrated supportive supervision.

8.1.4 Facility level conclusions

The research undertaken at facility level with staff, FHCs and communities indicates that all these groups in each of the three States report significant gains as a result of PATHS2’s activities relating to service availability and uptake, health improvement in terms of reduced mortality, staff competence in key, especially life-saving, skills, improved efficiency and morale through better managerial support and community engagement, improved physical environments, drug availability and referral arrangements. It is also true that the gains are not universally available and it is difficult to measure the level of coverage achieved. There is a lack of on-going investment and unless this

can be made good through, for example, MNCH2, the system will at best remain at its current level of performance and might even in time revert to pre-PATHS2 levels of performance.

8.1.5 Sustainability

A recurrent theme of this report is that whilst PATHS2's interventions have been effective in developing capacity almost whenever they have intervened, some of the capacity gains are in danger of being short-lived as result of lack of continuing investment. This problem has been intensified by the severe fiscal pressures that have resulted from the collapse of oil prices from late 2014, and the limited progress that has been made in developing mechanisms for stabilising priority public spending in the face of revenue uncertainty.

Immediate examples include the (temporary) loss of functionality of HRIS and HMIS software due to its corruption over time and lack of funds to have it professionally revised. The states have continued to report on the DHIS2 platform though the quality of data needs to be improved. There was a delay in the taking over of the HRHIS database by MNCH2 from PATHS2. The handing over of the database did not take place until the second half of February 2016. There have also been constraints on the ability to cascade life-saving skills enhancement to front line staff as repeatedly emphasised by facility staff interviewed by the study's researchers and a lack of resources to repair broken equipment in facilities. In the longer term the gains achieved through developing the individual capacity of key officers at Federal and State level will not be sustained as those officers move to other duties or are lost through retirement, since arrangements are not in place to ensure training of their replacements.

This report indicates that for capacity development in planning and budgeting and for the HMIS system, unless there is on-going funding available to maintain the gains made under PATHS2 they will be eroded by time and lost. This also applies to the improvements made in service delivery at facility level. Improvements in drug supply will continue to be made to the extent that additional facilities can be capitalised, but that also depends on future not past investment. HRH management will potentially improve with the introduction of SPHCDAs in the States and again these are not "front-loaded" gains but depend on work yet to be undertaken. The answer therefore appears to be that there are no future gains in outputs and outcomes to be anticipated from the investment made to date by PATHS2 beyond those delivered on a day to day basis by a better functioning health service – which are currently being provided as a result of PATHS2's interventions.

Sustainability depends on three main factors: political commitment, affordability, and capacity for continued implementation with reduced external support. It remains to be determined whether the temporary fiscal shock (in a context where state level spending on health does appear to have increased over time) that has affected budget implementation will be overcome and political commitment to improved health service provision continues. PATHS2 appears to have paid less systematic attention to its political engagement than has ESSPIN in the education sector. While capacity for strengthened system management has been developed, sustainability will require continued investment in both individual and organisational capacity.

8.1.6 Impact on utilisation of health services and health outcomes

There is evidence of improved health outcomes in the PATHS2 states, as shown in Table 1 and Table 2, though the extent to which these improvements can be attributed to PATHS2 interventions is difficult to establish. PATHS2 has generally achieved the milestones for Outcome 1 and 2 relating respectively to the number/proportion of pregnant women making at least four ante-natal

care visits in the supported States and the number/proportion of births attended by skilled birth attendants, though overall only one birth in four was attended by a skilled birth attendant.

Key informants at State and facility level considered that PATHS2's work had led to improvements in utilisation and health outcomes. This was especially strongly expressed at facility level where staff routinely reported a significant increase in their workload and demonstrable improvements in health outcomes as a result of improved health-seeking behaviour by the population and enhanced staff skills and resources. In Jigawa the Planning Directorate could plot the radical increase in uptake of PHC across the lifetime of PATHS2 and SMOH Permanent Secretaries were sure that PATHS2 had led to significant health gains.

8.1.7 Synergies with other initiatives

It is clear from key informants' responses as well as published material such as Annual Reports that especially at Federal and facility level, PATHS2's capacity development activities have been one of a range of development partner inputs. This report focuses on PATHS2's significant contribution and does not attempt to assess the relative impact of each partners' initiatives to capacity development which at best can only be an anecdotal analysis, although it is clear that care was taken both by PATHS2 and government to ensure that inputs were mutually supportive and duplication of effort was avoided.

PATHS2 was designed as part of the DFID State Level Programmes (SLP) Suite. There have been some complementarities in particular between the approach to planning and budgeting that PATHS2 has sought to promote, and the more general efforts to strengthen planning, budgeting and other public management systems under SPARC. However, generally progress in developing systems appears to have been based on initiatives implemented by PATHS2.

8.2 Implications for DFID

PATHS2 has demonstrated that a focus on health systems strengthening can yield results in terms of improved sector management and health outcomes, though this requires long-term commitment and engagement. However, the study has also concluded that the sustainability of the capacity development achieved is threatened by a lack of continued funding by States and LGAs with some initiatives (for instance the strengthening of the HMIS) appearing particularly vulnerable. Ongoing DFID support through MNCH2 provides a mechanism for some continuation and extension of training support, but sustainability will fundamentally depend on the extent to which political commitment to higher levels of spending on primary health, and to improving its management, has strengthened. This will be determined in part by the extent to which electoral benefits are seen by politicians as accruing to demonstrated success in strengthening service delivery, rather than just investing in visible physical infrastructure, or implementing high profile but often unsustainable policies of free drug provision. The major challenge for consolidating the capacity development achieved will be to secure recognition and encourage leadership from Federal and State level of the need for continued funding to implement reforms and roll out improved practice. The National Health Act provides a framework for this, but the approach of the new Federal government will be of key importance for providing policy direction.

PATHS2's experience has also highlighted the continuing need for integration and strengthening of PHC system management, and the need for greater attention to be paid to workforce planning and human resource management. Only limited progress has been made in implementing integrated PHC management through SPHCDAs, and while the Gunduma model in Jigawa has had some success, it also has not been replicated elsewhere.

These conclusions have the following implications for DFID's continued and future programming:

- DFID should continue to advocate, and to promote through its interventions and projects, a systemwide approach to strengthening PHC management and service delivery, in line with Nigeria's health policies and objectives.

- Greater attention should be paid to understanding political incentives and determinants of political commitment for DFID's health sector interventions, with lessons potentially to be learned for the health sector from ESSPIN's approach in the education sector.

- A clearer position should be developed (working in particular with NPHCDA and the FMoH) about the SPHCDA model and how integration and strengthening of management of PHC can in practice be achieved, noting that despite a long period of DFID support the Gunduma Board model developed in Jigawa has not been replicated elsewhere. While it is possible to strengthen management within the existing institutional arrangements for the health sector, the lack of mechanisms by which State Ministries of Health can implement policies or influence budgets, and the weak capacity of LGAs, means that appropriately implemented PHC consolidation under SPHCDAs may have significant advantages in strengthening management, as some positive examples have shown.[1]

- Greater attention should be paid to human resource management issues for the health sector since this appears to be a critical bottleneck to improved systems performance. Again, consolidating the management of PHC staff under an SPHCDA has potential and effective ways of implementing this need to established.

- It is notable that PATHS2 has focused largely on the public sector, although the private sector plays an important (and in some cases dominant) role in service provision in many parts of Nigeria, particularly in urban areas and the South. DFID's future interventions should reflect more systematically the role of the private sector, and issues of regulation and synergies with the public sector as part of an overall PHC strategy.

[1] E.g. in Adamawa as discussed in Jones, Nwachukwu and Ojegbile (2015).

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Annex A Terms of Reference

A.1 Background and Context

The Partnership for Transforming Health Systems Phase Two (PATHS2) programme is a six year (2008-2014) DFID-funded health development programme currently being implemented at federal level and in five focal states namely: Enugu, Jigawa, Kaduna, Kano and Lagos states. It is part of the suite of DFID-funded State Level Programmes (SLPs) that seek to improve governance and service delivery. PATHS2 seeks to bring about sustainable improvements in the delivery of health services in Nigeria by working with key institutions to bring about systemic change in the sector; developing capacity at the federal, state, local and facility levels; and leveraging Nigerian resources in support of State and Federal health sector plans. PATHS2 builds on previous programmes, in particular its predecessor PATHS1, recognising the interplay between demand and supply, the role of the community (the end users), the importance of information dissemination and feedback mechanism, managing for results, value for money and accountability.

PATHS2 has been phased out in Northern states in January 2015 and is currently in a transition period to the new DFID-funded Maternal, Neonatal, and Child Health programme (MNCH2

This document sets out the terms of reference for a study using both quantitative data and qualitative data of PATHS2's support to capacity development in basic health care in Nigeria. The study will contribute to the evaluation of the role of PATHS2 for improved service delivery in the context of the Programme Completion Reports for Jigawa, Kaduna, and Kano in 2015 and for Enugu and Lagos in 2016, and to the Final Evaluation of DFID's State Level Programmes in Nigeria, to be completed by September 2016 by the Independent Monitoring and Evaluation Project (IMEP). It will also provide lessons learned that can feed into the MNCH2 programme development.

The study will draw on both quantitative and qualitative sources. Qualitative primary data collection will be used to:

- Supplement the data collected by PATHS2 on capacity development inputs, processes, outcomes at the federal, state and LGA levels;
- Explore the transmission mechanisms through which PATHS2's activities at each level of the health system (federal, state, LGA) have filtered down to the health facility level;
- Seek to obtain evidence on the reasons for the success (or otherwise) of core capacity development activities carried out by PATHS2.

The PATHS2 capacity development study largely follows the same methodology as the ESSPIN capacity development study in order to provide comparable evidence for both SLPs.

A.2 Defining 'capacity'

An operational definition of "capacity" and "capacity development" is a prerequisite for the study and for defining its scope. "Capacity" refers to the ability of agents (individuals and organisations) to perform their functions, solve problems and set and achieve their objectives in a sustainable manner, where agents operate within an institutional environment which structures their incentives and scope for action. **Error! Reference source not found.** sets out a framework for analysing and

ssessing factors that affect capacity at the individual, organisational and institutional levels. This framework is based on North's (1991) definition of institutions as "humanly devised constraints that structure political, economic and social interactions" and which may be either formal (constitutions, laws, property rights) or informal (social sanctions, customs, traditions, taboos, conventions and norms). Organisations are collections of individuals engaged in a purposive activity. So capacity depends not only on the competence of the people who make up the organisation in performing their tasks (the *individual* level), but also on the structures and processes within which they work (the *organisational* level), and the framework of rules and conventions that constitutes the organisation's operating environment (the *institutional* level).

Figure 2 Levels of Capacity Development

Level	Capacity diagnosis	Capacity creation	Capacity utilisation	Capacity retention
Individual (knowledge, skills, competencies)	Assessment of individual skills, knowledge, competencies and attitudes in relation to organisational functions	Development of adequate skills, knowledge, competencies and attitudes	Application of skills, knowledge, competencies in the workplace	Reduction of staff turnover, facilitation of skills and knowledge transfer within organisations
Organisational (resources, management structures, and processes)	Assessment of organisational performance and factors affecting it	Establishment of efficient structures and processes and adequate resourcing	Integration of structures and processes in the daily workflows	Regular adaptation of structures and processes and continued adequate resourcing
Institutional (laws, regulations, policies, social practices)	Assessment of how institutional and policy environment impacts on organisational performance	Establishment of adequate institutions, laws and regulations, including implementation processes and compliance arrangements	Enforcement of laws and regulations to facilitate organisational performance	Regular adaptation of institutions, laws and regulations

Source: Adapted from OPM/SIPU (2012).

A key insight is that the institutional framework may impose constraints on organisational capacity, while organisational capacity will influence the extent to which individual capacities can be effectively used to further the organisation's purpose. Hence, in a situation of pervasive institutional weaknesses (i.e. sets of formal and informal rules that militate against the achievement of social goals through organisations), actions focused at the organisational or individual level may have only limited success in bringing about sustainable improvements in capacity. Even in a favourable institutional environment, providing individual training to staff may not lead to improvements in organisational performance if the organisation does not have the capacity to use and retain these skills (for instance because of weak management or dysfunctional internal incentives). Organisations play a central role, since these are how individual behaviour is most directly structured, and through which the influence of institutional factors is mediated. A capacity development strategy will need to operate at all three levels. Given its scope, this study is likely to focus on the organisational level. This means that some capacity, such as growth of competence of individuals which they could carry when moving to different posts or organisations will not be fully captured.

The components of capacity at each level may be difficult (in practice and in principle) to measure, since for example the relevant components of individual skills and knowledge or the functioning of management arrangements may not be directly observable. The most fundamental measure of capacity is how successfully organisations carry out their functions. The starting point for capacity development assessment is therefore to define the functions of each organisation, how their performance can be measured, and how this has changed over time. Dimensions of performance can be measured for particular organisations or groups of organisations (e.g. whether the budget is successfully executed) or for the state system of basic health as a whole (measured by the health-related results achieved). Some of this analysis has already been covered in the Annual Reviews.

The factors that explain changes in capacity can then be examined to seek to understand contribution to changes in performance. The type of analysis and empirical rigour of the explanation will depend on the resources and type of data available. For example, if there is data on both the performance and characteristics of a large number of similar organisations (such as facilities), it may be possible quantitatively to analyse the influence of different factors on performance. Where there is only a small number of comparable organisations (e.g. state ministries of health), the contribution assessment may depend on key informant assessments (focusing on the evidence for the validity of the Theory of Change that has guided a capacity development strategy).

Figure 3 Dimensions of organisational capacity development

	Functional-rational dimension	Political dimension
Internal dimension	Getting the job done – task-and-work system (skills, structures, etc.) INDIVIDUAL AND ORGANISATIONAL CHANGE	Addressing power relations and accommodating interests – systems for hiring and promoting on merit, rewarding performance, etc. ORGANISATIONAL CHANGE
External dimension	Creating an enabling environment – external factors and incentives affecting task-and-work system (external audit, protection from political influence, etc.) INSTITUTIONAL CHANGE	Forcing change in internal power relations – external factors and incentives affecting power and authority in the organisation (strengthening civil society, media scrutiny, etc.) INSTITUTIONAL CHANGE

Source: OPM/SIPU, 2012 derived from Danida (2007)

Error! Reference source not found. distinguishes two types of dimension of organisational apacity development. The first distinction relates to factors that are either internal or external to the organisation. The second distinction relates to functional-rational as opposed to political factors. A strategy to improve the capacity of an organisation to perform its functions may be focused on any one or more of the four categories of action defined by these dimension, and so this provides a framework for classifying capacity development strategies.

A.3 Task Description

A.3.1 Objectives

The purpose of this study is to assess PATHS2's contribution to building capacity in the five states in which it has worked in the following areas:

a. Developing systems and capacity in health policy, strategy and financing

b. Improving the Human Resources for Health system's capacity to plan, manage and develop the health workforce

c. Improving logistics systems to procure and supply drugs and equipment

d. Improving capacity to develop and maintain M&E and reporting standards through the Health Management Information Systems

e. Improving capacity of health facilities and providers to deliver quality maternal and child health services, improve access to services and enhance uptake of primary health care services

The study will also seek to explore the conditions under which PATHS2's activities have made contributions to improving performance in these areas, the likely sustainability of the capacity developed; and the routes through which its activities at each level of the health system have filtered down to lower levels (state, LGA, facility).

Where possible, focal and non-focal LGAs will be analysed separately to examine the role of the different extent of capacity-development support provided.

A.3.2 Scope

The study will review PATHS2's role on developing capacity within the following organisations:

- The Federal Ministry of Health (FMoH) and the National Primary Health Care Development Agency (NPHCDA), at the federal level
- The State Ministries of Health (SMoHs) and the State Primary Health Care Development Agency at the state level
- Local government area (LGA) health authorities;
- Health facilities (PHC – primary health care centre; CHC – comprehensive health care centre); facility health committees;
- Civil Society Organisations (CSOs)

The study will consider PATHS2's contribution from its inception in 2008 to the present, and at each level of the health system, from federal to facility level. It will involve an assessment of capacity development experience and results at state level, including collecting data on capacity development experience along the whole chain to the health facility level. The study will draw as much as possible on existing evidence, such as the three rounds of the PATSH2 survey which provides quantitative evidence on the health facilities, health providers and households' health-related attitudes and behaviour in the PATHS2 states as well as programme monitoring data. The

compilation of quantitative evidence will be complemented by further qualitative analysis in the states in which more intensive data collection will take place.

A.3.3 Research questions

The headline research question that the study will seek to answer is the following:

> *How effective has PATHS2 support to the federal level, to states and to LGAs been in developing capacity to perform their key functions, i.e. to develop health policies and legislation; to plan, finance, and manage health services, including adequate staffing and logistics; to set up and use reporting systems with high quality data; to deliver high quality health services, and to improve access to and utilisation of basic health services?*

The proposed specific research questions contributing to answering the headline questions are listed below. The questions start by linking any improvements in performance and outcomes to capacity-development, at each level (federal, state, LGA, facility) as well as changes channelled to lower levels (questions 1-7). However, capacity might have been built that has not (yet) translated into improved observable outcomes, possibly due to constraints at other levels of capacity development (institutional, organisational, individual) or external factors. These cases are explored in questions 8 and 9. Questions 10 and 11 examine the role of synergies across initiatives and enhanced stakeholder commitment and coordination for capacity development.

1. Have there been improvements in the performance of key functions, the utilisation of health services and health outcomes at the Federal and State level over the period of PATHS2 implementation?

2. Is there evidence that PATHS2 capacity development activities at the Federal and State level have contributed to improvements in the performance of key functions?

3. Have changes in capacity at the Federal or State level translated into improved service utilisation and health outcomes at the LGA and facility levels? What is the transmission mechanism for these changes?

4. To what extent have PATHS2 capacity development activities at the LGA level contributed to improvements in the performance of key functions?

5. To what extent and in what way have changes in capacity at the LGA level translated into improved capacity and outcomes at the facility level?

6. To what extent have PATHS2 capacity development activities at facility level translated into improved capacity in facilities?

7. To what extent and in what way have improvements in capacity at the facility level (medical/managerial/staffing/equipment etc.) translated into improved health outcomes?

8. How has the performance and effectiveness of PATHS2's capacity development activities differed between states and LGAs, and why? How do PATHS2 focal and non-focal LGAs differ?

9. Is there evidence that capacity has been built at institutional, organisational and/or individual level even where capacity development has not yet led to improvements in outputs and outcomes?

10. To what extent have synergies with other initiatives (e.g. other DFID programmes including the other State-level programmes, other donor programmes, Federal or State initiatives) contributed to the capacity development observed at each level?

11. How have the interests and influence of different stakeholders contributed to the capacity development observed at each level?

The research questions will be reviewed and finalised during the Inception Phase, including potentially identifying more specific research questions in relation to particular PATHS2 interventions.

A.4 Methodology

The core elements of the methodology suggested for this study are the following, although the detailed methodology will be developed during the Inception Phase:

1. Starting from a compilation and review of programme documents, a definition of capacity in the context of PATHS2 at the various levels and in terms of institutional, organisational, and individual capacity will be developed. This will be based on defining the functions that are performed by organisations in basic health (capacity to do "…"), at each level from the federal level to the facility and individuals involved in healthcare provision, as capacity relates to the ability of organisations to fulfil these functions sustainably over time. Programme documents should also be helpful to establish initial capacity diagnosis and intended capacity outcomes. The capacity development at different levels and the interactions among different aspects of capacity, both for supply-side and demand-side factors, and how they work (or fail to work) together can be analysed in a "capacity map" based on the Theory of Change, that links capacity-related inputs, processes and behaviours, outputs, to outcomes and impacts in terms of health service delivery.

2. Summarise how PATHS2 activities have sought to improve performance of these functions, including the resources used, activities undertaken, and the assumptions underlying the intervention logic that has guided these activities, through a review of documentation and discussions with PATHS2 state teams and other team members.

3. Based on the capacity map and links to PATHS2 activities, develop a list of quantitative indicators and analysis approaches that can be used to examine how capacity inputs, processes, outputs and performance have evolved during implementation of PATHS2. These will start from the logframe indicators and assess whether additional indicators or proxy indicators would be useful. The quantitative evidence will be examined for the federal level as well as state-level, showing trends as well as comparisons between states/between focal and non-focal LGAs where possible.

   The starting point for the quantitative analysis will be a review and compilation of analysis in existing reports and programme documents. Depending on the accessibility and richness of previous studies, further targeted analysis of the microdata might be carried out to complement existing analysis.

   Data sources that could be explored include:

   - PATHS2/other SLP data sources: PATHS2 surveys; citizen perception surveys, PFM data collected through SPARC; any other monitoring data collected by PATHS2.

- National data sources: DHS and MICS, Afrobarometer; HMIS; possibly HNLSS; National health and nutrition survey 2013 and 2014.

- Questions around data quality – already tackled to some extent in previous reports about the PATHS2 surveys and maternal health indicators from various data sources – will also be examined to establish in how far existing analysis and supplementary analysis can be used to respond to the research questions. Selected additional indicators will also be examined and a short summary assessment of the quality of reporting data will be developed. Given that better data and better use of data were capacity development objectives, data quality aspects will also be one of the capacity output indicators to be analysed.

4. Identify the knowledge gaps following the analysis of quantitative evidence (either because the relevant indicators are not measured or data quality is insufficient), and identify issues and hypotheses for further investigation during the qualitative study

5. Obtain evidence on changes in the performance of key federal and state functions over time from key stakeholders from the FMoH and National Primary Health Care Development Agency (NPHCDA) and stakeholders from the states, and identify the main constraints and achievement in capacity development. It is understood that no comprehensive self-assessment is planned as part of the PATHS2 project closure in Northern states. The team would therefore visit the three states to conduct interviews. One option would be to organise visits to state-level stakeholders at the same time as the more intensive studies outlined under point 6.

6. Undertake more intensive studies in all or some of the three states, including data collection at LGA and facility level, using participatory approaches where appropriate, to trace how PATHS2 activities have influenced capacity and system performance at each level from state to facility. Provisionally it is suggested that the fieldwork should cover two or three states, covering two LGAs per state and 6 facilities per state. After the inception phase a decision would be taken whether to select focal LGAs where both service-delivery work and systems strengthening were supported by PATHS2 or whether to select a mix of focal and non-focal LGAs to examine differences.

7. Seek to explain the pattern of (changes in) organisational performance that is observed, identifying the contribution that PATHS2 support has made to this. Seek to assess why PATHS2's efforts have worked (or not), and the factors that have shaped their effectiveness, and likely sustainability.

8. Identify lessons about the effectiveness and sustainability of PATHS2 capacity development activities.

Based on the methodology outlined above, the study will involve the following elements:

1. **Inception Report**: This will develop and finalise the conceptual framework and detailed methodology for each of the components of the study. The Inception Report will include a summary of the key features of PATHS2's capacity development approach, and the explicit and implicit intervention logic underlying it, and how this developed over the project's implementation, as well as a compilation and critical review of data available.

2. **Data collection to analyse the contribution of PATHS2 to capacity development**:

a. **Federal level study** of PATHS2 interventions that have focused on strengthening institutional and organisational functions and capacity at federal level and that have links to outcomes at state and LGA-level: based on programme reporting; analysis of quantitative evidence from the main national surveys, complemented by interviews with FMoH and NPHCDA.

b. **Comparative state studies** focused on identifying: what changes in capacity have occurred at the state level? What contribution has PATHS2 made to these changes? What aspects of its approach have been critical? What are the main contextual factors that have mediated the impact of PATHS2's activities? Which of these factors have supported capacity development, and which have undermined it? What are the transmission mechanisms from outputs of PATHS2 at the federal level to the state, LGA and facility level? The comparative analysis will also draw on programme documentation and an analysis of quantitative results, together with interviews conducted during state visits.

c. **LGA and facility-level data collection**: The review of quantitative data/analysis would also help identify a set of hypotheses on the factors that have influenced the changes in facility-level capacities and service uptake (in all PATHS2 states, based on PATHS2 and HMIS). These hypotheses will then be explored further as part of the qualitative LGA and facility-level studies. Field visits will be carried out to two or three states where additional data collection will take place at three levels. First, some interviews will be carried out at state level, focusing specifically on examining further links between state level capacity development support, and the rest of the health system. It is envisaged that data collection will take place in two LGAs per state. It is envisaged that the facilities and LGAs may be selected (at least in part) from among those covered by the PATHS2 survey, so that the research findings can be interpreted in conjunction with the quantitative data from PATHS2. The sample may also include some facilities and LGAs that have performed better than the state-level average in order to examine factors that have contributed to their superior performance. A key focus of this element will be to investigate the linkages between PATHS2's outputs (i.e. improvements in the performance of key functions) at the federal and state levels, and outcomes at the LGA and facility levels.

3. **Final Report**: The final stage of the study will pull together the findings of all of the previous elements to present overall conclusions and recommendations. The primary focus will be to address the overall research question, to assess which of PATHS2's capacity development strategies have been more effective for each of the organisations that it works with, in so far as evidence available permits.

The **political economy** of the context in each state will be analysed as part of the state level (and potentially also the LGA and facility) studies, based on an analysis of the assumptions about the interests and influence of stakeholders that underlie the Theory of Change that has guided PATHS2 capacity development actions. This will include a review of how PATHS2 has used political economy analysis and other approaches to understanding the context within which it has been working to inform its capacity development approach.

A.5 Activities and Timeframe

The timeline for the study is set out below. The study will be closely coordinated with the PATH2 Annual Review/ Northern States Project Completion Review, whose mission will take place during September 2015. Visits to the states will be coordinated to avoid duplication of meetings and information collection, with the PCR visit taking place before the field visits to the three states for this study. The PCR visit will identify issues for more detailed investigation during the field visits for this study.

Main study components	
Description	Proposed Dates
1. Inception Report, including detailed study methodology and initial review of data sources	by early October
2. Data collection for federal and state studies	October
3. Visits to the three states for field data collection	October
4. Synthesis process	early November
5. Draft Final Report: Conclusions and Lessons	Late November
6. Final Report	Mid-December

A.6 Resource Requirements and Staffing

The budget envisaged for the study is £152,500.

The roles and expertise required for Team members are set out in the Table below. Individual team members may combine more than one role.

Role	Main Tasks
Team Leader	Overall responsibility for the study methodology, and for delivery of the study outputs, including the Inception Report and Final Study Report. Responsibility for oversight of specific study components. Lead the field study in one state.
Study Director	Oversight of the study methodology, and review of study outputs. Liaison with the Steering Committee. Advice and support to the Team Leader.
Senior Researchers	Support design data collection process and instruments for state-level interviews and field data collection, focusing on LGAs and facilities, using appropriate participatory methods. Train the Field Team members, provide oversight of the Field Team work, and lead the process of write up of findings. Undertake visits to the two states not covered by the LGA and facility level fieldwork.
Study Manager/Researcher	Provide overall management of the study. Provide advice on development of instruments for field research (and field team training).
Research Support	Undertake analysis of data sources.
Field Teams for State Studies, including LGA/Facility interviews	Carry out visits to three states to undertake additional state level data collection, and LGA and Facility level data collection. Contribute to the drafting of report on the findings from the field visits.
Quality Assurance Reviewer	Quality review of methodology, analysis and reports.

A.7 Logistics and Management

The study will be managed by OPM on behalf of IMEP, with oversight provided by a Steering Committee comprising DFID, PATHS2 and IMEP. The Team leader and study manager will coordinate local arrangements with IMEP and with the OPM Abuja office.

A.8 Dependencies

The study's findings are expected to contribute to the PATHS2 PCR for Northern States and IMEP's final evaluation of DFID's State-level programmes in Nigeria (to be completed by September 2016). In line with this, the state-level studies should be carried out in September/October 2015, and the rest of the study by early November 2015. Timelines might be revised depending on decisions regarding the scope of the quantitative analysis and the number of states and LGAs visited in the qualitative fieldwork. These decisions will be made during the Inception Phase.

A.9 Reporting

The team will report on a day-to-day basis to the Team Leader and Study Manager, or other leaders as designated under the individual components of the study. The Team leader and Study manager will report to the Study Director, under the oversight of IMEP. The qualitative researcher and the leader of the state/LGA/facility study will manage the fieldwork process. The draft report will be submitted to DFID and PATHS2, and discussed by the Steering Committee, whose comments will be incorporated into a revised version. The task will be signed off once the team members have satisfactorily responded to DFID and PATHS2's comments.

A.10 Quality and Approval Process

Intermediate outputs will be quality-assessed as required within the reporting chain, and according to IMEP's normal procedures, and by independent experts, if deemed appropriate, as well as by the Steering Committee for the study (PATHS2, IMEP and DFID). The final report will be reviewed by at least one independent expert, and will be finalised in response to comments from the Steering Committee.

Annex B Research Instruments

B.1 Federal Topic Guide

Topic guide for: FEDERAL LEVEL STAKEHOLDERS

Participant(s) ID name/number:

Participant(s) specialism _____

Interviewer Initials |_|_|_| Audio Recording NO _____|_____

Date: |_|_/_|_/_|_| (DMY)

GUIDANCE:

The following topic guide includes a list of questions that can be used when interviewing *Federal Level stakeholders*. You do not need to ask all the questions in every interview. Instead, select the most appropriate questions depending on the experience/specialism of the respondent. For instance, a respondent with experience of the Federal Accounts should be asked questions mainly on financial and budgetary matters. ***However, all interviews should start and finish with the warm up and closing questions.***

Remember to explain the following information before starting the discussion:

- ✓ Purpose of study
- ✓ Aim of interview/discussion and duration
- ✓ Why participants cooperation and input is important
- ✓ What will happen with the data, confidentiality and anonymity
- ✓ Does the participant have any questions?
- ✓ Ask if the participant gives their consent to be interviewed
- ✓ Check audio device is working (if used)

When a participant raises an important issue, remember to follow up and explore this:

- ❖ What effect do these problems have on the performance of the health system and delivery healthcare services?
- ❖ Do the problems have anything in common, or what is the source of the problem?
- ❖ How did you resolve that problem?
- ❖ What has helped you to deliver better healthcare?
- ❖ Who helped you to do this?
- ❖ What influence did PATHS2 have, if any?

You can use the prompts under each question (indicated by a “reminder bell” symbol) to help get more information for each question and to keep the conversation flowing. However, give the respondent the chance to answer the question first and encourage them to answer the question in their own words. **Try not to use leading questions.**

A. Introductory and general key questions

A1. Can you tell me about your organisation and its role and functions?

- *How does your organisation contribute to healthcare delivery in the country?*

A2. What are the key capacities that your organisation needs to perform its roles and functions effectively?

- *What do you and your organisation need to be able to do to deliver quality healthcare?*

A3. How has your organisations capacity to carry out its roles and responsibilities changed over the last few years, and what impact has this had on the delivery of healthcare?

- *Have this change in capacity resulted in any changes in health outcomes or utilisation of health services? If so, how?*
- *What caused this change is capacity? How was this achieved?*

A4. What effect has PATHS2 had on your organisation's capacity to perform its functions?

- *Did PATHS2 help develop your organisation's capacity?*
- *Which capacities did PATHS2 develop? How did they do this?*
- *How have PATHS2 activities helped you to deliver your functions more effectively?*

A5. Do you require any additional support or capacity building, or is there anything else preventing your organisation from carrying out its functions effectively?

- *How could these barriers be resolved? Who is in control of this? Why is this problem so difficult to overcome?*

A6. Besides the work done by PATHS2, has anything or anyone else helped your organisation to become more effective at delivering its roles and responsibilities?

B. Governance, Management, Supervision, and Accountability questions

B1. Can you tell me how PATHS2 has supported your organisation to improve Nigeria's governance management and oversight functions?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

B2. How have national policies, strategies and frameworks designed to improve PHC services been developed and strengthened?

- *What is the implication of the National Health Bill Act 2014?*
- *Who were the main advocates for these healthcare reforms and how did they secure presidential support? What role did PATHS2 play in fostering support for the health act?*
- *Do you think these reforms have the backing and support of State level health bodies? What is the implication of this?*
- *In what way do these new policies ensure better coordination and alignment of federal, state and LGA health provision?*

B3. Are these changes to policies, strategies and frameworks supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Is there alignment and coordination of budgets with State level plans?*
- *Do the resources required to implement these strategies reach the health system levels where they are needed?*
- *What is the effect of this?*

B4. To what extent are national level policies implemented at State, LGA and Facility levels?

- *Who ensures that these national policies are communicated to the State and Local Government levels?*
- *What have been the successes and challenges regarding implementing national policies at State and LGA levels?*
- *How is the implementation of these plans being monitored to ensure that they are being adhered to?*
- *How much influence does the federal system have on the state health system?*
- *What mechanisms are there in place to reward performance and hold individuals/organisations accountable for poor performance?*

B5. What has been the effect of these PATHS2 activities on health outcomes?

- *Have there been any changes in health policies and planning processes?*
- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*

- *How important were the PATHS2 activities in driving this progress?*

C. Health Management Information Systems and M&E reporting

C1. Can you tell me how PATHS2 has supported your organisation to improve Nigeria's Health Management Information Systems and M&E reporting?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

C2. Can you tell me about any policies and guidelines that have been developed to improve monitoring and reporting of health data and strengthen the HMIS?

- *Do you think that there is sufficient systems capacity to realise these reforms? What role did PATHS2 have in these changes?*

C3. To what extent are the planned improvements to the HMIS and M&E reporting supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Do the resources required to implement these plans reach the health system levels where they are needed?*
- *What is the effect of this?*

C4. To what extent have the improved HMIS and M&E systems been implemented at LGA and Facility levels?

- *What are the main successes and failures?*
- *What has contributed to these successes and failures?*
- *How is the implementation of these plans being monitored to ensure that they are being adhered to?*

C5. What has been the effect of these activities on health outcomes, and how important was PATHS2 role in this?

- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *How important were the PATHS2 activities in driving this progress?*

D. Supply chain, logistics, drugs, infrastructure, and service delivery

D1. Can you tell me how PATHS2 has supported your organisation to improve the supply and quality of drugs and medical commodities and service provision in Nigeria?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

D2. Can you tell me about any policies and guidelines that have been developed to improve the supply and quality of drugs and medical commodities and service provision in Nigeria?

- *Do you think that there is sufficient systems capacity to realise these reforms? What role did PATHS2 have in these changes?*

D3. Can you tell me about the improvements to the drug quality control and health commodities regulations? Why were these needed and how important have the changes been?

- *What efforts have been made to improve the capacity of the State and LGA levels and regulatory agencies so that they can effectively deliver on policies?*

D4. To what extent are these planned improvements supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Do the resources required to implement these plans reach the health system levels where they are needed?*
- *What is the effect of this?*

D5. To what extent have the plans to improve the supply and quality of drugs and medical commodities and service provision translated to improved healthcare delivery at facility levels?

- *What are the main successes and failures?*
- *What has contributed to these successes and failures?*
- *How is the implementation of these plans being monitored to ensure that they are being adhered to?*

D6. What has been the effect of these activities on health outcomes, and how important was PATHS2 role in this?

- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *How important were the PATHS2 activities in driving this progress?*

E. Human resource planning, development, and utilisation

E1. Can you tell me how PATHS2 has supported your organisation to improve the quality, quantity and distribution of human resources available for healthcare in Nigeria?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

E2. Can you tell me about the policies and guidelines to improve human resources for health such as the Midwifery Service Schemes and the National Workforce Registry?

- *How were these strategies developed? Who was involved in strategy development?*
- *What role did PATHS2 play in this?*
- *Do you think that there is sufficient systems capacity to realise these reforms? What role did PATHS2 have in these changes?*

E3. To what extent are these planned improvements supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Has the updated Midwifery Service Scheme been incorporated into any annual operational or budget plans, at National or State levels*
- *Do the resources required to implement these plans reach the health system levels where they are needed?*
- *What is the effect of this?*

E4. To what extent have the plans to improve HRH in Nigeria translated to improved healthcare delivery at facility levels?

- *What are the main successes and failures?*
- *What has contributed to these successes and failures?*
- *How is the implementation of these plans being monitored to ensure that they are being adhered to?*

E5. What has been the effect of these activities on health outcomes, and how important was PATHS2 role in this?

- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *How important were the PATHS2 activities in driving this progress?*

F. Closing questions

F1. Thinking about all we have discussed, what is your overall opinion of the activities and support provided by PATHS2?

- *How important was their contribution towards improving the Nigerian Health System?*
- *What do you think as their most valuable contribution?*

F2. We have now reached the end of our discussion. Is there anything else you would like to add, or do you have any questions for me?

B.2 State Topic Guide

Topic guide for: STATE LEVEL STAKEHOLDERS

Participant(s) ID name/number:

Participant(s) specialism _____

Interviewer Initials |_|_|_| Audio Recording NO _____|_____

Date: |_|_/_|_/_|_| (DMY)

GUIDANCE:

The following topic guide includes a list of questions that can be used when interviewing *State Level stakeholders*. You do not need to ask all the questions in every interview. Instead, select the most appropriate questions depending on the experience/specialism of the respondent. For instance, a respondent with experience of the State Accounts should be asked questions mainly on financial and budgetary matters. ***However, all interviews should start and finish with the warm up and closing questions.***

Remember to explain the following information before starting the discussion:

- ✓ Purpose of study
- ✓ Aim of interview/discussion and duration
- ✓ Why participants cooperation and input is important
- ✓ What will happen with the data, confidentiality and anonymity
- ✓ Does the participant have any questions?
- ✓ Ask if the participant gives their consent to be interviewed
- ✓ Check audio device is working (if used)

When a participant raises an important issue, remember to follow up and explore this:

- ❖ What effect do these problems have on the performance of the health system and delivery healthcare services?
- ❖ Do the problems have anything in common, or what is the source of the problem?
- ❖ How did you resolve that problem?
- ❖ What has helped you to deliver better healthcare?
- ❖ Who helped you to do this?
- ❖ What influence did PATHS2 have, if any?

You can use the prompts under each question (indicated by a “reminder bell” symbol) to help get more information for each question and to keep the conversation flowing. However, give the respondent the chance to answer the question first and encourage them to answer the question in their own words. **Try not to use leading questions.**

G. Introductory and general key questions

A7. Can you tell me about your organisation and its role and functions?

- *How does your organisation contribute to healthcare delivery in the country?*

A8. What are the key capacities that your organisation needs to perform its roles and functions effectively?

- *What do you and your organisation need to be able to do to deliver quality healthcare?*

A9. Have the roles and functions of your organisation changed in recent years? [Especially important for the SPHCDA]

- *What additional roles and responsibilities and functions has your organisation taken on?*
- *Why have these functions been given to your organisation to manage and implement?*
- *Do you have the capacity to carry out these new functions?*
- *[If applicable] Why were these functions taken away from your organisation and who manages them now?*

A10. How has your organisations capacity to carry out its roles and responsibilities changed over the last few years, and what impact has this had on the delivery of healthcare?

- *Have this change in capacity resulted in any changes in health outcomes or utilisation of health services? If so, how?*
- *What caused this change is capacity? How was this achieved?*

A11. What effect has PATHS2 had on your organisation's capacity to perform its functions?

- *Did PATHS2 help develop your organisation's capacity?*
- *Which capacities did PATHS2 develop? How did they do this?*
- *How have PATHS2 activities helped you to deliver your functions more effectively?*

A12. What efforts have been made to ensure that LGAs and Facilities have the necessary skills, resources, and functional systems to successfully implement State-Level strategies?

- *Who provided this capacity development support? Were these efforts successful and does sufficient capacity now exist?*
- *What role did PATHS2 play in this?*

A13. Have States and LGAs been provided with the necessary budgets and resources to be able to carry out their roles and responsibilities and implement State-level plans?

A14. Is there anything else preventing State or LGA healthcare organisations from carrying out their functions effectively?

- *How could these barriers be resolved? Who is in control of this? Why is this problem so difficult to overcome?*

A15. Besides the work done by PATHS2, has anything or anyone else helped your organisation to become more effective at delivering its roles and responsibilities?

H. Governance, Management, Supervision, and Accountability questions

B6. Can you tell me how PATHS2 has supported your organisation to improve your State's governance management and oversight functions?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

B7. What has been the effect of these PATHS2 activities on health outcomes?

- *Have there been any changes in health policies and planning processes?*
- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *How important were the PATHS2 activities in driving this progress?*
- *Has anything or anyone contributed towards these changes?*

B8. How have State-level policies, strategies and frameworks designed to improve PHC services been developed and strengthened?

- *Who were the main advocates for these healthcare reforms and how did they secure support?*
- *What role did PATHS2 play in technical capacity building and fostering support?*
- *Do you think these reforms have the backing and support of State level health bodies?*

B9. Who does the State work with to develop and implement health policies and budgets?

- *To what extent are Federal and LGA level organisations involved in the planning and implementation process?*
- *Did PATHS2 have any role in coordinating and incorporating these stakeholders into State-level health plans?*

B10. How were these strategies/policies/frameworks communicated to other governmental departments and disseminated to LGAs and Facilities?

- *Who is responsible for communicating state health strategies to LGAs and overseeing that these strategies are implemented?*

B11. What was the process for costing these health plans and ensuring that they were financially sustainable?

- *What role did PATHS2 have in this?*
- *Have there been any efforts to make healthcare financing more equitable and pro-poor?*
- *Do these policies have political support and backing?*

B12. To what extent have these budgets been operationalised and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Have they been incorporated into State Level Budgets and have funds been disbursed according to polices?*
- *Do the resources required to implement these strategies reach the health system levels where they are needed?*

B13. Are there any mechanisms in place to track healthcare spending at different levels of the health system?

- *Who has responsibility for ensuring that State money is spent according to State priorities?*
- *Have there been any difficulties regarding tracking spending and holding LGAs accountable for their healthcare spending?*

B14. To what extent are State-level plans been implemented at LGA and Facility levels?

- *What have been the key successes and challenges?*
- *Have these plans been incorporated into LGA Annual Operating plans and have funds been disbursed by the LGA according to the Federal and State polices?*

B15. Who has the responsibility for implementing these plans at State, LGA and Facility Levels? Are there clear and discrete roles and responsibilities? What is the chain of responsibility from Federal to LGA levels?

- *How are responsible parties held accountable for performance? What are the incentives for good performance and the implications for bad performance?*

I. Health Management Information Systems and M&E reporting

C6. Can you tell me about how the M&E and reporting data provided by health facilities and LGAs has changed over the last few years?

- *What have been the main problems facing the HMIS and data reporting quality and timeliness?*
- *What is being done to resolve these issues?*

C7. Can you tell me how PATHS2 has supported your organisation to improve the State's Health Management Information Systems and M&E reporting?

- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

C8. What has been the effect of these PATHS2 activities on health outcomes?

- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Have these changes only occurred in PATHS2 facilities or more widely?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*

- *Has anything or anyone contributed towards these changes?*

C9. To what extent are the planned improvements to the HMIS and M&E reporting supported by appropriate budgets, and have the allocated finances and resources be disbursed to the State?

- *Do the resources required to implement these plans reach the health system levels where they are needed?*

C10. To what extent have the improved HMIS and M&E systems been implemented at LGA and Facility levels?

- *What are the main successes and failures?*
- *How is the implementation of these plans being monitored to ensure that they are being adhered to?*

C11. Who is responsible for improving the data quality of the HMIS at State, LGA and Facility levels?

- *How do the various organisations and health system levels coordinate with each other?*
- *Is there a clear chain of accountability?*

C12. How difficult is to enforce reporting expectations at different levels of the health system? Are any incentives being used to encourage and reinforce good performance?

- *Are private or alternative (e.g. faith-based or traditional medicine providers) health providers required to comply with reporting requirements? How is this enforced?*

C13. How is the State supporting the LGAs and Facilities to improve their HMIS reporting?

- *Do they have the capacity and operating systems to implement the changes?*

C14. Can you tell me how the data from the HMIS is being used?

- *Who consolidates, analyses and report this data?*
- *Is there sufficient capacity to interpret this data?*
- *What action is taken based on this data?*

J. Supply chain, logistics, drugs, infrastructure, and service delivery

D7. Can you tell me about how the supply and quality of drugs and medical commodities in this State has changed in the last few years?

- *What have been the main problems facing the drug supply and quality?*
- *What is being done to resolve these issues?*

D8. Can you tell me how PATHS2 has supported your organisation to improve the supply and quality of drugs and medical commodities and service provision in your State?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

D9. What has been the effect of these PATHS2 activities on health outcomes?

- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Have these changes only occurred in PATHS2 facilities or more widely?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *Has anything or anyone contributed towards these changes?*

D10. Can you tell me about any policies and guidelines that have been developed to improve the supply and quality of drugs and medical commodities and service provision in this State?

- *Do you think that there is sufficient systems capacity to realise these reforms? What role did PATHS2 have in these changes?*

D11. What role do private or alternative healthcare providers have in service provision in this state?

- *How have they been engaged with the public health system?*
- *What measures are in place to regulate private or alternative providers?*
- *What role did PATHS2 have in supporting these activities?*

D12. To what extent are these planned improvements supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Do the resources required to implement these plans reach the health system levels where they are needed?*
- *What is the effect of this?*

D13. Can you tell me about any changes to the Drug Revolving Fund, Logistics and Equipment Management in your State?

- *Who is responsible for making and implementing these changes?*
- *What role did PATHS2 have in this?*

D14. How are State Level Annual Budgets aligned to DRF and medical supply plans so that funds are available to procure drugs and supplies?

- *If a State Sustainable Drug Supply System Committee is responsible for the DRF, how much control do they have over drug financing accounts and procurement decisions?*
- *What mechanism are in place to ensure fiscal responsibility and sustainability of the DRF?*

D15. How are drug and medical supplies tracked and monitored at LGA and Facility levels to ensure improved accessibility, availability, and affordability of quality medicines and consumables in public health facilities?

- *What mechanisms are there to ensure accountability?*
- *Can you provide any examples of this?*

D16. How is the State supporting the LGAs and Facilities to improve their DRF and logistics management?

- *Do they have the capacity and administrative systems to implement the changes?*
- *What have been the greatest challenges and successes?*

D17. What impact have these improvements to the DRF, Logistics and Equipment management had at LGA and facility level?

- *Has there been any improvements in the accessibility, availability, and affordability of quality medicines and consumables in public health facilities?*
- *Are there any remaining challenges or barriers to improved drug and medical equipment supply?*

K. Human resource planning, development, and utilisation

E6. Can you tell me about how the quality, quantity and distribution of human resources for healthcare have changed in the last few years in this state?

- *Have human resources for primary healthcare become more of a priority?*
- *Are more medical staff being recruited?*
- *Is more training being provided?*
- *Are there any changes to how medical staff are allocated to different LGAs and facilities?*

E7. Can you tell me how PATHS2 has supported your organisation to improve quality, quantity and distribution of human resources for healthcare in this state?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

E8. What has been the effect of these PATHS2 activities on health outcomes?

- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Have these changes only occurred in PATHS2 facilities or more widely?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *Has anything or anyone contributed towards these changes?*

E9. Can you tell me about the policies and guidelines to improve human resources for health such as the Midwifery Service Schemes and the National Workforce Registry?

- *How were these strategies developed? Who was involved in strategy development?*
- *What role did PATHS2 play in this?*
- *Do you think that there is sufficient systems capacity to realise these reforms? What role did PATHS2 have in these changes?*

E10. To what extent are these planned improvements supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Has the updated Midwifery Service Scheme been incorporated into any annual operational or budget plans, at State levels*
- *Do the resources required to implement these plans reach the health system levels where they are needed?*
- *What is the effect of this?*

E11. How are human resources identified and tracked? How is this information being collected and how accurate is it?

- *Is a human resource information system used? How is this information being used?*
- *If a human resource audit has been conducted, what did this show? Were any important issues identified? What action will be taken as a result of the findings?*

E12. Where there is limited human resource availability, what measures are being taken to resolve this?

- *Expanding the healthcare workforce? Redistributing the workforce or changing roles? Developing the workforce and improving their knowledge, skills and abilities? Please provide examples?*
- *What role did PATHS2 have in these activities?*

L. Closing questions

F3. Thinking about all we have discussed, what is your overall opinion of the activities and support provided by PATHS2?

- *How important was their contribution towards improving the Nigerian Health System?*
- *What do you think as their most valuable contribution?*

F4. We have now reached the end of our discussion. Is there anything else you would like to add, or do you have any questions for me?

B.3 Local Government Area Topic Guide

Topic guide for: LGA LEVEL STAKEHOLDERS

Participant(s) ID name/number:

Participant(s) specialism _____

Interviewer Initials |_|_|_| Audio Recording NO _____|_____

Date: |_|_/_|_/_|_| (DMY)

GUIDANCE:

The following topic guide includes a list of questions that can be used when interviewing *LGA Level stakeholders*. You do not need to ask all the questions in every interview. Instead, select the most appropriate questions depending on the experience/specialism of the respondent. For instance, a respondent with experience of the LGA finances should be asked questions mainly on financial and budgetary matters. ***However, all interviews should start and finish with the warm up and closing questions.***

Remember to explain the following information before starting the discussion:

- ✓ Purpose of study
- ✓ Aim of interview/discussion and duration
- ✓ Why participants cooperation and input is important
- ✓ What will happen with the data, confidentiality and anonymity
- ✓ Does the participant have any questions?
- ✓ Ask if the participant gives their consent to be interviewed
- ✓ Check audio device is working (if used)

When a participant raises an important issue, remember to follow up and explore this:

- ❖ What effect do these problems have on the performance of the health system and delivery healthcare services?
- ❖ Do the problems have anything in common, or what is the source of the problem?
- ❖ How did you resolve that problem?
- ❖ What has helped you to deliver better healthcare?
- ❖ Who helped you to do this?
- ❖ What influence did PATHS2 have, if any?

You can use the prompts under each question (indicated by a “reminder bell” symbol) to help get more information for each question and to keep the conversation flowing. However, give the respondent the chance to answer the question first and encourage them to answer the question in their own words. **Try not to use leading questions.**

M. Introductory and general key questions

A16. Can you tell me about this LGA and its role and functions?

- *How does the LGA contribute to healthcare delivery in this area?*
- *How do these functions and responsibilities differ from those carried out by the State Level PHC Agencies? What are the key distinctions in roles?*

A17. What are the key capacities that this LGA needs to perform its roles and functions effectively?

A18. Have the roles and functions of this LGA changed in recent years?

- *Has the LGA taken on additional roles and responsibilities or have some functions been taken away from the LGA?*

A19. How has this LGA's capacity to carry out its roles and responsibilities changed over the last few years, and what impact has this had on the delivery of healthcare in this area?

- *Have this change in capacity resulted in any changes in health outcomes or utilisation of health services? If so, how?*
- *What caused this change is capacity? How was this achieved?*

A20. What efforts have been made to ensure that LGAs and Facilities have the necessary skills, resources, and functional systems to successfully implement State-Level strategies and LGA plans?

- *Who provided this capacity development support? Were these efforts successful and does sufficient capacity now exist?*

A21. What effect has PATHS2 had on this LGA's capacity to perform its functions and implement plans?

- *Did PATHS2 help develop LGA capacity?*
- *Which capacities did PATHS2 develop? How did they do this?*
- *How have PATHS2 activities helped you to deliver your functions more effectively?*

A22. Has this LGA been provided with the necessary budgets and resources to be able to carry its functions and implement State-level strategies and associated LGA PHC plans?

A23. Is there anything else preventing this LGA and the Facilities in this area from carrying out their functions effectively?

- *How could these barriers be resolved? Who is in control of this? Why is this problem so difficult to overcome?*

A24. Besides the work done by PATHS2, has anything or anyone else helped this LGA and the facilities in this area to become more effective at delivering their roles and responsibilities?

N. Governance, Management, Supervision, and Accountability questions

B16.Can you tell me how PATHS2 has supported this LGA in improving its governance management and oversight functions?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

B17. What has been the effect of these PATHS2 activities on health outcomes?

- *Have there been any changes in health policies and planning processes?*
- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *How important were the PATHS2 activities in driving this progress?*
- *Has anything or anyone contributed towards these changes?*

B18. Can you tell me how LGA level PHC plans are developed?

- *Do LGAs have any input into the LGA PHC planning process which they are responsible for delivering?*
- *Is this only determined by the State or does the LGA have some autonomy? Does anyone else have influence over the planning process?*
- *Are the LGAs clear on what they should be implementing? Is there support available if LGAs have difficulties? Have PATHS2 provided any support in this?*

B19. To what extent are community members represented in the health planning process?

- *How does the LGA and the Health Facility Committee cooperate to run the Health Facility? How are the relationships?*
- *Is there political support for the health plans at the LGA-level? Did PATHS2 have any role in fostering this support?*
- *Who has the strongest say into how healthcare is delivered at the PHC level?*

B20. How are State and Federal plans or initiatives communicated to LGAs?

- *Does this work well or has it caused problems?*

B21. How are LGA budget allocations determined and have LGAs received sufficient finances and resources to implement PHC policies and plans?

- *Who determines the funding and resource allocation to the LGA PHC department? Does it all come from the State, or are there any other funding mechanisms?*
- *How are allocations determined? Are these aligned with the LGA operating plans? Are allocations based on services required by patients, or catchment area, or the performance of the facility, or capacity development needs?*
- *Are the planned and resource allocations sufficient to implement the LGA operational plans? If not, what is the shortfall and what is the implication of this?*
- *How closely do the planned allocations match real allocations?*
- *Are the finances and resources received on time and according to budgetary plans?*

B22. To what extent have the State-level plans been implemented by this LGA and the facilities in this area?

- *Have the 2014 and 2015 LGA PHC plans have been operationalised at LGA and Facility Levels?*
- *How closely have the activities and budgetary expenditure and disbursement matched the LGA plans and budgets?*
- *Can you give reasons for any discrepancies? Are there been any implications for failure to deliver on plans and budgets?*

B23. What accountabilities and reporting mechanisms does the LGA PHC department have to entities at the LGA, State and Federal Levels?

- *How do these accountabilities align with the LGA's responsibilities? For instance, are the LGAs accountable for things over which they have control?*
- *Who does the LGA PHC department report to? What does the LGA report and how often? How is this information used and who by?*
- *How is performance assessed? Does the LGA receive recognition or rewards for good performance, or are the penalties for bad performance?*

B24. Have there been any difficulties implementing LGA healthcare plans due to lack of capacity?

- *Do LGA and facility staff have the necessary skills and capacity to successfully implement the operational plans? Are administration and finance and reporting systems fit for purpose?*

B25. To what extent did PATHS2 support the implementation of the LGA plans?

- *What did you find the most and least helpful?*
- *Have PATHS 2 been able to respond to needs as they arose?*
- *Do you feel in a stronger position to implement LGA plans and support facilities than you did a few years ago? In what ways?*
- *How important were PATHS2 in building your capacity to do this? Do you think you will be able to sustain the progress you have made when PATHS2 concludes?*

O. Supervision of PHC facilities

C15.Can you tell me how the LGA PHC department supervises healthcare facilities?

- *Does the LGA conduct supervision visits? What does this involve? What assessment tools do the LGA use when they conduct supervision visits?*
- *How often are supervision visits supposed to take place? In reality, how often do LGAs physically visit facilities? If there is a difference, why is this?*
- *When was the last time a facility was inspected? Can you show me your recent facility supervision forms so I can see how you inspect facilities?*

C16. How regularly do LGA officers meet with facility managers and staff to provide supportive supervision?

- *What does this involve? How are staff appraised and supported?*
- *When was the last time this was done? Can you show me the record sheet?*
- *How do LGAs provide support and assistance to facilities to implement operating plans?*

C17. Does the LGA PHC department receive M&E reporting data from the facilities? If so, is this used to monitor faculties' performance?

- *Who interprets or analyses the M&E data? What are the key measures used to determine performance? Can you show me an example of this analysis of M&E data?*

C18. Are there sufficient resources available to properly supervise facilities?

- *If not, why? Who should provide these resources? What additional resources would be need to effectively carry out supervision?*

C19. If a facility is underperforming what happens?

- How *are facility managers held accountable and what penalties or extra support is provided?*
- *Alternatively, if a facility is doing well, are there any mechanisms to reward the facility?*

C20. Have PATHS2 provided you with any support in supervising the facilities? If so, how helpful was this?

P. Health Management Information Systems and M&E reporting

D1. Can you tell me how the HMIS and M&E system is functioning at LGA and facility levels? How timely and complete has the data provided by facilities been?

- *What have been the main problems facing the HMIS and data reporting quality and timeliness?*
- *What is being done to resolve these issues?*

D2. Can you tell me how PATHS2 has supported your LGA and facilities in your area to improve the Health Management Information Systems and M&E reporting?

- *How effective were PATHS2 at building the capacity of this LGA and local facilties to carry out these functions?*

D3. What has been the effect of these PATHS2 activities on health outcomes?

- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Have these changes only occurred in PATHS2 facilities or more widely?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *Has anything or anyone contributed towards these changes?*

D4. To what extent are the planned improvements to the HMIS and M&E reporting supported by appropriate budgets, and have the allocated finances and resources be disbursed to the State?

- *Do the resources required to implement these plans reach the health system levels where they are needed?*

D5. Are LGAs able to provide guidance and support to improve HMIS and M&E reporting in facilities?

- *How difficult is to enforce reporting expectations in health facilities? What could be done to improve this?*
- *Are any incentives being used to encourage and reinforce good performance? What can be done to motivate staff to complete HMIS forms to the required standards?*

D6. How is this HMIS and M&E data used at the facility and LGA level?

- *Does anyone analyse and interpret the data?*
- *What actions or changes have been made as a result of M&E data?*
- *Is this data used when developing LGA PHC plans? Can you provide any examples or evidence of this?*

Q. <u>Supply chain, logistics, drugs, infrastructure, and service delivery</u>

D18. Can you tell me about how the supply and quality of drugs and medical commodities in this LGA has changed in the last few years?

- *What have been the main problems facing the drug supply and quality?*
- *What is being done to resolve these issues?*

D19. Does the LGA have the capacity to effectively manage the DRF and the supply of medical commodities/family planning services?

- *How is the State supporting the LGAs and Facilities to improve their DRF and logistics management?*
- *Do they have the capacity and administrative systems to implement the changes?*
- *What have been the greatest challenges and successes?*

D20.What support has the LGA given facilities in managing the DRF and the supply of medical commodities/family planning services?

D21.Can you tell me how PATHS2 has supported this LGA to improve the supply and quality of drugs and medical commodities and service provision in facilities?

- *Has PATHS2 provided any support, capacity building, mentorship or training in how to effectively manage the DRF and supply of medical commodities/family planning services?*
- *Who did they provide this to? How effective has this support been?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

D22.What has been the effect of these PATHS2 activities on health outcomes?

- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Have these changes only occurred in PATHS2 facilities or more widely?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *Has anything or anyone contributed towards these changes?*

R. Human resource planning, development, and utilisation

E13.Can you tell me about how the quality, quantity and distribution of human resources for healthcare have changed in the last few years in this LGA?

- *Have human resources for primary healthcare become more of a priority?*
- *Are more medical staff being recruited?*
- *Is more training being provided?*
- *Are there any changes to how medical staff are allocated to different LGAs and facilities?*

E14.Can you tell me about the attitude of the workforce in health facilities? Are they motivated and professional or are there problems with worker performance?

- *What is the cause of this?*
- *Are workers' salaries sufficient and are they paid what they are owed, and on time? If not why not? Whose responsibility is this?*
- *What else could be done to improve workers motivation and performance?*

E15.What clinical training and professional development have local health staff received?

- *Has this been important and who provided this training?*
- *Are there any major clinical skills gaps or technical deficiencies that have been difficult to solve? If so, what are they and what measures have been taken to resolve them?*

E16.Can you tell me how PATHS2 has supported your organisation to improve quality, quantity and distribution of human resources for healthcare in this state?

- *How did PATHS2 do this?*
- *How effective were PATHS2 at building the capacity of your organisation to carry out these functions?*

E17.What has been the effect of these PATHS2 activities on health outcomes?

- *To what extent have these changes translated to improved service delivery and health outcomes?*
- *Have these changes only occurred in PATHS2 facilities or more widely?*
- *Is there anything that prevents the PATHS 2 work from having an impact?*
- *Has anything or anyone contributed towards these changes?*

E18.To what extent are the planned improvements to HRH supported by appropriate budgets, and have the allocated finances and resources be disbursed to the different healthcare levels?

- *Do the resources required to implement these plans reach the health system levels where they are needed?*

S. Closing questions

F5.Thinking about all we have discussed, what is your overall opinion of the activities and support provided by PATHS2?

- *How important was their contribution towards improving the Nigerian Health System?*
- *What do you think as their most valuable contribution?*

F6.We have now reached the end of our discussion. Is there anything else you would like to add, or do you have any questions for me?

B.4 Facility Level Topic Guide

Topic guide for: FACILITY LEVEL

Facility name/ID number:

Participant(s) name/ID number:

Interviewer Initials |_|_|_| Audio Recording NO (if used) _____|_____

Date: |_|_/_|_/_|_| (DMY)

GUIDANCE:

The following topic guide includes questions that should be used when interviewing *Facility Level managers and staff.*

Remember to explain the following information before starting the discussion:

- ✓ Purpose of study
- ✓ Aim of interview/discussion and duration
- ✓ Why participants cooperation and input is important
- ✓ What will happen with the data, confidentiality and anonymity
- ✓ Does the participant have any questions?
- ✓ Ask if the participant gives their consent to be interviewed
- ✓ Check audio device is working (if used)

When a participant raises an important issue, remember to follow up and explore this:

- ❖ What effect do these problems have on the performance of the health system and delivery healthcare services?
- ❖ Do the problems have anything in common, or what is the source of the problem?
- ❖ How did you resolve that problem?
- ❖ What has helped you to deliver better healthcare?
- ❖ Who helped you to do this?
- ❖ What influence did PATHS2 have, if any?

You can use the prompts under each question (indicated by a “reminder bell” symbol) to help get more information for each question and to keep the conversation flowing. However, give the respondent the chance to answer the question first and encourage them to answer the question in their own words. **Try not to use leading questions.**

T. Questions for all facility workers

1. What are the main functions of this health facility?
   - *What health services should your facility provide?*
   - *What management, financial planning and budgeting functions should this facility perform?*
   - *What medical supply and logistical functions should this facility perform?*
   - *What monitoring and reporting functions should this facility undertake?*

2. Are there any functions that your facility has difficulty in delivering, and if so, what prevents you from carrying out these functions effectively?
   - *Is there a problem with Federal, State or LGA process?*
   - *Is there a lack of finances?*
   - *Is there a lack of resources, equipment, or facilities?*
   - *Is there a lack of suitable human resources?*
   - *Is there a lack of management or administrative skills?*
   - *Is there a lack of clinical skills or staff?*

3. What effect does this have on service delivery and patient health outcomes?
   - *Does it prevent you from providing health services?*
   - *Does it lower the quality of services?*
   - *Does this reduce demand for health services?*

4. Did you have sufficient staff at this health facility and do they have the required skills, knowledge, and motivation to perform their duties effectively?
   - *Are there too few or too many staff?*
   - *Are any particular cadres or types of staff lacking?*
   - *Are staff motivated?*
   - *Are there any clinical skills lacking?*
   - *Are there any management or admin skills lacking?*

5. Do you receive any supervision or guidance in carrying out your roles and responsibilities? If so, what does this involve and do you find this useful?
   - *Are there any facility supervision visits from the LGA?*
   - *Is performance data collected, analysed and reacted to?*
   - *Are staff supervised by the facility manager? How?*
   - *Is anyone held accountable for performance?*
   - *Are problems resolved?*

6. Is HMIS and reporting data collected by this facility? If so, how is this data collected and who is this data reported to?
   - *How regularly is this reported, and is it reported on time?*
   - *Are there any difficulties using the M&E system?*
   - *Do staff think this is important or useful?*

7. Can you tell me how the drug supply and medical commodity system is functioning in your facility?
   - *Have the availability of drugs and medical supplies and equipment improved?*
   - *Do you have the correct storage equipment for your drugs and medical supplies?*
   - *When was the last time you had a drug stock out? Are drugs ever out of date?*

8. What has PATHS2 done to build this facility's capacity to provide quality health services?
   - *Did PATHS2 provide facility staff with training or mentorship?*
   - *Did PATHS2 undertake or help provide any facility or service improvement?*
   - *Did PATHS 2 provide or negotiate the provision of any resources or finances for the facility?*
   - *Did PATHS2 help to improve the efficiency of any management or administrative processes?*

9. Have these PATHS2 activities helped this facility to provide better quality health services? If so how?
   - *What health facility functions has PATHS2 improved?*
     - *Management and supervision*
     - *Financial planning and budgeting*
     - *Drug and medical supply management*
     - *Availability of staff and clinical skills*
     - *Monitoring and reporting*

10. What impact have these PATHS2 activities had on utilisation of health services and patient health outcomes?

11. Besides the work done by PATHS2, has anything or anyone else helped your facility to become more effective at delivering its roles and responsibilities?
    - *If so, who and what effect did this have?*

B.5 Community Level Topic Guide

Topic guide for: COMMUNITY LEVEL

Community name/ID number:

Participant(s) name/ID number:

Interviewer Initials |_|_|_| Audio Recording NO (if used) _____|_____

Date: |_|_/_|_/_|_| (DMY)

GUIDANCE:

The following topic guide includes questions that should be used when interviewing *community representatives of health facilities.*

Remember to explain the following information before starting the discussion:

- ✓ Purpose of study
- ✓ Aim of interview/discussion and duration
- ✓ Why participants cooperation and input is important
- ✓ What will happen with the data, confidentiality and anonymity
- ✓ Does the participant have any questions?
- ✓ Ask if the participant gives their consent to be interviewed
- ✓ Check audio device is working (if used)

When a participant raises an important issue, remember to follow up and explore this:

- ❖ What effect do these problems have on the performance of the health system and delivery healthcare services?
- ❖ Do the problems have anything in common, or what is the source of the problem?
- ❖ How did you resolve that problem?
- ❖ What has helped you to deliver better healthcare?
- ❖ Who helped you to do this?
- ❖ What influence did PATHS2 have, if any?

You can use the prompts under each question (indicated by a “reminder bell” symbol) to help get more information for each question and to keep the conversation flowing. However, give the respondent the chance to answer the question first and encourage them to answer the question in their own words. **Try not to use leading questions.**

U. Questions for all community representatives of health facilities

12. Can you tell me about the health services provided by your health facility?
    - *What services does the facility provide?*
        - *Antenatal care?*
        - *Family planning services?*
        - *Patient transport and referral?*
        - *Drugs and medical supplies?*

13. What do people think about the quality of services provided by the health facility?
    - *Are any services particularly bad or good, if so, why?*
    - *Is the health facility clean?*
    - *Are there long waiting times?*
    - *Are drugs and medical supplies available?*
    - *How do staff treat patients?*

14. Do people use the services provided by the health facility? If so, which ones? If not, why?
    - *Which services are popular or unpopular? Why?*
    - *What stops people from using the health service?*
    - *Are there barriers to access such as time, money, or distance?*

15. When you or anyone you know needed drugs, medical supplies or family planning commodities, were these available and affordable?
    - *When was the last time you or anyone you know needed or bought supplies from the health facility?*

16. When you or anyone you know needed patient transport or referral to another health facility, was this available and affordable?
    - *When was the last time you or anyone you know needed patient transport or referral?*

17. Have you or anyone you know heard radio shows or been spoken to Women's Groups or Religious Leaders about health issues and the importance of attending the health facility? If so, did they go to the health facility as they were instructed?
    - *When was the last time this happened?*
    - *Do you think these radio shows and community events are important and helpful? Why?*

18. Are there any problems with the services provided by the health facility? If so, how could the service provision be improved?

19. Are there any ways for the community to provide feedback on the health facility or have a role in running the health facility?
    - *How is the community represented?*
    - *Does the community's opinion matter?*
    - *Can the community hold the health facility accountable?*

20. Is there a Health Facility Committee? If so, what does this committee do and do you think it is useful?
    - *What are the committee's roles and responsibilities?*
    - *Do committee members have the required skills and expertise?*
    - *How does the committee work with the LGA and facility?*
    - *Does the committee provide effective supervision and guidance?*
    - *How regularly does the committee meet?*

21. Did you know if the Health Facility Committee or community members received any training or support in how to help run the health facility? If so, was this helpful and did it improve their ability to help run the health facility?

22. Have you heard of PATHS2? If so, what has PATHS2 done to improve the quality of services provided by this health facility?
    - *Did PATHS2 provide facility staff with training or mentorship?*
    - *Did PATHS2 undertake or help provide any facility or service improvement?*
    - *Did PATHS 2 provide or negotiate the provision of any resources or finances for the facility?*

23. Have these PATHS2 activities helped this facility to provide better quality health services? If so how?
    - *Have services have improved?*
    - *Have staff skills and behaviour improved?*
    - *Are drugs and supplies more available?*

24. What impact have these PATHS2 activities had on utilisation of health services and patient health outcomes?

25. Besides the work done by PATHS2, has anything or anyone else helped your facility to improve service provision?
    - *If so, who and what effect did this have?*