TRUST, ACCOUNTABILITY AND PERFORMANCE IN HEALTH FACILITY COMMITTEES IN ORUMBA SOUTH LOCAL GOVERNMENT AREA, ANAMBRA STATE, NIGERIA

CREHS

POLICY BRIEF
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This policy brief is based on a research report, "Examining the links between accountability, trust and performance in health service delivery in Orumba South Local Government Area, Nigeria". The report is available on the CREHS website http://www.crehs.lshtm.ac.uk

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INTRODUCTION

Trust and accountability in the relationship between health service users and their healthcare facilities are important in the delivery of services and the functioning of the health system. The Government of Nigeria has recognised the importance of community participation in health services. The national guidelines for the development of the Primary Healthcare system established Health Facility Committees as one of a range of implementing structures to this end. Health Facility Committees operate at the village or ward level and are responsible for: determining drug pricing, supply and payment; ensuring financial accountability; monitoring health service performance and ensuring democratic accountability.

Yet little is known about the effects of accountability on service delivery in Nigeria. This study examined why some Health Facility Committees are functional when others are not and also sought to trace the effects and impacts of Committees on health service delivery including human resource issues and financing. It also investigated the influence of trust on how well they functioned. The research was conducted in Orumba South, a rural Local Government Area. Orumba South is about 70 kilometres from the state capital and is comparable in general development terms to other rural Local Government Areas in the state.

The case study material in the longer report that accompanies this brief draws a rich picture of the operating environment and structures which influence local health services. This brief will be of interest to Nigerian policy makers aiming to improve the delivery of healthcare and in exploring ways in which community involvement can leverage improved public services. It also provides learning for Health Facility Committee members and local communities who wish to develop and improve their performance. Finally this research may have utility for policy makers and health service implementers in other settings who wish to better understand the role of trust and accountability in improving health outcomes.

METHODS USED

- Engagement with local health officials to secure an understanding of the project and to collate relevant national and state documentation for review.
- Document review to understand current policy trends and the experiences of local-level committees.
- Rapid appraisal of 25 Health Facility Committees to assess their levels of basic functionality by interviewing the Health Officer In-Charge of the facility and the Committee Chairman. The information collected was validated by comparing it with minutes of Committee meetings where available. Functionality was assessed in terms of: gender composition of the Committees; the frequency of the Committees' meetings; consistency of member attendance over time; and whether the committees kept minutes of their meetings.
- 2 Health Facility Committees were chosen for detailed investigation. One was more functional (Site A)[1] and the other less functional (Site B).
- Data was collected through in-depth interviews, focus group discussions with community members and observations of Committee meetings. One month was spent in each selected site. 16 and 11 in-depth interviews were conducted in Site A and Site B, respectively. 2 focus group discussions were conducted per case study site, with separate focus groups for men and women. In each site, two meetings of the Health Facility Committee were attended.
- A case study approach allowed for a detailed examination of the functionality of the Committees, their effect/impact on health worker performance and resource mobilisation and use. The role of trust in the functioning of the committees and their linkages with other stakeholders in the community was also explored.
- Data analysis was conducted using Nvivo 8 software.

[1]The names of the communities have been altered to preserve the anonymity of the individuals who participated in the study.

KEY FINDINGS

The two Health Facility Committees that were chosen for more in-depth analysis were located in Site A and Site B. The following sections explore the key differences between Site A, which was judged to be a high functioning Committee and Site B which was functioning poorly (see Figure 1).

FORMATION AND MEMBERSHIP

The Health Facility Committee in Site A was established in 2005 and the community was mandated by the Local Government Authority to select individuals to represent them. The selection of the Chairman was made by the Site A Development Union, the town's union government. The Site A Development Union asked community members to ensure that all organised groups in the community were represented on the Committee by mandating each group to send a representative. Groups represented on the Committee included the church group and the Site A Women Congress. These members were chosen through an election process. The committee consists of a Chairman, Secretary, Public Relations Officer, Assistant Secretary, Financial Secretary, Security Officer and Treasurer. The Chairman is an executive member of the Site A Development Union as well as a lay reader on the church committee.

In Site B the idea of establishing the Committee came up in response to the community's request for the establishment of a health post. The members were inaugurated in 2007. The community was mandated by the Local Government Authority to select capable people. Two people were selected from each of the villages by their villagers. The criteria for selection were based on: capacity to do the work effectively, including education; the ability to communicate effectively; the ability to attract financial contributions from one's village; integrity; and gender. The Chairman was said to be specifically appointed by the Site B Development Union because of his track record of being hardworking and honest. The executives of the committee include the Chairman, Secretary, Public Relations Officer, Assistant Secretary, Financial Secretary and Treasurer. There was no attempt to have representation from various groups in the community.

SUPPORTIVE COMMUNITY STRUCTURES

In Site A the Committee has support from the Site A Women Congress which is made up of all women who are married into Site A irrespective of their original place of origin. Most of the financial needs of the Health Facility Committee are met by these women. The chairman of the Committee is an executive member of the Site A Development Union. He also facilitates the sharing of information through the church and Social Club because of his membership of both. The Igwe, the traditional ruler or leader of the community, has a cordial relationship with the Site A Development Union and there is transparency between the Union, Committee and Igwe. The Igwe is accessible, being a retired civil servant who lives in the community, which means he visits the health facility and also provides material support.

Site B has slightly fewer local structures than Site A. These include the Igwe and the Site B Development Union, security, youth, abroad and religious groups. The Health Facility Committee members are not composed of representatives from all these structures and as a result their voices are not strongly represented.

TRAINING

In Site A the committee members received some formal training on what their functions are. In Site B a doctor came and provided some guidelines on how to run a health post.

MEETINGS, AGENDAS AND MINUTES

In Site A the agenda for most of the meetings was drawn up by the Chairman and this is done twice a month and occasionally on an emergency basis. In some months, this may mean three meetings in a month. The chairman either informs the Secretary to notify members about upcoming meetings or does it himself. The quorum for a meeting is 6 members. Issues raised at the meetings are mainly ones that will help the health centre both in terms of the services rendered and infrastructural development. All the members are allowed to speak during the meetings, female members are allowed to equally express themselves, and decision making is agreed unanimously.

In Site B the meetings are usually conducted only on an emergency basis. The Committee has no specific times for holding their meetings and this makes meeting times erratic and disorganised. Even when an emergency meeting is fixed, some members do not attend. According to a Committee member, the only truly consistent member of the Health Facilities Committee is the Chairman. Whenever the Committee holds their meetings, decisions are usually arrived at by taking a vote from the few members that attend. Minutes had not been taken for their last meeting because of disagreements over who should be Secretary.

RESPONSIBILITIES

In Site A the Committee's responsibilities are to ensure that the health centre functions effectively. This includes: addressing health issues; ensuring that drugs are brought from the Local Government; disseminating information to community members about availability of drugs and bed nets in the health centre; participating in distribution of bed nets; ensuring that the health centre is functional, properly maintained, and kept clean; informing the community about problems that need to be addressed; and monitoring health workers to ensure that they are performing their duties effectively and maintaining a cordial working environment. Committee members regularly visit the health facility to monitor staff attendance and behaviour. Negative health worker behaviour is occasionally reported to the Health Officer In-Charge. She cautions staff and encourages them to behave better. If their performance does not improve she brings the matter to the Committee. Non-performing healthcare workers can be issued with a warning or reported to the

Site A Development Union. In practice the Committee has been instrumental in removing a poorly performing Health Officer In-Charge in the past through this process.

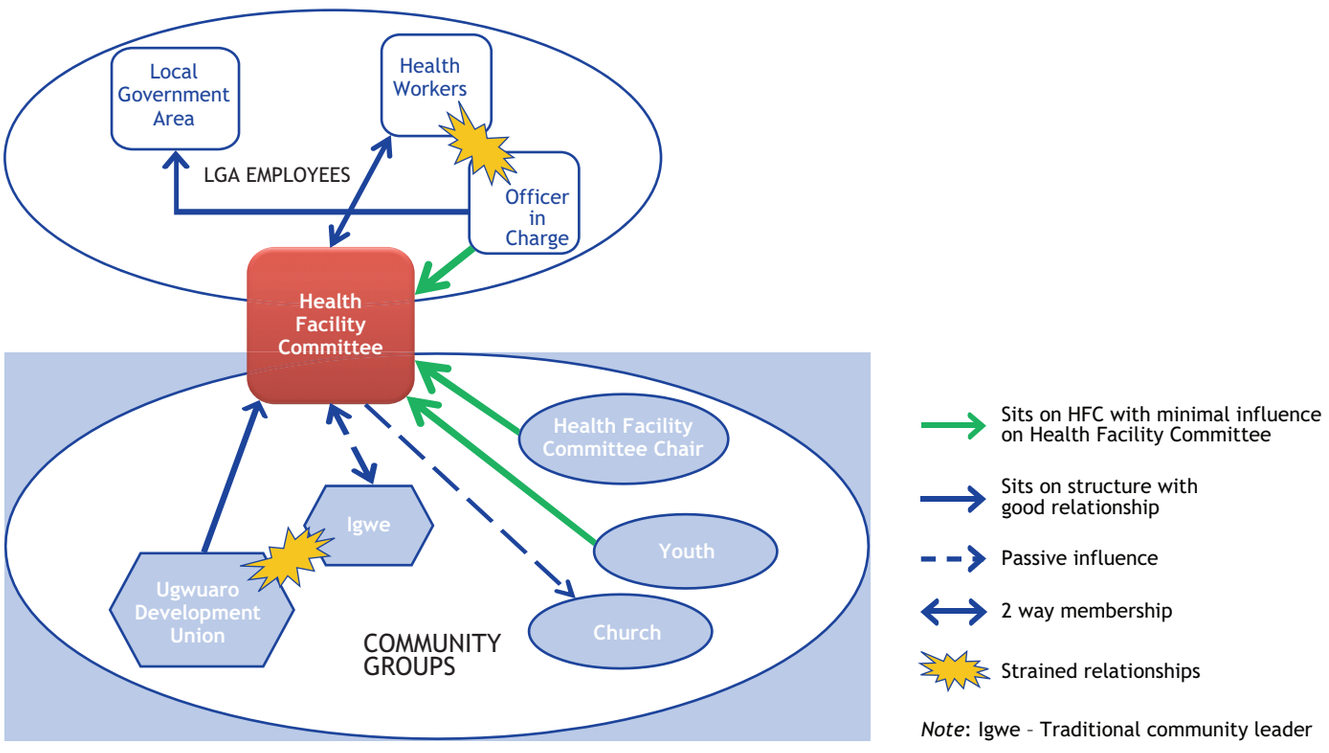
In Site B, the Committee does not have autonomy to act on its own and usually the Local Government Authority and Site B Development Union have the final say. The Health Facilities Committee is expected to ensure that the health centre functions effectively by: sourcing funds for maintenance of the health post; monitoring health workers; and ensuring that the health post is functional and that the welfare of the health workers is ensured. However, in practice, these functions are not carried out as none of the members go to the health facility except the Chairman. The Chairman closely monitors the activities of the health care workers to make sure that they provide a good quality of care to the patients and checks on them to make sure they keep to the normal working hours. Some of the health workers are usually punctual to work, but the majority are not. When this was reported to the Committee by community members, no action was taken. The Chairman only cautioned the erring staff and did not take any disciplinary measures.

FINANCING

In Site A the Health Facilities Committee helps provide support for equipment and infrastructure through the commitment of the Site A Women Congress and Site A Development Union when it is not forthcoming through the Local Government Authority. This has included tables, beds and even the construction of the health centre to a modern standard. They have also supported the construction of a borehole and latrines.

In Site B the Health Facilities Committee has not managed to mobilise much support for their activities. The Committee claimed to have engaged in fundraising activities from both community members and the government for the proposed new health centre and also to help in maintaining the present one by raising the money for paying the rent. However, from observations made and the interviews, it appears that this is not the case. What money they have raised has come from the Site B Development Union and the abroad group (community members who live elsewhere). This has only happened when the Committee makes an active request and to date the levels of support have been insufficient. The Committee has tried to generate resources through village levies and contributions, particularly from community members living outside the community but this has been unsuccessful. Any funds generated are not managed solely by the Committee and before any funds can be disbursed the Site B Development Union must be informed. No money comes from the Local Government Authority, making things more difficult. Some Committee members have spent their personal money on the health centre and they have not been reimbursed. Most of the lack of interest in Health Facility Committee matters and disillusionment with the Local Government Authority was blamed on a lack of financial incentives and reimbursement.

Figure 1: Relationships and linkages in Ugwuaro



TRUST

In Site A the Health Facility Committee members knew each other, worked collectively and treated each other respectfully. There have been no reports of conflict between the Health Officer In-Charge and the Committee. In fact Committee members visit each other outside the formal meetings and activities for example at village gatherings, church or the market. The Health Facilities Committee has a good relationship with the community and provides active feedback through church announcements and through the other community bodies. The support, financial and otherwise, of the community allows them to follow through on their commitments. The basis of this trust was the representation of community groups on the Committee. The Health Officer In-Charge provides a bridge with facility staff and represents their interests. The Health Officer In-Charge also has a strong link with the Local Government Authority and feeds back to them.

In Site B there were not strong relationships of trust between Committee members. This was exacerbated by non-reimbursement of personal costs. In addition, some people felt aggrieved that they were not selected to participate in some Health Facility Committee activities and the Chairman was accused of preferential treatment in assigning people to particular tasks like distributing bed nets. The infrequency of meetings and poor attendance means that information is not shared. A majority of the Committee reported that there is a cordial relationship between themselves and the Site B Development Union and that the community is happy with their services such as immunisation and distribution of bed nets. The Committee notifies the community before embarking on activities, and the Site B Development Union makes financial contributions for approved activities. However, this trust relationship has not transformed into a reasonable financial commitment by the Site B Development Union and the community to the Committee's work.

The Igwe has a strained relationship with the Site B Development Union. These two institutions are traditionally regarded as the power block of the town with their various functions; therefore, they are expected to work in harmony to achieve results. This friction is a de-motivating factor for the Committee and is likely to undermine trust. Most Committee deliberations do not reach the Igwe and he lives in (distant) Lagos and is not readily available so he has little impact on their work.

CONCLUSION AND POLICY RECOMMENDATIONS

- When Health Facility Committees function well they can have a positive impact on resource mobilisation and the performance of health service staff.
- Ensuring representation of existing community groups on Health Facility Committees may help facilitate their work and feedback to the community. The existing membership guidelines should be updated to reflect this.
- Training for Health Facility Committees may help them: function better; understand levels of authority and boundaries; keep records; run meetings efficiently; and be more representative of their community constituents and staff. This should also form part of the guidelines for Committees.
- The standard of service provided by the Health Facility Committees is influenced by community life and structures.
- Relationships and trust can affect the impact of the Committee. Trust in relationships with other community structures contributes to impact.
- Committees should be stimulated through, at least, minimal financial incentives to manage their meetings.
- There is a need to document the good practices of Health Facility Committees and the Government should consider sponsoring study tours between the more functional and less functional Committees so that they can share experiences and good practice.

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