Nigeria State Health Investment Project

A Mid-term Qualitative Study to Assess Implementation of NSHIP in Pilot States

12 June 2018

This report is prepared by Dr Aarushi Bhatnagar and Dr Lanre Ikuteyijo.
For any questions, please contact Dr Aarushi Bhatnagar at
abhatnagar1@worldbank.org

Table of Contents

Acknowledgements

Undoubtedly, a national study of this dimension would not have been possible without the invaluable support of some individuals and organisations. To this end, the qualitative team of the Nigeria State Health Investment Project (NSHIP) Midterm Evaluation Project acknowledge the following people for their immeasurable supports during the process of planning and data collection:

The World Bank which provided the financial and technical support for the study, as well as focal persons including Drs Odutolu and Fadeyibi. The Ministry of Health represented by the Principal Investigator, Dr. Meribole and Mr Ikechukwu Okwudili who provided the logistical support. We appreciate the assistance of the National Primary Health Care Development Agency (NPHCDA) as well their counterparts at the state level (SPHCDA). We are particularly grateful to Ms Binta Ismail for her leadership as well as to Dr Michael Ajuluchuku, Mr Muhammed Mashin, Mr Ismail Salihu, Ms Kemi Olagunju and Ms Hyeladzira Gamvwa for their inputs in to the design of the study.

The Chairmen of SPHCDAs in all three states were ready to speak with us despite their very busy schedules. We were also generously assisted by the three NSHIP Project Coordinators Mr Yakubu Ogienyi (Nassarawa State), Dr Ige (Ondo State), and Dr. Mangwa (Adamawa State). We are also grateful to the CMD, Nasarawa State Hospital Management Board, Dr. John Dagana, the Permanent Secretary of the Ondo State Hospital Management Board, Dr. Adeniran Ikuomola and The Executive Chairman of Adamawa State Hospital Management Board, Dr. Lawan Halidu for their time.

We are thankful to all the community leaders who served as gatekeepers as well as the respondents interviewed during the study. We appreciate the tireless efforts of the research team; Mrs Toyin Alaba, Mrs Azhee Akinrin, Mr. Umar, Mr. Adeniran Mayokun and Mr. Ibrahim Ogiri.

……..

List of Abbreviations

ANC:	Ante Natal Care
CHEW:	Community Health Extension Workers
CMD:	Chief Medical Director
DFF:	Decentralised Facility Financing
DLI:	Disbursement-linked Indicators
FGD:	Focus Group Discussion
FMOH:	Federal Ministry of Health
GH:	General Hospital
HMB:	Hospital Management Board
IDI:	In-depth Interview
KII:	Key Informant Interview
LGA:	Local Government Area
MPH:	Master in Public Health
NPHCDA:	National Primary Health Care Development Agency
NSHIP:	Nigeria State Health Investment Project
O and G:	Obstetrician and Gynecologist
OIC:	Officer in charge
PBF:	Performance-Based Financing
PHC:	Primary Health Care
PI:	Principal Investigator
PIU:	Project Implementation Unit
RBF:	Results-based financing
RBFTA:	Results-based Financing Technical Assistant
SPHCDA:	State Primary Health Care Development Agency
WB:	World Bank
WDC:	Ward Development Committee

Executive Summary

The implementation of the Nigeria State Health Investment Project (NSHIP) has provided the opportunity to test alternative financing strategies for the health sector. NSHIP, which began as a pre-pilot in 2011 in one LGA in each of the project states of Adamawa, Nasarawa and Ondo, has been successfully scaled up to all the 50 LGAs in the three states (Adamawa 19, Nasarawa 13 and Ondo 18) since 2014, with half receiving performance-based financing (PBF) and the remaining block grants in the form of decentralized facility financing (DFF). At the time this study was conducted, NSHIP had completed two full years of implementation (2015 and 2016).

The main objectives of this study are to assess the implementation fidelity of activities included in the program design of NSHIP, including both PBF and DFF arms, as well as to better understand the changes brought about by the NSHIP pilot in behaviors of health workers and organisational structures and processes at the health facilities. In addition, the study also aims to document the experiences of community members in accessing and using services from facilities receiving PBF and DFF. The findings of this study will be triangulated with the results of the mid-term quantitative assessment, to ascertain what has worked and what has not, and the reasons for the same, in the implementation of NSHIP up to mid-point of the project.

This study followed a qualitative research methodology, including focused group discussions with beneficiaries in the catchment area of project facilities, in-depth interviews with health workers and supervisors, and key informant interviews with state and federal level stakeholders. The study was conducted in a total of nine LGAs – six PBF and three DFF – across the three project states. The nine LGAs were selected based on the principle of maximum variation, using routine monitoring data, such as one high performing PBF, one low performing PBF and an average performing DFF LGA were selected from each state.

Main findings of the study suggest a very high degree of implementation fidelity has been achieved at NSHIP facilities. This encompassed all facilities following due contractual procedures mandated by NSHIP's project design, receiving trainings on PBF and DFF principles, and creating new institutional arrangements, in the form of management committees. In addition, facilities adhered to developing business and activity plans for setting goals and designing implementation strategies. Furthermore, they created a common bank account to carry out all financial transactions in a transparent manner. All facilities, LGA PHC Departments, and verification agencies followed new guidelines outlined by NSHIP for data collection, collation and verification. These findings were common across both PBF and DFF LGAs.

This study found that new management mechanisms had been established while existing ones had been further strengthened. In particular, it was perceived that

supervision had improved, both in frequency as well as in its nature. Before the introduction of NSHIP, most facilities received supervisory visits from higher authorities once in a few months. However, with the advent of NSHIP, the intensity of supervision provided to PBF facilities increased exponentially, often in the form of surprise visits. While respondents in DFF facilities did not suggest the same degree of increase in supervision visits, they reported a significant improvement nonetheless. Moreover, the nature of supervision, in both cases, saw a shift from being an inspection to a coaching session using structured checklists.

NSHIP reportedly brought about paramount improvements in structural quality of both PBF and DFF facilities. Additional monetary resources enabled facilities to upgrade their infrastructure and procure much needed drugs and supplies. In addition, NSHIP facilities were able to recruit human resources for health thereby filling in acute shortages of staff as well as train them in standard treatment protocols. These changes along with a new paradigm of management interventions enhanced capacity, both ability and disposition to work, and engagement of health providers working in these facilities. Additionally, this enabling environment also brought about better staff relationships and teamwork.

In the case of PBF facilities, performance bonus payments received by individual health workers reportedly improved their financial status, and made them more punctual, motivated and committed to work. However, findings from the study suggest that there still exist mixed opinions with regard to the adequacy of the amount of performance bonus relative to the additional work load as well as the fairness in its distribution across various staff members in the facilities. Some considered that bonus payments truly reflected their efforts relative to the amount of work they carried out as well as their colleagues. On the other hand, some perceived that the bonus distribution mechanism favoured other staff and did not give them their due amount.

As a result of the above-mentioned changes, as well as lowering cost of services, community members reported to patronize services at NSHIP facilities, particularly for key maternal and child health services. They considered the facilities to be in a better position for delivering good quality services. In many cases, particularly among clients of PBF facilities, respondents mentioned receiving free items, such as soaps, clothes for babies etc, from the facilities free of cost. Most of the participants also observed that outreach activities had increased over the past two years and that health workers visited their hamlets and markets to immunize their children.

While NSHIP brought about many positive changes at the facility and community levels, the study also found certain gaps in its implementation as well as recurrent challenges deterring it from achieving its full potential. Geographic and financial access remained the most common problem faced by the beneficiaries, resulting from poor connectivity and high transportation and consultation costs. NSHIP's efforts to serve the most disadvantaged sections of the community, via the creation of an

Indigent Committee, did not seem to have a very strong reach. Community members also considered poor attitudes of health providers to be a strong deterrent for not utilizing services at some NSHIP facilities. Additionally, socio-cultural norms, especially prevalent in Adamawa and Nasarawa, prevented them from taking up family planning services.

While all health workers interviewed acknowledged that NSHIP had many advantages and benefits, it had severely increased their work load. In some cases, they narrated managing the excessive workload by hiring additional staff through the resources received through NSHIP. However, in places where facilities were not able to hire additional staff or were experiencing a much higher patient volume despite having extra staff, respondents complained of fatigue and stress. In some cases, they also considered that their base salary from the government was less relative to the amount of effort that they were expected to put in. This was further compounded by delay in receiving salaries from the government and in a few cases through NSHIP as well.

Most respondents from PBF LGAs described the process of verification and counter-verification that was carried out at their facilities. External verifiers visited their facilities to check registers to ascertain the number of patients that were consulted and whether appropriate formats were followed to record the procedures. However, in some cases, across all states, the respondents expressed concerns over this process stating that they often disagreed with the verifiers' assessment of their work. Moreover, they considered that different verifiers did not follow the same standard during their assessment, hence confusing them with regard to the changes that they are expected to make and often resulting in them losing out on services that are purchased.

In general, the lower cadres of health providers appeared to be less aware of various procedures and mechanisms of NSHIP. Among those interviewed, most had not attended the direct training on PBF and DFF provided to their OICs or other senior colleagues. Many of them were also not aware of the process of developing the business/activity plans and hence were not included in the priority-setting exercises. A few of them also mentioned not understanding the formula through which their performance bonus payments were calculated.

While both PBF and DFF facilities gained tremendously from additional monetary resources, this study found a few qualitative differences across the two types of LGAs. For example, PBF facilities were more likely to provide additional incentives to communities to attract them to patronize their services, and experienced a more rigorous supervision and verification process. On the other hand, respondents from DFF facilities faced financial difficulties to a greater extent and expressed a desire to transition to PBF. In addition, differences across the three project states mirrored the broader socio-cultural and political context existing in them. For example, uptake of

family planning services appeared to be higher in Ondo, shortages in technical staff and security concerns greater in Adamawa, and political leadership strongest in Nasarawa.

Thus, NSHIP brought about a paradigm shift in health service delivery by providing much needed financial inputs into the Nigerian health system. In addition, it introduced new management principles and processes, for both PBF and DFF, enabling facilities to effectively prioritize resources, set goals and carry out implementation plans. Moreover, PBF increased motivation and commitment of health workers by providing individual performance bonus, as well as further opportunities for knowledge and skill enhancement. As it enters its next phase, NSHIP needs to work towards improving some of the existing challenges and gaps to further improve quantity and quality of service provision, and continue to innovate to attract community members to use those services.

1. Background

Nigeria continues to be overwhelmed with several unfavorable health indicators such as low coverage of key interventions, especially those pertaining to reproductive, maternal and child health, inadequate quality of care and high cost of health services. The situation in the health sector therefore requires bold innovations and reforms in order to shift the focus to strengthening service delivery and improve health outcomes. The Nigeria State Health Investment Project (NSHIP) was introduced with the aim of increasing delivery and use of high impact maternal and child health interventions as well as improving the overall quality of care in the three pilot states in Nigeria - Adamawa, Nasarawa and Ondo. The project builds on lessons from the State Health Systems Development Projects and principles of fiscal decentralization to support targeted health systems reforms for the effective use of public resources to deliver essential health services to the poor. It recognizes that enhanced input financing alone is not an assurance to ensure the attainment of desired health outcomes, nor increase accountability of providers to users. Thus, NSHIP provides the opportunity to test alternative financing strategies for the health sector, namely performance-based financing (PBF).

NSHIP aims to impact service delivery and health outcomes by using principles of Results Based Financing (RBF). Two RBF approaches, namely Performance Based Financing (PBF) and Disbursement Linked Indicators (DLI) are used in the project states. PBF is applicable at the health facilities and LGA PHCs while DLI is applicable at both LGA and state levels. In addition, NSHIP also uses and compares the mechanisms of Decentralized Facility Financing (DFF) with that of PBF. Appendix 6.1 provides a detailed description of these project components. PBF includes performance related grants provided to health facilities based on quarterly quantity and quality of services provided. These funds are to be used for operational costs, such as for maintenance and repair, supplies and other activities (about 50%), and as performance bonus for health workers (about 50%). It provides health facility autonomy, ensuring independent running of the facilities and encouraging autonomous use of funds within project guidelines. On the other hand, DFF also provides quarterly block grants to health facilities, but these are not linked to performance in terms of quantity or quality of services. In addition, these funds should be used for health facility operational costs, but not for performance bonus.

NSHIP has created and institutionalized various organizations and committees at the federal, state, LGA and facility levels. The Project Steering Committee (PSC) and Technical Working Group (TWG) are operating at both federal and state levels while the RBF steering committee is at the LGA. At the facility level, the RBF and Ward Development Committees (WDC) are for the PBF and DFF facilities respectively. At the federal level, the Minister of State for Health heads the PSC, and the committee

provides strategic and policy direction as well as monitors the overall project implementation and results. The TWG is headed by the Executive Director of the National Primary Health Care Development Agency (NPHCDA) and is responsible for providing overall technical guidance for NSHIP. The state PSC is headed by the Commissioner for Health and is responsible for providing overall stewardship role to the project including planning, management and monitoring of project activities. The state TWG is responsible for providing operational support and improved supervision to all the LGAs within the state, and is headed by the Executive Director of State Primary Health Care Development Agency (SPHCDA). The state Hospital Management Board (HMB) coordinates the activities of all participating General Hospitals while the LGAs implement, monitor and report to the SPHCDA on the accomplishment of the LGA DLIs. The LGA Steering Committee is housed within the LGA Primary Health Care (PHC) Department and is responsible for the supervision and verification processes associated with both PBF and DFF modalities.

NSHIP, which began as a pre-pilot in 2011 in one LGA in each of the project states of Adamawa, Nasarawa and Ondo, has been successfully scaled up to all the 50 LGAs in the three states (Adamawa 19, Nasarawa 13 and Ondo 18) since 2014, with half receiving PBF and the remaining DFF. At present, NSHIP has completed two full years of implementation (2015 and 2016). This accounts for a scale up from the initial 36 health facilities in 2011 implementing PBF to 466 in 2015. Likewise, DFF was operational in 38 health facilities across the three states in 2014 and has been scaled up to 418 health facilities by February 2015.

2. Objectives and Research Questions

The main objectives of this study are to assess the implementation fidelity of activities included in the program design of NSHIP, including both PBF and DFF arms, as well as to better understand the changes brought about by the NSHIP pilot in behaviors of health workers and organisational structures and processes at the health facilities. In addition, the study also aims to document the experiences of community members in accessing and using services from facilities receiving PBF and DFF. The findings of this study will be triangulated with the results of the mid-term quantitative assessment, to ascertain what has worked and what has not, and the reasons for the same, in the implementation of NSHIP up to mid-point of the project.

The main research questions are as below:

1. To what extent were the activities regarding the training of health workers, the purchase contracts, the performance payments, and monitoring and verification, implemented as initially planned?

   The first research question pertains to assessing the fidelity of the NSHIP design and implementation for both PBF and DFF arms i.e. to what extent activities designed and planned were actually carried out with the appropriate content and frequency[1]. Fidelity will be measured on the basis of the intervention's adherence (content, coverage and temporality)[2], with an aim to understand the activities that were carried out, their intensity and coverage, along with a documentation of moderating influences.

2. To what extent has the program design and implementation of PBF changed health worker behaviors over a period of three years? How and why did these changes take place? To what extent, and why, are the experiences of health workers in DFF facilities different?

   The second research question aims to understand how different components of the PBF design have influenced health provider knowledge, behaviours and practices, and the reasons for the same. Firstly, the study would explore the extent to which health providers have understood different mechanisms of PBF, namely the purchase contract, indicators for deciding incentive payments, calculations of individual and facility-level incentive payments, data reporting formats, decision-making processes, as well as clinical standards for enhanced quality of care; the

[1] Ridde, Valéry, Anne-Marie Turcotte-Tremblay, Aurélia Souares, Julia Lohmann, David Zombré, Jean Louis Koulidiati, Maurice Yaogo, et al. 2014. 'Protocol for the Process Evaluation of Interventions Combining Performance-Based Financing with Health Equity in Burkina Faso'. *Implementation Science : IS* 9 (October). doi:10.1186/s13012-014-0149-1

[2] Bodson, O., S. A. Barro, A. M. Turcotte-Tremblay, N. Zante, and V. Ridde. 2017. 'Assessing Implementation Fidelity of a Results-Based Financing Intervention in Burkina Faso'. Accessed June 25 2017.

reasons for improvement in knowledge and the current lacunae in their understanding. Secondly, the study would document the extent to which health providers consider incentive payments to be aligned with the objectives of the program and sufficient given their additional workload, and their reasons for doing so. Thirdly, the study would aim to understand the changes in health provider motivation, brought about by both incentive payments and organizational changes, including relationships and coordination among co-workers and those with supervisors. Finally, a similar set of questions would be posed to the health workers in DFF facilities to understand their experiences of receiving DFF and changes in their work environment, motivation and practices.

3. To what extent has the program design and implementation of PBF changed organisational structures and processes, including key management practices, at primary health centers and first-referral hospitals since its inception? How and why did these changes take place?

   This component of the study would aim to understand changes at the organisational level of the health facility, including both primary health centers and secondary hospitals. Firstly, it would explore the extent to which new management practices, including, but not restricted to, making a business plan, calculating incentive payments, supportive supervision practices, have been integrated into routine management of the facility and the effects of the same. Secondly, it would document organisational changes that have taken place, as perceived by health providers and supervisors, pertaining to resource availability, use of data, target setting, autonomy, transparency and accountability, along with reasons for achievements and remaining gaps.

4. What have been the experiences of community members in accessing health services from health facilities receiving PBF and DFF?

   The final component of the study would document experiences of community members, living in the catchment areas of facilities receiving both PBF and DFF, in accessing (both geographic and financial) and using health services, and their levels of satisfaction with the quality of care that is provided to them. In particular, the study would focus on perceptions of community members on availability of resources (manpower, drugs, equipment) and services, interactions with health providers and quality of care (waiting time, privacy, provider responsiveness) received. The study would also explore the amount of funds that they are spending on accessing and using services from project facilities.

3. Methodology

This study used a qualitative methodology to address the abovementioned research questions, including focused group discussions (FGD) with community members, in-depth interviews (IDI) with health providers and supervisors, key informant interviews (KII) with state and federal level program managers, along with a review of existing documentation and monitoring data.

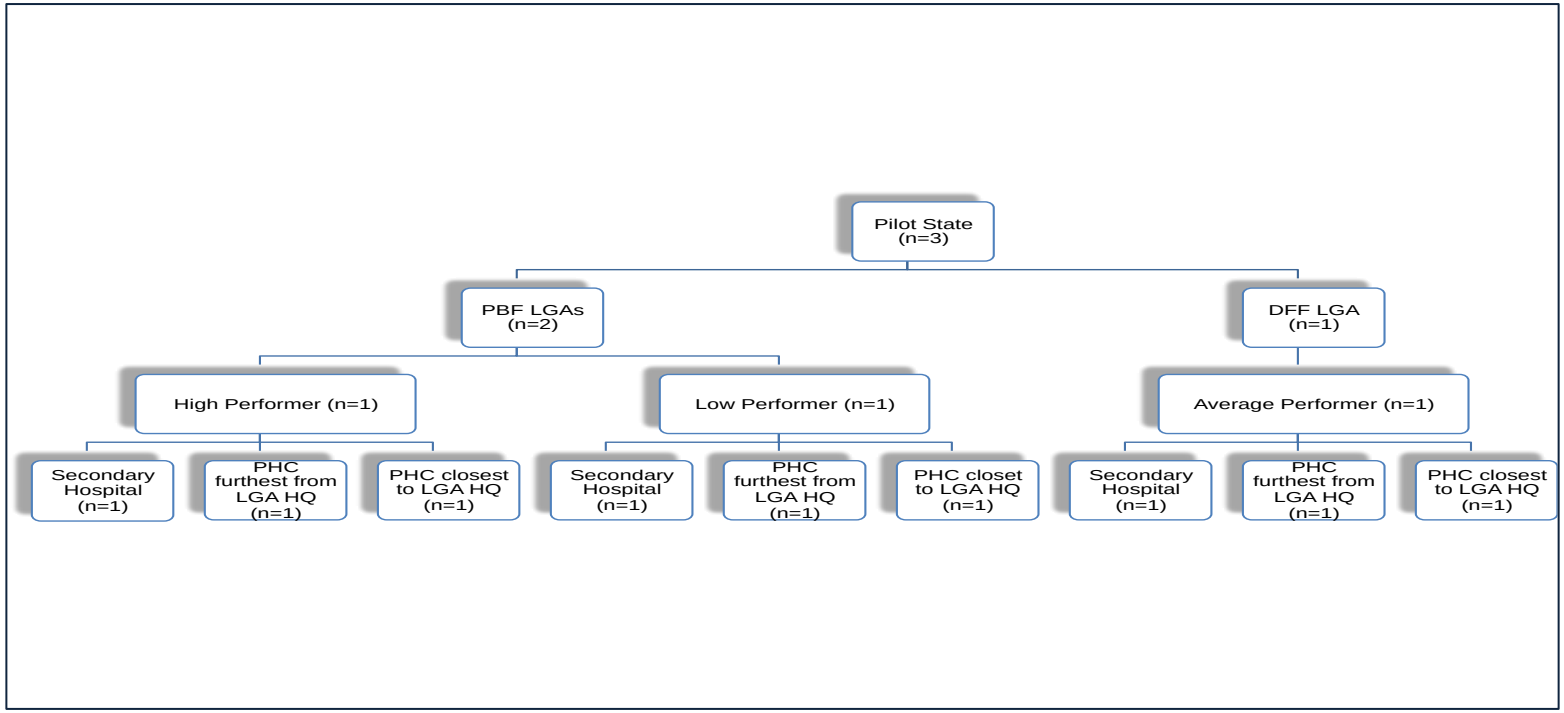
Study Site and Respondent Selection

To achieve sufficient data saturation without compromising quality, the study used a maximum variation sampling approach. Under this approach, a small number of sites that maximize the range of variation on dimensions of interest were purposefully selected. In qualitative research, any common pattern emerging from great variations is of particular interest and value in capturing core experiences and shared aspects. This approach was helpful in identifying common themes that cut across variations.

The study was conducted in all three pilot states of NSHIP – Adamawa, Nasarawa, and Ondo. Two LGAs receiving PBF were purposively selected from each state, based on monitoring indicators, such that one was a high performer and the other low over the past two years of project implementation. Appendix 6.2 describes the monitoring data used to make the selection of PBF and DFF LGAs. From each LGA, the secondary hospital and two primary health centers were purposively included in the study, with the latter selected based on the facility categorization in PBF (one from each category 1 and category 4/5 were selected) and on the basis of distance from the LGA headquarters for DFF LGAs. In addition, from each pilot state, one LGA receiving DFF was purposively selected using routine monitoring data and identifying the LGA with average performance across all DFF LGAs. The same number of facilities, using the same selection criterion, was selected from each DFF LGA. Figure 1 provides a schematic description of the selection criteria for the study sites.

From each selected facility (health centers and hospitals), the officer in-charge and the second senior most health provider were interviewed. Additionally, supervisors from the LGA PHC Department and Hospital Management Board (HMB) were also requested to participate in interviews. Moreover, FGDs with men and women, having a child aged two years or younger, in the catchment areas of each of the selected facility were carried out separately. Finally, KII with stakeholders at the state and federal level, namely State Project Implementation Unit (PIU), State Primary Health Care Development Agency (SPHCDA), National Primary Health Care Development Agency (NPHCDA), RBF Technical Assistance agency, were conducted.

Figure 1: Study Sites



Data Collection Methods

As described above, data was collected via in-depth and key informant interviews, focused group discussions, and review of available project documents. Interaction with multiple stakeholders along a range of common themes allowed for a more holistic understanding of the implementation of NSHIP, while also allowing for triangulation of findings.

A team of experienced and well-trained qualitative researchers conducted the above-mentioned interviews. In particular, a team of two researchers carried out each interview, namely a facilitator (native Yoruba/Hausa speaker depending on study site) asked the questions and facilitated the interaction while a recorder took down notes and observations. The research team took appropriate consent from all participants prior to beginning the interviews and discussions. All interviews were audio-recorded after taking the permission of respondents, transcribed verbatim and translated in to English. In addition, the research team took exhaustive notes during the interview as well as maintained a reflexive diary to record their observations, perceptions and positionality during the interviews. A daily debrief meeting was held between the research team at the end of each day of data collection.

These interviews were carried out at the respondents' place of work, in the case of facility providers, supervisors and key informants, and at an appropriate and central location of the village/town for the FGDs. All efforts were made by the research team to ensure a private setting for these interactions such that interruptions would be avoided and participants were able to express their views comfortably.

The research team sought appointments with facility providers, supervisors and key informants, prior to reaching their place of work. Participants for the FGDs were selected during a transec walk exercise carried out with members of the village leadership facilitated by a local guide hired by the research team. In case of large villages or town, especially for the catchment area of the hospital, appointments with the village/town leadership were sought ahead of time to design an appropriate approach for recruiting participants.

Training of the research team took place in Abuja during the second week of September, followed by pretesting of questionnaire guides in Nasarawa. The entire team subsequently completed data collection in Nasarawa state. The team then split in to two to carry out data collection in Ondo and Adamawa simultaneously, and completed all interviews and discussions by the second week of October. The transcription and translation of recorded interviews commenced shortly after data collection and were completed by end of November, 2017.

Data Analysis

Data analysis commenced following a thorough check of translated interview transcripts. Data were analyzed using the framework analysis approach using Atlas.ti qualitative software.

Data analysis underwent the following stages recommended in the Framework Analysis approach[3]:

1. Data familiarisation: Analysts designed and tested the questionnaire, observed fieldwork and read transcripts and notes
2. Thematic framework identification: A priori code-book was created as a guide to interpret the data. However, emergent codes were also added to it.
3. Indexing: Data were delineated into distinct categories allowing for a quicker, more systematic retrieval of coded data for analysis. Initially two researchers tested the a priori codebook, following which a team of four researchers coded the data.
4. Charting: At the time of preliminary analysis, data were rearranged by its index – for example, a table with themes in rows, cases in columns, and summaries in cells was created
5. Mapping and interpretation: Charts and matrices were also developed to look for patterns and associations in the data, developing explanations and mapping the range of phenomena
6. Quotations: Quotes from interviews and discussions were used in the text to illustrate the analysis

Moreover, data sources were triangulated during analysis, both across interviews as well as with existing documents and monitoring data.

Ethical Considerations

The study, being a part of the NSHIP Impact Evaluation, received approval from the Nigeria Health Research Ethics Committee.

As described above, appropriate consent was taken from each participant prior to commencing the interview. The research team was also trained in explaining the study objectives and process to respondents as well as to reassure them of maintaining confidentiality of their responses.

[3] Ward, DJ, Furber, C, Tierney, S, Swallow, V. 2013. Using Framework Analysis in nursing research: a worked example. Journal of Advanced Nursing 69(11): 2423–31.

4. Findings

The following section summarizes the main findings from this qualitative study. It describes the respondents that were interviewed, followed by highlighting some of the achievements of NSHIP as well as existing challenges. It also attempts to draw qualitative comparisons across PBF and DFF LGAs, as well the three study states of Adamawa, Nasarawa and Ondo.

4.1 Characteristics of Respondents

As described in the methodology section, this study included focused group discussions (FGDs) with men and women residing in the catchment areas of selected NSHIP facilities. In addition, in-depth interviews were conducted with officer in-charge (OIC), a second health provider and the LGA PHC Coordinators across nine LGAs. Moreover, key informant interviews were conducted with important stakeholders at the state and federal levels. The following section briefly describes the characteristics of respondents.

Respondents of FGDs

Generally, the median age of all FGD participants was 30 years while the median age for women was 26 years and men 35 years. In terms of occupation, most of the participants in the rural areas were farmers while there were some Fulanis among them who were mainly herders. Majority of the participants in the rural areas had no formal education while those in the urban had between primary and post primary educational qualifications. In Nasarawa State, some of the predominant tribes of the participants were Hausa, Alago, Mada, Gwandala and Afo, while in Adamawa State the dominant tribes were Bachema, Fulani and Lunguda. However, most of the participants in Ondo State were Yorubas.

Respondents of IDIs

In the three states, 54 IDI sessions were held with Officers in Charge (OICs) of facilities and heads of secondary health facilities. In each state, 3 interviews were held with PHC Directors from each of the LGAs. In Ondo State, 2 of the LGA PHC Directors were medical doctors while 1 had an MPH. One of the three Directors was a female.

However, among the 18 OICs and their assistants in Ondo State, 11 were females while 7 were males but in Adamawa and Nasarawa, most of the OICs were males and mostly assisted by female health providers. Across the states, most of the PHCs were headed by Community Health Extension Workers (CHEW) and Community Health Officers (CHO), while the secondary facilities were headed by medical doctors. In Ondo state, the longest serving OIC had spent 17 years in the facility while the least number of years spent by any OIC was 1 year. The second providers interviewed at primary health facilities were Junior Community

Health Extension Workers (JCHEW); and Staff Nurses at the secondary hospitals. Less than quarter had been in service for the past five years, about a quarter had been in service for more than ten years while the rest had served between 6-10 years.

Box 1: Characteristics of Study Settings: Summary Findings from Transec Walk

- The general hospitals and the high performing PBF and DFF health facilities were located in urban to semi-urban communities of the study local government areas. On the other hand, the low performing PBF and DFF health facilities were located in rural communities which were sparsely populated.
- The urban communities were not far from the local government secretariat (usually less than 5 kilometers in all the LGAs) and they are averagely to densely populated. The people live mainly in houses built with cement blocks and metal roofs.
- The rural communities were very far usually 50 to 100 or even more kilometers from the LGA secretariat.
- Most of the rural communities were hard to reach with very bad road network and topography and people lived in houses built predominantly with mud and other local materials. Houses were usually built amongst farmlands.
- The rural communities were sparsely populated and most of the people were farmers
- The people in the urban and semi urban settings were engaged in various occupations such as teaching, tailoring, other hand work/vocation, petty trading and business in addition to farming.
- Most of the women in all the communities were housewives
- People in the urban or semi urban communities traveled for shorter distance to the health facilities while those in the rural community have to travel for longer distance and time to the health facilities.
- Almost all the rural communities had no electricity, cable TV and not all the houses had toilet facilities.
- Some of the houses in the urban communities had cable TV and majority had toilets in their houses. All the urban and semi urban communities had electricity (connected to the National grid)
- In all the three local government areas, there was usually one or two PHCs close to (within 5 kilometers) to the general hospital.
- In all the communities there were schools (usually government primary and secondary) and place of worships (Churches and Mosques) within and close to the health facilities under study.
- Most of the communities had boreholes while some few others relied on well water and water from the stream/river

Respondents of KIIs

For the Key informants, 3 RBFTAs were interviewed in the states. All of them had a minimum of Master in Public Health (MPH) and had worked in the state for over a year. In Ondo and Nassarawa States, the RBFTAs had worked in Cameroun prior to their posting to the state, while the RBFTA in Adamawa State had worked in Rwanda prior his posting to the state. Also, the State Primary Health Care Development Agency was headed by experienced medical practitioners who were quite conversant with the development of NSHIP over the

years. In Adamawa, the Executive Secretary was the pioneer head of NSHIP in the state and had been part of NSHIP since commencement in the country. The Executive Secretary of SPHCDA in Nasarawa was also not new to NSHIP as he was one-time Special Adviser to the Governor on Health Matters. In Ondo State, the Executive Secretary was a former Medical Director of three hospitals in the state and had put in 21 years in service.

The 3 Chief Medical Directors of the Hospital Management Board in the State were also interviewed. The Head of the Hospital Management Board in Nasarawa was designated as a Permanent Secretary and he was a consultant in Family Medicine. He was the pioneer Chairman of SPHCDA in State and he took part in the World Bank-sponsored PBF training held in Nairobi, in 2009. The Hospital Management Board in Adamawa State was headed by a medical doctor and former lecturer at the University of Maiduguri. He was a former Commissioner for Health in the State. In Ondo State, the HMB was headed by a consultant in Obstetrics and Gynaecology and a former CMD of the State Specialist Hospital.

In the three states, the NSHIP office was headed by the Project Coordinators (PC). The PC in Nasarawa State was well versed in NSHIP operations as he had been part of the project since inception. The PC in Adamawa had an MPH and joined the agency in 2014, while the PC in Ondo was a female medical doctor who had an MPH and over 10 years' experience in public health management.

4.2 NSHIP Success Stories

The following section highlights various achievements of NSHIP across the three states, namely the high degree of fidelity achieved in its implementation resulting in establishing stronger management systems and supervision processes. It also describes the changes in staff knowledge, motivation and engagement, and the overall improvement in their working conditions. It finally concludes that these structural changes in the health service delivery systems along with a more committed workforce has led to higher uptake of services at NSHIP facilities.

4.2.1 High Degree of Fidelity of NSHIP Implementation in Study Sites

Discussions with Officer In-charge (OIC) and LGA PHC Coordinators suggest that a very high degree of implementation fidelity has been achieved in their respective NSHIP facilities. This encompassed all facilities following due contractual procedures mandated by NSHIP's project design, receiving trainings for learning about PBF and DFF principles, and creating new institutional arrangements, in the form of management committees, as well as reinvigorating existing institutional structures. In addition, facilities adhered to developing business and activity plans for setting goals and designing implementation strategies. Furthermore, they created a common bank account for the health facility to carry out all

financial transactions in a transparent manner. All facilities, LGA PHC Departments, and verification agencies followed new guidelines outlined by NSHIP for data collection, collation and verification. These responses were common across both PBF and DFF LGAs.

Introduction of NSHIP: Contracts, Take-off Grants, Training

All facilities visited had a valid signed contract with the purchaser of their services, namely the State Primary Health Care Development Agency (SPHCDA). Officer In-charge of these facilities reported to have signed these contracts on an annual basis before implementing any service, agreeing to various terms and conditions of NSHIP, and thereby becoming eligible for selling their services to SPHCDA. Similarly, respondents from LGA PHC Department described that they had also signed a contract with SPHCDA. In a few cases only, individual health workers mentioned entering into a contract, called the "motivation contract", with the health facility OIC.

"Yes we did, I signed and my chairman signed, WDC chairman and then the Ondo State Primary Health Care Board Executive secretary signed too and so we entered a bond with them and even when it got to a year, last year October we still signed that bond again, upper year October we signed the bond and I know this October we would still sign another bond." (IDI, OIC, PBF LGA, Ondo)

"We signed the agreement that every year, the contract will be renewed, and the way they want us to manage, if we are mismanaging their funds, they will hold us responsible." (IDI, OIC, DFF LGA, Nasarawa)

"We signed an agreement with them for a year and in any of this agreement, include a lot of laws so whenever we violate any of this law the contract can be withdrawn so like buying drugs from a vendor that is not licensed or not approved by the NSHIP, like not providing the receipt of any contract that we embark upon or not fully giving the free treatment to under-five children and the pregnant women." (IDI, OIC, DFF LGA, Ondo)

"I signed, facilities too signed, the NSHIP people signed, I think the Agency too. The MoU outlines what we have agreed to do, what the facilities have also undertaken to perform etc." (IDI, LGA PHC, DFF Adamawa)

In addition to signing a contract, OICs of all facilities confirmed that they received a "takeoff" grant at the inception of NSHIP. This grant was provided to them to prepare their facilities and upgrade their structures and amenities in order to be able to participate in this initiative.

"At that juncture, that take-off grant was given. And the purpose of that grant at that moment was to renovate...you can see this place shining, it was as a result of that fund. They painted here, they made some construction, as you can see the incinerator there, it's part of it. And you can see that shed there, where our women do come for immunization, they have

their time there to sit down there, and that a lot of things. You see this cabinet, this fridge, all these...most of the things, furniture, it's as a result of that fund." (IDI, OIC, PBF LGA, Nasarawa)

"After receiving the first payment of 125,000, we looked at the environment to see what we can do at that time so that we can justify the use of the money because everywhere needs attention, everywhere in this hospital needs attention. So we started with the priority areas which are the lab, we allocated money to lab, to pharmacy, then we bought some instruments to be use in the work. That was how we started it." (IDI, OIC, DFF LGA, Adamawa)

"We used the first grant for, we did some repainting, because the paint was very old, and then we did repairs of some equipment, then we bought some machines too, we bought suctioning machine, we bought sphig, and I think we bought printer." (IDI, OIC, PBF LGA, Ondo)

Most of the Officer In-charge (OICs) who had been posted in the facility when NSHIP was introduced reported that they have received training on PBF and DFF, focusing particularly on management of additional funds, from a core group of experts.

"They trained us basically on the issue of this PBF. PBF is now on the pipeline and that PBF is just a business that we are going to establish between the health facility and the NSHIP. That we are to do a very quality and quantity service. Then they will come and buy the services and they will now post the money to our account. Then we shall be using part of that money for the clinic and that is why you are seeing a lot of things like this." (IDI, OIC, PBF LGA, Adamawa)

"They lectured us on what they wanted from us. They lectured us on how to take care of patients, the guidelines to follow, how to relate with patients. So, they taught us all these things. They made us realise that we should be the ones searching of pregnant women… you know, initially we thought patients should be the ones to come to us whether they are sick or not but now we have to search for them. They lectured us on all that. We spent five days in Akure and when we go there we were accommodated in a hotel and even had the seminar in that same hotel. They took great care of us and we were given the necessary lectures." (IDI, OIC, PBF LGA, Ondo)

"Well, the first one, it involved both the General Hospital and the PHCs, and some Local Government persons of interest as is related to the program. Then they...we now went for a refresher. January last year, and that one was not...it was practically all the facilities. You understand, so...that is to talk about the uniformity of the training. You understand? Whatever we were taught, there is uniformity of the training, as far as I'm concerned. (IDI, OIC, PBF LGA, Nasarawa)

"They trained us on how we are going to manage the NSHIP money because they are

giving us fund, how they want us to be managing the fund." (IDI, OIC, DFF LGA, Nasarawa)

However, in many cases the OICs interviewed had joined the facility after the inception of NSHIP. Most among them talked about being provided with necessary manuals that described the project.

"No. I don't know who trained them and I don't know what they were trained on. The only thing is, the focal person or the supervisor of this ward, then, gave me the handbook for the training; and that was what I went through and... that was what helped me to carry out the activities of NSHIP." (IDI, OIC, DFF LGA, Adamawa)

New Institutional Structures

Respondents from all facilities talked about having constituted various new committees as well as strengthening existing ones. For example, PBF facilities, including General Hospitals, had constituted a Results-based Financing (RBF) Committee whereas DFF facilities had reinforced the role of the existing Ward Development Committee. Similarly, LGA PHC Departments were now answerable to the LGA Steering Committee. The main role of these committees was to ensure effective utilization of resources and to monitor the progress of service delivery and quality every quarter. In addition, meetings of these committees served as a platform to discuss challenges faced by staff and to set targets that facilities should aim to achieve.

"*Apart from the take-off grant, the program stated, or let me say the workshop stated, it on how to start the program by creating a WDC committee, by creating an indigent committee, and also the staff, there must be an internal management committee for the staff, before any other business start*." (IDI, OIC, PBF LGA, Nasarawa)

"And again, ward development committees and village development committees were redundant before the coming of NSHIP. They are the body saddled with responsibility of monitoring day-to-day affairs of the facilities." (KII, State-level Official, Nasarawa)

"The steering committee meets quarterly where its representatives come to verify the job done validate and quantify it to suit their standard based on the checklist they give such as consultations, relationship with staff, cleanliness of the environment and then rate it and release money for activities. That money will be verified by the quality team which includes the state NSHIP, hospital management board and state ministry of health. They come to assess services provider to patients from consultations to investigations undergone, admissions and surgeries done and then they award scores. The steering committee will now

sit and look at scores on quantity and quality and based on that they award money which the facility receive at the end of the quarter." (IDI, OIC, PBF LGA, Adamawa)

Target-setting using Business and Activity Plans

Responses from OICs and LGA PHC Coordinators suggest that all NSHIP facilities are following due procedures with regard to preparing business (for PBF) or activity (for DFF) plans on a quarterly basis. Moreover, they are using these plans for target-setting, prioritization of resources, and for monitoring outcomes as envisaged by the project design. Respondents talked about developing these plans as a team, including other members of their respective facilities as well as those in the RBF or Ward Development Committees. They also elaborated on the process of using data to decide whether their efforts in the past quarter had been successful or not, and how they should proceed to incorporate the pending targets in the new business/activity plan. Table 1 describes narratives heard from respondents in both PBF and DFF LGAs.

Verification Processes

Most respondents, particularly among PBF facilities, talked about having an external verification process in place. They described this to entail external verifiers visiting their facilities on a monthly basis to crosscheck records and registers. In addition, they also visited community members who had visited the facility as per records to confirm their presence and the treatment that they sought.

"The verifiers that we have are all health related personnel that have been trained in performance based financing. First of all the selection process was very good, very good. The lowest score we got was about 70 within the 3 states during the (internship) training. It was a one-month training. It had a lot of fieldwork; it had a lot of modules to build their capacity as regard to coaching and mentoring, applying the tools and understanding the contents. So they go to the health facilities on a monthly basis." (KII, Federal-level)

"There was a time they brought external people to come and validate our data they go into register, even into our cards to really validate so what they now get that we make a common data that we now have." (IDI, LGA PHC Coordinator, PBF LGA, Ondo).

Table 1: Target-setting using business and activity plans

Target-setting using business and activity plans	
PBF LGAs	**DFF LGAs**
"We do business plans quarterly and we also go by the business plan too, because there are some things you need to put in your business plan that you want to have them, then you put in inside and when the quarter runs out, if you're able to meet one or two, you'll still skip them because in doing another business plan after three months, you might not enter those things but the ones you didn't meet are the ones you push and still continue pushing until maybe at the end of the year if you are successful with them, fine and if you're not successful, you'll still carry them forward." (IDI, OIC, Adamawa)	*"We do produce activity plan quarterly, which are vetted and approved before we get funding for it, we run it like a budget and so we use the fund as per what we have in our activity plan, so all the money that come for the quarter, we channel them into all those activity that we plan to cover every aspect of the hospital needs."* (IDI, OIC, Nasarawa)
"Business plan before making it we have a committee, the committee of RBF (Result Based Financing) that will sit together then the facility members we do come together we set the needs then we prioritized them based on their importance then there is this quality evaluation form that they use to assess us on, on quarterly bases which at the end of the day when we score our low mark we go back to see what they are requesting for to be able to ensure we are improving when we plan alongside the staff and the RBF committee they give approval they we move on." (IDI, OIC, Ondo)	*"Well, as we do the activity plan, we send it do the managers of the program. So they are the ones, based on the funds they give us we then choose the area that is of paramount importance, we prioritize then we attack that area before we go to others. Then if it is not achieved in that quarter we carry it forward to the next quarter."* (IDI, OIC, Adamawa)
"The same thing at the LGA level, we sit down with the Directors and develop our plans; what we want to do, which areas do we want to cover; do we want to do renovations, purchase stationaries; how much is supervision going to cost; quality assessment, how is it going to cost? We develop that of our own at the LGA level and also send e-copies and hard copies to the State Primary Healthcare Development Agency quarterly for approval and till they approve before we start operating." (IDI, LGA PHC Coordinator, Adamawa)	*"Actually we have a team - the LGA team, we sit and discuss what we want the fund for which is basically for operational purposes, there are items we need to do or we need to have in PHC authority also funds for supervision that is basically what we do, it is been prepared by the LGA team not one person anyway. After preparation of the activity plan which we are supposed to prepare before 15th of next month or the next quarter and we submit it to the NSHIP office for approval."* (IDI, LGA PHC Coordinator, Ondo)

4.2.2 Strengthening of Management Systems and Processes

Building on the above section, NSHIP had envisaged to bring about fundamental changes in the management of the health system in Nigeria. This study found that indeed some of these new management mechanisms had been established while existing ones had been further strengthened. The following section describes improvements in management process, including financial transactions, as well as use of data and greater autonomy in decision making.

Stronger Management Systems

Many respondents, particularly OIC and LGA PHC Coordinators, considered that NSHIP brought about stronger management of their respective facilities and LGA PHC Departments. They discussed being exposed to several new management practices, such as making business plans, budgets, organizing and attending management meetings, documenting data and processes, and managing staff and clients. They also talked about being able to prioritize limited resources and strategize to further improve service delivery at their facilities. One respondent also considered that having a strong management in place would allow them to overcome all bureaucratic obstacles. These perceptions were common among respondents from both PBF and DFF LGAs to a large extent.

"The NSHIP has helped to emphasize the ideal. What is the correct thing, about management, about administration, financial management, patient management, you know, it has helped to emphasize it. So, of course, since it's emphasized, it draws your thoughts in that direction and you want to see how you will improve." (IDI, OIC, PBF LGA, Nasarawa)

"I don't have any doubt that any of my facility managers can be appointed as commissioner of health in this state, because the know how to manage. Everybody, every package has a file, every activity have its own file. They meet monthly too, they have the structure there; they have Internal Management Committee, they have RBF committee meetings in the LGA level, they meet- take their minutes, they know how to do it, they have their computers – they can even email you a report from the health facility." (IDI, LGA PHC Coordinator, PBF LGA, Adamawa)

"I would say its, my personal experience, is just help me appreciate the beauty of having a proper running system. I don't even know whether they were making budget before this program started….there was no system at all, not to talk of whether it was functional, but now that we have, we make budget, we can even evaluate ourself about how much we are performing, how much you are achieving, that managerial aspect for me is one thing I appreciate quite well and I believe that you know, it is something that every person in civil service should be allowed to

participate in, not just in health sector, educational sector and all aspect. (IDI, OIC, DFF LGA, Nasarawa)

"Because it has brought us to a thing we feel like we can handle everything in this hospital given the needed funds, even without the intervention of the state government I think we can manage the hospital and we can even transform the hospital to specialist hospitality, I have that feeling. If I have enough funds why should I be seeing hundred patients alone, there are doctors outside, invite them in and pay them at the end of the month, and they will continue to come. So is just a matter of strategizing, when you strategize, you will discover that there are a lot of changes." (IDI, OIC, DFF LGA, Adamawa)

"Taking note of whatever I do is number one, every meeting must be documented, every action taken must be documented, then later I have to go back to those decisions I have taken before and see whether I have been able to implement some things, if not I have to look at the shortcomings and the challenges and how to overcome them." (IDI, OIC, DFF LGA, Ondo)

Similarly, LGA PHC Coordinators also talked about having new management systems in place which greatly streamlined their roles and responsibilities. For example, one respondent from Ondo said that *"before in the LGA PHC team there was no proper job description for each program officer but now there is proper job description and everybody knows what to do. You do your work as planned, give your deliverables at the of the month, go for supervision to know what everybody is up and doing."*

Effective Financial Management, with Higher Transparency

In addition to management processes pertaining to planning, budgeting, organising and documenting, respondents were explicitly asked to describe their experiences with changes in financial management. On the whole, across both PBF and DFF LGAs, respondents narrated positive experiences of learning how to effectively use additional financial resources. Moreover, many of them also talked about greater transparency in financial transactions, citing examples of use of a common facility bank account which ensured no misappropriation by any individual staff member. In particular, they considered that NSHIP enabled a shift from the practice of individual health providers selling drugs at facilities to drugs being sold through the facility with all revenues being submitted to a common facility bank account.

"Now is better that before in terms of finances. Because, we have money now, more than before. Before we even have money and we do not know how to use it effectively but now we have money and we know the right way to use the money now." (IDI, 2nd Health Provider, PBF LGA, Ondo)

"PBF has also helped in that area too because before the facilities were not able to make account for the money spent but now there is accountability on a daily basis. They have to put down the expenses of the money they have spent, what comes in through PBF, things should be documented because there are processes that monitor all their finances." (IDI, OIC, PBF LGA, Ondo)

"Now that am here, I see the hospital has an account for transaction, no matter how small, you have to send it to an account, that's another change, before there was no any account, the only thing is you just come and buy your drugs and pharmacy will not keep it in account." (IDI, OIC, DFF LGA, Nasarawa)

"You know, before, we used to sell drugs and the it's the manager that buys the drugs, because we didn't have money from the government and we weren't given drugs. Our facility was operating without drugs. So, I used to buy drugs on my own and bring to the facility to sell. Anyone who comes, we treat him with the drugs and he gives us the money. But in this NSHIP now, they're the ones that give us money, we use the money to buy drugs and every one of our staff know the prices of these drugs. If you sell it, give the money to the treasurer. But before, I kept my drugs in my bag, I didn't use to give anybody to sell it, because they would just use your money. But in this NSHIP, now I've told them, these people monitor strictly on their drugs, if you sell it, give the treasurer the money. If you can't, know that any time they come for verification or supervision, I will call your name and say that you used their money. That's it. (IDI, OIC, DFF LGA, Adamawa)

Better Use of Data for Decision-making

Most health providers reported to have recorded large volumes of data on service delivery and quality at their facilities. Moreover, they also reflected that they were increasingly using those data for decision making at their facilities. In many cases, they talked about using data from the existing month for forecasting the requirement for repleneshing the stock of drugs and supplies for the coming months. They also used patient records to monitor their follow-up visits, especially for antenatal care and immunisation. Additionally, they used data on service utilisation indicators to assess what services were not being used by clients in order to investigate the root cause of the same and bring about improvements.

"After month ending, every month end the OIC checks the register and see if there is anyone she needs to act on, she will now act on creating awareness if our malaria case is high, she will call our attention to it, create awareness in the community, telling them to use their mosquito net so that for the next month the case will not be too high again." (IDI, 2nd Health Provider, PBF LGA, Ondo)

"Regarding drugs, we might have a lot of patients in a particular month and in the following month… let's say we had fifty patients in the previous month. According to how we were taught by the pharmacist, we would sum up all the test we

have done in six months, tests such as PCM, we would use each drug to determine the average coverage we should get and that how we decide that in the coming quarter… with the number of patients we have that month, we would use that as a basis for determining the least amount of drugs we must have in the coming month." (IDI, OIC, PBF LGA, Ondo)

*"We use to check our records to know who supposed to come for what and at what time otherwise we make a kind of follow up to track the people that supposed to come for what and did not." (*IDI, 2nd Health Provider, PBF LGA, Nasarawa)

"As we discussed with our WDC, Ward Development Committee before, during the last meeting we had, based on the register, we've discussed about the deliveries. Before, in a month, we used to take about 15 - 17 or more deliveries per month, but recently, we are having less than 10. So, we discussed together with them. Through that register, we have shown them what delivery has been like this month, the turn up is very poor. They have to encourage our community, so that they may be coming to the facility for delivery and the rest of the activities that we can do here." (IDI, OIC, DFF LGA, Adamawa)

However, in one particular case, the respondent considered that the major change was more in terms of data recording in a timely and efficient manner, given data entry operators had been employed in several places, but not in terms of usage for decision making particularly at the facility level.

Greater Autonomy for Decision-making

Many respondents considered that they had greater autonomy to make decisions for their respective facilities. This enabled them to hire additional staff, procure drugs and equipment, create structures as they saw fit for their facilities. This gave them a better understanding of changes that were needed given their context and a better sense of ownership of their facilities.

"Most importantly, what NSHIP has brought that we feel it is very difficult to accept is facility autonomy. Most facilities have autonomy today. If a facility finds that they lack a nurse or a lab scientist, they have the right to contract staff and ensure that everything is moving fine without waiting for the government to do it for them." (KII, State-level Official, Nasarawa)

"That PBF of a thing has given us autonomy, unlike before, I don't buy drugs, they are bringing drug for the LGA, they are the one stocking the place and we give to clients but now PBF has helped us a lot, it has given us autonomy to do things on our own and at least without anybody coming to do things for us, what we are doing in the facility we are doing it ourselves." (IDI, OIC, PBF LGA, Ondo)

"There are also improvement drastically, I remember that we have issues when it comes to our replenishment because initially when we are going to our board headquarter to get its approval for the particular amount to be spent on replenishment, whatever we requested for or budgeted for in replenishment, was subject to what the board will give, so we felt that was not giving us enough autonomy, because the things we needed as per people on the ground, decentralization of facility financing which is the essence of DFF was not been represented by that way of doing things." (IDI, OIC, DFF LGA, Nasarawa)

One respondent from Ondo provided an example to describe how NSHIP had the potential to prevent political interferences thereby enabling facilities to provide better quality services.

"If there is less political interference there would be more quality of services being delivered. Let me explain this, before if programs were to be carried out for example if they want to do immunization program and you write a proposal of for example #500,000, and you submit to the local government, at the end of the day they will approve that #500,000 and they will give you the cheque and they will tell you to bring like #300,000 back to them, they will take #300,000 back now and they will now expect you to use that #200,000 to run that program and make that program successful. Definitely that would affect health services, and with this DFF program and the way the program is being done where funds are being paid directly to the facility so that political interference is not there that has greatly improved the quality of being rendered."

On the other hand, another respondent from the LGA PHC Department considered that the current design of the program made the health facilities "*a bit too autonomous*". He felt that because they received their funds directly, they didn't listen to him anymore and this made it difficult to supervise them.

4.2.3 Reinforced Supervision

A majority of respondents considered that supervision had improved both in frequency as well as in its nature. Before the introduction of NSHIP, most facilities received supervisory visits from higher authorities once in a few months at best. However, with the advent of NSHIP, the intensity of supervision provided to PBF facilities increased exponentially, often in the form of surprise visits. While respondents in DFF facilities did not suggest the same degree of jump in supervision visits, they also reported a significant increase nonetheless. Moreover, the nature of

supervision, in both cases, saw a shift from being an inspection to more like a coaching session using structured checklists.

"In times past, our supervisors do not come regularly but with PBF, someone might just come, someone we don't even know, and claim he is from so, so and so and he has come to inspect. We don't always let our guard lose, and our works are always perfect, so whenever they come we are always prepared." (IDI, OIC, PBF LGA, Ondo)

"It has been helping us because when they come, when you say you have done this and you have not done this well, they will tell you this is how to do it." (IDI, OIC, PBF LGA, Nasarawa)

"Before we are not having visitors from the Local Government because there is no drugs, there is no nothing nothing, but now that the NSHIP came, they do visits us to see what we are doing, if we are doing the right thing or not, whether we are doing what they told us or not." (IDI, OIC, DFF LGA, Nasarawa)

"In the past, we hardly used to see any supervisors. Before you see them when we'd be doing house-to-house immunization or measles campaign. But in NSHIP, every month...even in a month, we have many supervisors, more than 3 or 4 before the end of the month." (IDI, OIC, DFF LGA, Adamawa)

Discussions with LGA PHC Coordinators also corroborated the above narratives. They described their own experiences of undergoing training to carry out supervision using structured checklists. They also mentioned the availability of additional funds to fuel their vehicles and provide them with incentives to travel to remote facilities for carrying out supervision.

"At the level of the local government, you will discover that they are more present on the field now unlike before because they have indicators on which we evaluate them too. For them to have their payment they have to make sure that all their deliverables have been achieved at the end of the quarter. So, now, the LGA teams they have sufficient funds to actually go down to most of these health facilities, to supervise the health facilities. So supervision now is more regular unlike the case before where supervision was just done from the office, coaching of these health facilities by the LGA teams is more regular now because what the LGA team does is that when they go for supervision is supportive supervision, they identify areas in most of those health facilities where they can tailor coaching." (KII, Adamawa State)

"Before PBF I can not even say that there is a protocol to supervision but now there is PBF with constant supervisory visit even the health staff now know how we do it and they too can even score themselves before the LGA team will score them. People knowledge has improved as far as the role and responsible are concerned." (IDI, LGA PHC Coordinator, PBF LGA, Ondo)

"When DFF has not started the work is not as much as this, but since DFF has started we have all been busy even much busy than before because we know monitoring teams this one we come. We do our validation is it not day before yesterday and now you are another set that has come another set may come next week. So that is how they have been coming we are all we are busy round the clock here." (IDI, LGA PHC Coordinator, DFF LGA, Ondo)

Similarly, respondents from the LGA PHC Department also described supervision received by them from higher authorities, namely the SPHCDA.

"The agency comes to evaluate our work every quarter. They buy our services based on how we have performed. They too have checklists that they use for the evaluation. They ask for our supervision reports, HMIS, Cold Chain, they check our data. Based on how we perform, they give us money. However, the funds we receive is based more on population than just our performance." (IDI, LGA PHC Department, PBF LGA, Ondo)

4.2.4 Significant Improvements in Staff Knowledge, Motivation and Engagement

On the whole, one of the most significant achievements of NSHIP was found to be in terms of staff knowledge and behavior. Respondents across the board described improvements in their knowledge and skills. In addition, they expressed higher levels of motivation, commitment and engagement due to both financial and non-financial benefits received through this project. This also brought about better staff relationships and teamwork.

Knowledge and Skills Enhancement

Most respondents, from both PBF and DFF LGAs and across all states, reported an improvement in their knowledge and skills with the advent of NSHIP. This could be categorized into basic and technical knowledge (see Figure 2). For instance, as result of increase in patronage of the facilities, the health workers had more cases to attend to, thereby increasing their skills. On the other hand, they attributed this change to a series of trainings as well as standard treatment protocols that were given to them. Many respondents talked about learning new procedures, such as inserting implants or using partographs, while others considered that the training refreshed their knowledge and boosted their confidence to provide treatment to their clients. In particular, this change appeared to affect junior health workers more with many reporting to have learnt new skills, that were not taught to them during their pre-service education, which allowed them to often substitute for their senior colleagues.

"In the area of family planning, it is through this programme I learn how to insert implants. Previously I don't know how to use it but now I became an expert." (IDI, OIC, PBF LGA, Adamawa)

"I don't think we treated any extreme conditions then but since the inception of PBF and when people got to know there are enough drugs here - if a person has an accident and maybe his leg needs stitching such person would come here. For instance, I didn't know how to stitch a wound before but with PBF…." (IDI, OIC, PBF LGA, Ondo)

"Through this program now, they introduce many trainings. I went for this PMTCT training, I went for IMCI training, I went for LSS training. You know this one has made me to improve and have more knowledge. Before, it wasn't everything that I was able to do. But now, I'm able to take delivery; even if we have retained placenta, I can try and remove it. It's through the training that I learnt these things." (IDI, OIC, DFF LGA, Adamawa)

"Personally, with the coming of NSHIP, there is more awareness in my work area, though it is not that we don't do it before but we know it that we are supposed to do, all these things are not new to us but we don't normally take time to do it as expected but with the coming of NSHIP and with the incentives we have got, we know that if we do not do the rightly, they would not give anything for that, and so we tend to do it the way we are supposed." (IDI, OIC, PBF LGA, Nasarawa)

"Yes, our knowledge has increased because at the moment I can act as a registrar to the facility to issue card to patients as a laboratory technician. I can also seat in for the in- charge or his deputy just as am acting right now. In fact our knowledge had increase in various forms coupled with series of training we had attended. The use of partograph was unknown to me before the coming of PBF." (IDI, Junior Health Provider, PBF LGA, Nasarawa)

For the Officer In-charge, the improvement in knowledge was not restricted to only clinical treatment and procedures but also to management process and principles. Several OICs talked about learning how to set goals, and plan and manage services and resources for their facilities. Some of the participants reported that they developed leadership skills such as; transparency, accountability, responsibility and participation. Other skills reportedly gained include courage and problem-solving skills. This also appeared to be the case for supervisors in the LGA PHC Department and Hospital Management Board. Some of the excerpts were as follow;

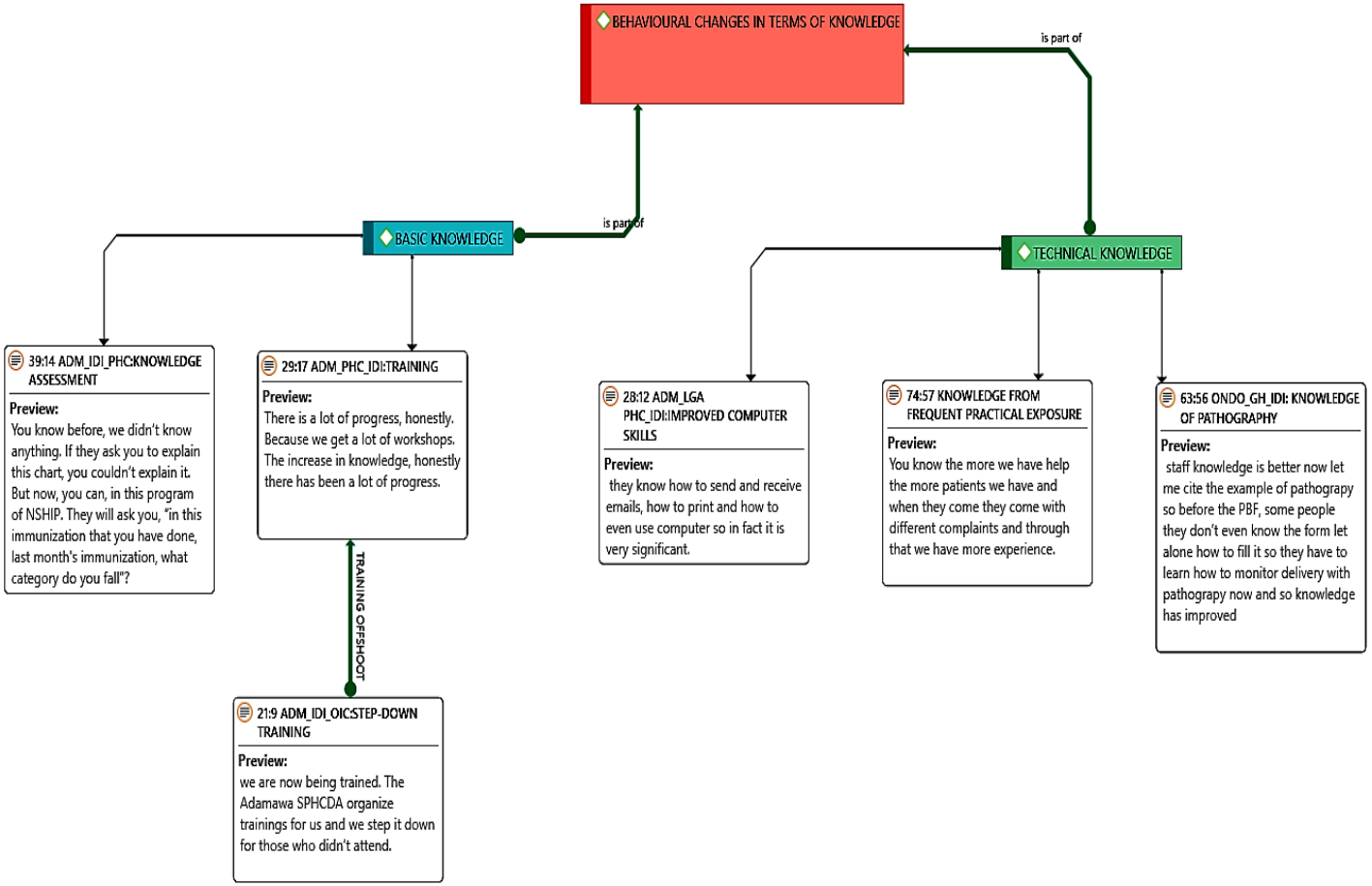
"I am now able to have discussion with people like you but before now, I could not stand before people to talk" (IDI, OIC, PBF LGA, Adamawa).

"As a doctor I thought before my own work is limited to giving of medical issue but from DFF have been able to get managerial experience". (IDI, OIC, DFF LGA, Ondo)

"But I have been trained as a manager to hire and fire so if you cannot work according to norms, I cannot go with you. If you are a staff of primary health care, I will just leave you when you come to work you come, if you don't come that is not my business. My business is that when the ES asks me, I will just tell him about you. And if you signed a contract with PBF, I will strike it out. With this if you ask them, they will say they don't like PBF because I don't give them bonus. They will be happy if PBF ends today. The PBF is about work and financing. So, if you don't work how will I finance you? I have about two or three here that are like that. Since they don't want to work, anything concerning PBF I don't include them in it." (IDI, OIC, PBF LGA, Adamawa)

"I learnt how to manage; it improved my skills in coordination and entrepreneurship, they've really improved my skills. They've thought me how to think outside the box, to see how I can develop my skills and improve my services in order to earn. I've also learnt how to manage available resources to achieve my desired targets". (IDI, LGA PHC Coordinator, PBF LGA, Adamawa)

Figure 2: Perceived Changes in Knowledge of Health Providers



Improvement in Motivation due to Salary Top-up

An overwhelming majority of respondents talked about being motivated because of additional bonus payments received through PBF. They considered that these bonus payments improved their financial situation allowing them to live their lives comfortably and paying for their children's education. This was particularly beneficial to those hired directly by facilities on a contract as the bonus was typically their main source of income. In several cases, especially in Adamawa and Ondo, respondents mentioned that the bonus payments were extremely useful as health workers had not received their regular salaries for many months. In fact, one respondent from Adamawa considered that the bonus payments were responsible for "uplifting about 20 to 30 percent of health workers out of poverty".

"From the bonuses, I have seen somebody is sponsoring his child to a private school who before wasn't able to pay ordinary school fees for his children in public schools. But now his child is studying in a private institution because of the money he got from the program. You know, it's about six months now that we've not been paid salaries but being that these bonuses have been paid, you cannot even know from my staff that they don't get salaries." (IDI, LGA PHC Coordinator, PBF LGA, Adamawa)

"It has affected them a lot because there are times they will say "my boss I don't have money for my child's school fee" but when they get their performance bonus, everyone will be calling me and thanking me, so it has helped them too and many of them have used the money for the betterment of themselves." (IDI, OIC, PBF LGA, Ondo)

"All of them like how their bonus is being given to them. They always appreciate it, most of the staff here are voluntary workers, and they are not employed. They are all contracted staff under the NSHIP so at least you should guess how much they will like this program. Without this program they will not be paid but as far as the NSHIP is concerned they will give them their salary monthly, bonus will be given at the end of the quarter. Everybody likes money no matter how small he or she is. That bonus there is making them to become more committed to the facility and the services rendered." (IDI, OIC, PBF LGA, Nasarawa)

In a couple of interviews, respondents talked about the demoralising effects of punitive sanctions resulting in less bonus payments received by health workers. For example, a LGA PHC Coordinator from a PBF LGA in Ondo said "*it wasn't easy (for them). You know before we were favourably disposed to the additional workload because PBF money was coming in bulk but now there are sanctions here and there which of course demoralized them a bit but they just have to do it because when it was good they enjoyed and now that there is sanction they just have to bear it*."

Improvement in Motivation due to Non-Financial Incentives

While respondents from PBF LGAs talked about experiencing higher levels of motivation and commitment to their work due to bonus payments, there were many non-financial incentives that appeared to motivate health workers across both PBF and DFF LGAs. These positive stimuli ranged from having an enabling work environment with all necessary equipment and infrastructure, supportive supervision mechanisms, gain in knowledge and professional experiences as well as respect and recognition received from the community and peers.

For example, a health worker from a PBF hospital narrated how she used to be concerned about carrying out night shifts prior to the programme as she would be concerned about sleeping alone in the dark. However, with PBF funds the hospital was able to buy a generator dispelling her fears and encouraging her to attend her night shift. On the other hand, a doctor from a hospital in Adamawa talked about gaining valuable professional experience through NSHIP, as he was able to attend to many patients and treat a wider case-mix of illnesses. In addition, several health workers reported to experience higher levels of satisfaction by providing good quality services at lower or no costs to members of their community, particularly those who are financially disadvantaged. For example, an OIC at a PHC in Ondo talked about how converting frowns and tears of her patients in to smiles would make her feel very happy.

"For the program to make funds available for me to get some basic things we need to run the hospital, to attend to patients, to give them quality services, yes it motivates me. Some things you need are there, so you're motivated. I'm not demoralized, even just stethoscope, BP apparatus, all those small small basic things." (IDI, OIC, DFF LGA, Nasarawa)

"The PBF has motivated me a lot, sincerely. It has improved my knowledge and skills. PBF has given me the zeal to always want to learn more and the coming of the supervisors and other visitors have also made us to become more interested in knowing more about our job and what is happening. So even if they don't give me bonus, I am very motivated by the work because of the knowledge I have gained through the program." (IDI, 2nd Health Provider, PBF LGA, Adamawa)

"Personally, my orientation of this LGA job I found it not challenging enough that is not busy but with the NSHIP program I found it more challenging and it actually put me into task, makes my brain working, make me up and doing, read more, go to seminars, workshops and keep my brain active." (IDI, LGA PHC Coordinator, PBF LGA, Ondo)

"I like the recognition it has given me. What everybody says is that it is during my time that all these changes have happened. They don't really understand much

about NSHIP. All they know is that it happened during my tenure, so they attribute it to me. I like that." (IDI, LGA PHC Coordinator, DFF LGA, Adamawa)

"Because people can see obviously that things are improving generally and because of that people are encouraged to join the team…because of those improvement people want to associate with something that is good. They look at services becoming better quality, everything is becoming better, so because of that I think our staff are motivated not monetarily but psychologically." (IDI, OIC, DFF LGA, Ondo)

"*The indigent consultation is the most important services that make me to become a better person because a client or patient will come, you will give free card, free consultation, all advices, education and everything. At the end of everything we will just ask them to go freely so I really like that service."* (IDI, OIC, PBF LGA, Nasarawa)

"Well, honestly, you know that health work has to be done with altruism. You should do it if there's money or not."(IDI, 2nd Health Provider, PBF LGA, Adamawa)

Increase in Punctuality, Discipline and Commitment

Almost all respondents from PBF LGAs reported a disproportionate change in their own as well as their colleagues' levels of punctuality and discipline. They talked about coming to work more often than before, and on time. They linked this change directly to the use of the individual evaluation framework, which took in to account their punctuality and discipline in order to calculate their bonus payments at the end of each quarter. These narratives were not heard among respondents from DFF LGAs.

"Initially, before the advent of PBF, some may not come to work more than once or twice in a week but now they have what they call time sheet, as in daily register. As you come in, you write your name and sign and at the end of the month, they use the number of days they have come to work to calculate their performance. So they now know that if they don't come to work and if they don't do their job, they would be short-paid." (IDI, OIC, PBF LGA, Adamawa)

"Because with PBF, there's discipline. If among the staff...it's in the voucher that staff are paid with, there are questions they ask, from character, mode of dressing and so on of a person. If among the staff there is a quarrelsome person, there are punishments for that in PBF." (IDI, 2nd Health Provider, PBF LGA, Adamawa)

"Before PBF there is something Yoruba used to say "ago ta ago o ta owo alaaru ape" (whether they work or not they will get paid) that if they come...if they work or not work, they will receive their salary. They used to come to work anyhow

but during PBF now everybody knows that you must attend…you must resume to his or her duty according to the time so it improves the punctuality, the PBF improves the punctuality." (IDI, 2nd Health Provider, PBF LGA, Ondo)

"Again, because of the performance bonuses that the staff are getting, it has elevated their spirit to get committed into doing their jobs. Their dedication to work has improved a lot so much that some of them don't even want to go on leaves again, unlike before that they demand for their leaves every now and then." (KII, Nasarawa State)

Strengthening of Team Engagement

Across both PBF and DFF LGAs, respondents considered that NSHIP had improved staff relationships and teamwork. Among those belonging to PBF facilities, main reasons cited for stronger team engagement included shared goals of improving service delivery and quality, common platform of RBF committee which brings them together to discuss their challenges as well as the individual evaluation framework which scores them on their behavior towards other staff members. On the other hand, health workers from DFF facilities talked about more cordial relationships among staff due to greater role clarity and the change in practice of staff members individually selling drugs to earn money to now a centralized pool of funds at the facility level.

"It has changed the way we work as a team because with PBF as staff we have to be one, we are having one goal, we want to render quality service and before we can get all these we have to be in good accord so this PBF has helped us, unlike before we say there is no concern about that but now we know a lot of things concern us about others. We have to be at the same page before we can achieve our aim and so it has improved our relationship." (IDI, OIC, PBF LGA, Ondo)

"In that individual performance evaluation there is an aspect dealing with staff to staff relationship so if you quarrel too much with someone certain marks will be deducted. Therefore even if you hate someone you must hide the hate rate and is impartial whatever you did is clearly stated there, no course for why one is paid less and the other high, time book is available for arrival and closing and it is clear." (IDI, OIC, PBF LGA, Adamawa)

"Well, I will say improvement not just changes, change could be either way because there are many things about this is not what this person is supposed to do, a lot of confusion there about who is supposed to do what and all that, all those things have improved in that most of the staff knows what they are supposed to do and they face challenges they report to the appropriate quarters, you know, not that particular attitude of it has spoilt and they keep pilling, staff interaction has improved." (IDI,

OIC, DFF LGA, Nasarawa)

"Among staff; the doctors, the nurses, the CHEW we work together as a team because I think part of the factor that would affect teamwork is if I am getting money in the facility and this person is not getting money there will always be clashes but now everything we have, every money gathered is put in a central place, so everybody is just depend on their salary and look up to God. There is teamwork everybody come to work to do their services." (IDI, OIC, DFF LGA, Ondo)

Box 2: Mixed perceptions of fairness in distribution of bonus payments	
Respondents across all states expressed a mixed opinion on the fairness in distribution of bonus payments. Some considered that bonus payments truly reflected their efforts relative to the amount of work they carried out as well as their colleagues. On the other hand, some perceived that the bonus distribution mechanism favoured other staff and did not give them their due amount. This was particularly articulated by junior cadres of health workers. On the other hand, a couple of doctors felt that while other cadres may consider that they are receiving more bonus, unless they were there to provide services the hospital would not be functional and hence they deserved to get a higher amount.	
"It's fine, no problem. Because, I know that personally, since this started, I have never felt unfairly treated. Because I know, when it's being done, everyone is carefully assessed. As the name implies, it's pay based financing. You're paid based on the work that you have done. If I didn't work, I know that I haven't; if a person gets money for something he doesn't deserve, I will be able to tell. It's not bad, honestly" (IDI, 2nd Health Provider, PBF LGA, Adamawa)	*"Then what I think about the PBF is the issue of the bonus whereby the managers are the ones given the mandate to distribute the bonus to us. There should be people that are employed solely for the purpose of grading us and distribute the money to us. Some staff are not comfortable that the manager and maybe the WDC are the ones handling the evaluation and payment of staff bonus because they feel that some staff are favored more than others. You hear a lot of infighting where some staff feel like others are being favored unfairly. You get angry at first, then you calm down later. We need a more unbiased way of rating staff. It'll improve performance.* (IDI, 2nd Health Provider, PBF, LGA, Adamawa)
"It is fair, they are the ones preparing it, and I don't prepare it for them. I just tell them this is the amount credited into my account, I give them my phone, they will see the amount, it is not an hidden something, it is open thing, they will see it and go and do the working on their own, they will do it and bring it to me, they score themselves, they know the number of days each of them come, they do the performance bonus on their own and bring it to me." (IDI, OIC, PBF LGA, Ondo)	*"I normally hear from my co-workers that there is not enough bonus compared to the services they are rendering, before it's not so, they use to receive something tangible for their bonus, but this day, they receive token amount for their bonus, that they don't know what is happening, they are complaining about"* (IDI, OIC, PBF LGA Ondo)
I can't say if it is fair or otherwise because it is based on performance. It is not that a staff will just be given the bonus. That is every staff should know what she should get based on her work. One staff may earn more than another because he/she worked more than the other	*"Is any amount ever adequate? You understand, but if you look at it from the angle that this is a bonus o, it's a bonus, you understand? Like, you have DFF facilities, from what I understand, though I've not been in any, but from what I gather, they don't give them bonus, so from that*

staff. (IDI, 2nd Health Provider, PBF LGA, Nasarawa)	*angle, at least something is entering your hand. But if you want to talk about the amount, no amount is ever adequate o [laughs]."* (IDI, OIC, PBF LGA, Nasarawa)

4.2.5 Improvement in Working Conditions

In general, NSHIP reportedly brought about paramount improvements in structural quality of both PBF and DFF facilities. The injection of additional monetary resources enabled facilities to upgrade their infrastructure and procure much needed drugs and supplies. In addition, NSHIP facilities were able to recruit human resources for health thereby filling in acute shortages of staff. As a result of these initiatives, community members reported to find these facilities more attractive. Selected narratives describing these changes are below:

Most of the community members cross the states attested to the fact that they observed increased in quality and quantity of personnel at the facilities. In situations where staff where not adequate, participants, (including the RBFTAs) observed that there were increase in staff to the extent that some of the facilities were running shifts (day and night). Some of the OICs also confirmed that they were able to hire additional hands using proceeds from the PBF intervention funds;

"Firstly, we experienced change with respect to health care workers. Health care workers are now trying their best to handle all the challenges of our patient. Secondly, there is modern renovation of the wards. We now have new resting chairs and many new facilities unlike we used to have two years ago. This really indicates to us that our hospital has improved." **(**FGD – Men, PBF LGA, Adamawa)

"Because in the past, this facility only had two staff. Like I told you at the beginning, you could come here and find the facility closed with no one. But now, even in the middle of the night, no matter what time it is, you will find staff here. Some staff were sent by the LGA and are full-time staff of the Primary healthcare, while others were also contracted and are paid using PBF funds." (IDI, 2nd Health Provider, PBF LGA, Adamawa).

"Before now the situation at the PHC was very bad but now there are a good number of health care workers, good equipment and some drugs in the PHC." (FGD - Women, PBF LGA, Nasarawa)

"*Yes, we hired midwife, medical laboratory technologist and CHEW and security guards."* (IDI, OIC, DFF LGA, Adamawa)

"Previously the workers are not well qualified but now it seems they've employed qualified people, who are very good at their work. The way they discharge their duties is better than then." (FGD - Men, PBF LGA, Ondo).

"We have recorded so many of these health facilities they have been able to recruit staff, recruit and pay their staff. So we no longer have that issue because previously, we had that issue where we had this challenge of human resources for health, so most of these health facilities now, they can actually recruit and the health facilities now they are opened 24/7 unlike before. Hardly will you go to any PBF facility and you will not see a staff because the number of staff, you know we have had improvement in terms of the number, and the quality of staff, that is in the quality and quantity of staffs at the level of the health facilities." (KII, State-level, Adamawa)

In terms of facilities, findings revealed that most of the participants were impressed with the overall improvement in working conditions at the amenities available at the health facilities. They reported that the facilities were equipped with better toilets, chairs, beds, generators, nets, and other amenities which had made the health facilities more attractive to members of the communities. Also, some of the health facilities were also provided with laboratory and technical staff to carry out tests when necessary.

"To me there is real change in the Cottage hospital, we previously used to have one health worker attending to all health challenges brought to the hospital, in the sense that he is the one attending to the patients, prescribing medicine to them, admitting them, scanning and other tests. So, in short, we have inadequate health workers before, but now there is an improvement with respect to this. Secondly, facilities for maternity are provided, we even have pregnancy scanning machine." (FGD - Men, PBF LGA, Adamawa).

"In the past, we didn't have lab. But now we have a well-equipped lab with a lab technician. So that is also a great change." (IDI, 2nd Health Provider, DFF LGA, Adamawa).

"(laughs) four ago, we used to sit on the wooden chairs whenever we come for antenatal but now we sit on plastic chairs, there used to be only one or two doctors but presently there are enough doctors." (FGD - Women, PBF LGA, Ondo).

"I would say the blood banking system, because it is a lifesaving equipment or process, I remember we lost a patient earlier this year to postpartum hemorrhage and a lot of people die from severe anemia and even children, so having that helped us a lot, not just the hospital but the whole local government cause we sort of collaborated with the primary health center in the community in such that whenever they have a patient that they believe you know might needs blood transfusion, they just have to refer the patient to the facility." (IDI, OIC, DFF LGA, Nasarawa)

"One of the differences is that before there was absolutely nothing, nothing is happening there but due to PBF they are running currently that is why there is improvement, that is about the PBF, initially there was no security at that place to the extent that people are always afraid to go there but with this PBF, they have provided security for themselves internally, they also provided mosquito net, so that's the little difference, there is little improvement, more improvement is needed as my colleague rightly said" (FGD - Men, PBF LGA, Ondo).

4.2.6 Higher Uptake of Maternal and Child Health Services

Most participants reported that they patronized the health facilities for antenatal care (ANC) as a result of improved quality of care and this resulted in increased uptake of ANC services across the three states. Some of the excerpts are as follow;

"We are satisfied with the services of the Basic Health Centres because they attend to us whenever we get there. They attend to both the young and old, so we are completely satisfied with their services." (FGD – Women, PBF LGA, Ondo)

"When my wife was receiving ANC treatment, she was well taking care of, the husband has the right to ask about the outcome of the treatment sought. She said she was well taken care of, given injection and drugs." (FGD – Men, DFF LGA, Ondo)

Likewise, most participants reported that they patronized the facilities more for deliveries as a result of increased confidence in the quality of care received from the health providers as well as the improved conditions of the facilities. In many cases, particularly among clients of PBF facilities, respondents mentioned receiving free items, such as soaps, clothes for babies etc, from the facilities free of cost.

"The labour room contain beds when I was admitted there is a leather covered mattress that will not allow blood to be soak, they attended to me till the time I delivered they washed and clean everything and free of charge." (FGD – Women, PBF LGA, Adamawa)

"At the moment so many of us go to the hospital during delivery compared to before so that had made our cases (of ill-health) reduced beyond expectation." (FGD – Women, PBF LGA, Nasarawa)

"When there is any birth complication, the hospitals are better equipped to handle such cases. In my case, after I delivered, I had retained placenta and had to be injected. I'm still very thankful that I chose to deliver in the hospital. If I had been at home, I wouldn't have had access to appropriate care." (FGD with women in Burthi, PHC, Guyuk, Adamawa)

Participants also reported that there was an increase in immunisation of their children as they were encouraged by the health workers to bring their children regularly for vaccinations. Most of the participants also observed that outreach activities increased over the past two years and that health workers even visited their hamlets and markets to immunize the children.

"Yes, they are immunized up to 9 months age, we even used to receive health workers at our respective houses who offer our children polio and other diseases vaccine. Sometimes we received them in the market; we are making these efforts in order to prevent our children from disease as prevention is better than cure. So, before our children are affected by any disease we have taken the preventive measures." (FGD – Men, PBF LGA, Adamawa)

"They go to the hamlets, if they don't want to give them there they may come to town on market days to give them the immunization, they are trying." (FGD – Men, PBF LGA, Ondo)

"Yes, there is improvement in the health output indicator because in the past patients don't come to the health facility and we don't go to them but now with the coming of PBF we have a roster which we use to educate the people on the importance of immunization and we also go for outreach. We educate parents to bring their children to the hospital even if they don't have money." (IDI, 2nd Health Provider, PBF LGA, Nasarawa)

"The few changes I observed about that measles is that, there was a period the nurses were going about giving immunization from one house to the other. And measles incidence has reduced as a result of the immunization." (FGD – Men, DFF LGA, Ondo)

4.3 Current Challenges and Gaps

While NSHIP has brought about many positive changes at the facility and community levels since its inception, the study also found some gaps in its implementation as well as recurrent challenges deterring it from achieving its full potential. This section briefly describes some of these challenges and gaps, including problems faced by communities in accessing health services, both in terms of geographic location and financial bearings, perceptions of poor attitudes of health providers and other socio-cultural norms preventing them from taking up family planning services. On the other hand, health workers expressed concerns of excessive workload especially in the presence of systemic shortages in manpower, as well as other issues around implementation of the project, including some challenges in financial transaction and verification processes.

4.3.1 Implementation Gaps: Structures, Manpower and Processes

Request for More Structures and Manpower

Despite reporting that NSHIP, across both PBF and DFF LGAs, had brought about overwhelming changes to availability and upgrading of infrastructure, when asked what further improvements are required in their facilities most respondents requested for additional structures. In most of such cases, their appeal to the government included expanding of existing structures or constructing new buildings to provide them more space in their facilities. In many cases, these requests were also echoed by members of the communities.

"*They have tried a lot in this facility, but what I think can be improved upon is that, the money we are being paid cannot be used to erect a new building. As you can see, this building does not look like a hospital but rather like a boys-quarter, you would also notice the lab was constructed using plywood but if they could please be more dedicated to it… even if is two or three rooms because there is no space in this facility. This cold chain should be in another room… you are also sweating and we should put on the fan but due to the fact that there is no space we can't put it on*." (IDI, OIC, PBF LGA, Ondo)

"Because as it is right now, they have only 2 rooms and it's too tight, sometimes patients have to lie down outside in the waiting room, to receive infusions. So, if there were more space, and more staff, they can attend to everyone adequately" (FGD with women, PBF LGA, Nasarawa)

"I want to appeal to the government to assist us so that the health center can be expanded, because at times when two or three patients are there, there will be no more space for us. If you go to an environment you are unfamiliar with, some changes

would have occurred. That is what I understand and I am able to explain." (FGD with Men, PBF LGA, Ondo)

"You see, in [NAME] General Hospital, there's a mosque. But for us here, once its 2pm, we have to come back home to pray. There's nowhere to pray there. Every hospital or office should have a place of prayer, ours and theirs. We need that, so that needs to be done." (FGD with women, PBF LGA, Nasarawa)

"*We have problem with our source of water, we used to go out to fetch water. Also, if possible they should add ward for us to admit more patient because there are no separate wards for male and females."* (IDI, 2nd Health Provider, DFF LGA, Adamawa)

In one particular case, the respondent also talked about not having adequate means for referral services. He described a scenario where community members hired ambulances through an NGO without realising that the service was not free of cost. As a result, there was an altercation between the patient's family and the ambulance driver. He had to intervene to calm the situation and also had to pay some part of the transportation cost.

Again, despite hiring of contractual staff using NSHIP funds, in a few instances, and especially from Ondo, respondents requested for additional manpower to be hired by the government.

"If we have more competent hands, it will improve our services like to employ more staff, more technical staff, it will improve our services for example now, at this health center we don't have lab officers, so to assess some of the tests it is very difficult for us, we need to send them to at least to town to assess all these tests so these are some of the challenges, we can recommend so at least we could have some of the personnel and the quality of the service will improve." (IDI, OIC, DFF LGA, Ondo)

"*Presently, the work load is much on some of the facilities that don't have the power to employ due to the low fund coming into the facility and the human resource from the state but generally we need more staffs to be employed by the state government and this will help a long way"* (IDI, LGA PHC Coordinator, PBF LGA, Ondo)

Further Strengthening of Financial Mechanisms

While most respondents praised NSHIP for injecting additional monetary resources in to their health facilities, in a handful of cases respondents expressed concerns about low amount of funds and delay in receiving these payments.

"Well, number one the disbursement of the money is coming late. You know by now third quarter supposed to be out because we have entered third quarter but I

don't think it will be out by next week." (IDI, 2nd Health Provider, DFF LGA, Adamawa)

*"I think I noted it before about the reduce of fund, though we have locally adjusted ourselves to that but I believe that the quarter should start when it starts both financially and programmatically such that we won't have backlog of activities undone, running into a quarter. If that should be done, that would be very good. (*IDI, OIC, PBF LGA, Nasarawa)

*"The fund is not all that much again, it's not much like they use to send it before. We stopped getting much again, I don't know the reason why the fund is not coming much, but if the fund is coming much, we will work harder to do one or two things." (*IDI, OIC, DFF LGA, Nasarawa*)*

"One of the major challenges we have is, inadequate funding through the boards as the supervising agency, we have seventeen hospitals and Adamawa State has one of the difficult terrains in Nigeria. You can see that we are surrounded by hills, so some hospitals are located very close by here that it will take you a whole day to reach there, then we have rivers everywhere which we have to use boats or we travel for about hundred (100) kilometers in other to just go round and gain access. I think the funding is inadequate for us here" (KII, Adamawa State).

"Yes, we've faced challenges and those I think…yes the funds are being released for us but the funds are most time not released on time, the funds are not being released on time and that has been a challenge, there are some times we have a gap where we might not have operational funds to work with, I think that they can improve on, let the funds be released on time for us to do the work we are supposed to do." (IDI, LGA PHC Coordinator, DFF LGA, Ondo)

In a couple of other cases, respondents also talked about difficulties in managing financial resources in a transparent manner. For example, one Officer In-charge from Adamawa narrated an incident where conflicts arose between staff members because they blamed him for misappropriation of funds.

"In terms of leadership, we have problem with staff because sometimes they say we are embezzling funds. This has caused some problems among us. They think we are embezzling the money, but we are not; the money we get is the money we share. So that is the problem we have, but our relationship with them is OK. As I said, the PBF has help us even in terms of services, when you assign a staff to a task, he goes and does it without complaint. Before, they would refuse to go." (IDI, OIC, PBF LGA, Adamawa)

In another case, a LGA PHC Coordinator also described tension between OICs and Ward Development Committee members owing to the fact that latter do not receive any monetary benefits as a part of the current DFF design.

"Well, you know each person manages differently so there are differences. In most cases they work in collaboration with the WDC and this sometimes leads to

conflicts because of money. You know, once money is involved, these things happen. Some members of the WDC feel like they should be paid, but they are managing to resolve such conflicts somehow." (IDI, LGA PHC Coordinator, DFF LGA, Adamawa)

Difference in Expectations between PBF Facilities and Verifiers

Most respondents from PBF LGAs described the process of verification and counter-verification that was carried out at their facilities. External verifiers visited their facilities to check registers to ascertain the number of patients that were consulted and whether appropriate formats were followed to record the procedures. Moreover, some also described that verifiers recorded the phone number and other information of patients in order to trace them in their communities. However, in some cases, across all states, the respondents expressed concerns over this process stating that they often disagreed with the verifiers' assessment of their work. Moreover, they considered that different verifiers did not follow the same standard during their assessment, hence confusing them with regard to the changes that they are expected to make and often resulting in them losing out on services that are purchased.

"The verifiers come, look at your invoice, look at some documents, agree with some of the things you put down in the invoice, disagree with some of the things you put down, at the end, after all of that, then your earnings are now totalled, and you'll now know what you'll get. Even though, like I said, you disagree sometimes. So, though it is less, but it's still there. There are a number of times the verifier thinks like this and you think like this. So that one is still there. You can't keep on...all the time you're always arguing, arguing, so at a time, you just want to let things...yes. You can't be arguing over the same things over and over again, so you just want to let it be." (IDI, OIC, PBF LGA, Nasarawa)

"Well one thing I have discovered is that I have had the opportunity of working with different verifiers. I discovered that different verifiers have different standards that they come to tell us. For instance, let me give you one clear example. They will say okay ehm like your STD cases put them under the general consultation register. Now we will put them under the general consultation register. Next time maybe that verifier will not come another verifier will come. When he comes and sees SDT cases are in the general OPD register, he will say he will not purchase it because we did not put it in the special STD register. It is for the agency to gather the verifiers and give them one standard." (IDI, OIC, PBF LGA, Adamawa)

In one case, the respondent also complained that the professional background of the verifier (one of a general nurse) was not relevant for assessing service delivery at the primary health care level.

"*She is a nurse. I even complained bitterly why a nurse? She is not a community nurse but a general nurse. What does she know concerning primary healthcare? So those things you see, you're supposed to work with somebody that knows this line better. If you know the line better, you'll know how to cancel better and you'll know how to correct mistakes. There are some mistakes that you are not supposed to cancel but just to correct or correct this one. "I corrected these services for you and I'm going to buy these services now, but then next month I don't want to see it like this." This is how you're supposed to do it but then for her, it is not like that, she'll just cancel everything*" (IDI, OIC, PBF LGA, Adamawa)

These respondents also expressed their dissatisfaction with these encounters lamenting that they often led them to feel demoralised. In a particular case, there also appeared to be personal conflicts between the health workers and verifiers.

"You know if there's a way to address this disagreement between facility and verifiers. In fact, if there's a way to address it, it'll also help. You know, a facility may feel, oh I'm doing my best, you understand? And after having done my best, the verifier comes and disagrees with it, and with what you've been able to come up with, you see that .... it's improving, it's reducing but, you know sometimes, if you're not careful, in the facility, there could be demoralization." (IDI, OIC, PBF LGA, Nasarawa)

"*Well, I cannot say they score me low or high, I always say it is fair because some of the other services you'll be doing, you cannot have 100% because in one way or the other, you'll be lacking somewhere. The problem is just that some of the TAs are greedy. Greedy in the sense that they seem to go out of their way to tarnish your image or just to stop you from getting what you are supposed to get. They are like that, in fact, the TA we are having now is giving us tough time like this." (*IDI, OIC, PBF LGA, Adamawa)

One respondent from Ondo also talked about reducing efforts to carry out outreach services due to the fact that if verifiers did not find the same people in the community as recorded in their facility registers, which they felt was often the case, they would be charged for fraud.

"I wouldn't lie to you, presently outreaches are neither here or there due to what happened last year and our facilities don't find it funny to go out there to get patients because they would be asked different questions that are you sure this patient is from this community and once that patient is not from that community that data might not be counted for them and it might be seen as fraud so they are been careful going out of their facility to even do outreach right now." (IDI, OIC, PBF LGA, Ondo)

Box 3: Sanctions

Respondents from a few facilities that were visited as a part of this study reported to have been sanctioned from receiving PBF funds since the inception of the programme. In some cases, they explained that these sanctions were imposed early on in the life of the project and were due to the fact that they had not fully got the hang of PBF in those initial months.

"Because we didn't know the work. We didn't know how to do the work, our registers were not well kept, when they come they take us round and they tell us what they need. We were getting poor scores, that was why we are lacked money. That time I think we got 300,000 and 300,000 is the least money we ever got in this clinic." (IDI, OIC, PBF LGA, Adamawa)

"The program had just started when it happened and we were incapable of providing what was requested from us but due to the money we have collected over time… if we take you round this facility you would notice that we have touched all the things they expect from us and that is why we are getting more points and with the help of God I don't think we have had lesser than ninety percent." (IDI, OIC, PBF LGA, Ondo)

In other cases, respondents considered that they were sanctioned either due to their own negligence or certain externalities, such as bad weather and strikes.

"It was because of our negligence because we did not keep record very well so they didn't buy our services very well. they bought some of our OPD cards then some of the ANC they bought some, they could not buy all, and they didn't buy family planning, our lab they didn't buy it." (IDI, 2nd Health Provider, PBF LGA, Nasarawa)

"*Well, that one is at the health facility level, mostly, you know like this tracer drugs; sometimes you can get it now and in the pharmacy, before the counter verifiers come, there might be some discrepancies. And the area of waste management. You know this is rainy season now, all these health facilities use burn-and-bury kits i.e. the incinerators are burn-and-bury in nature and because of the nature of this area (having rivers), and the water will fill up the pits so you see that quality is no longer there. There is no way they can score that area always and so, this area always becomes a problem."* (IDI, LGA PHC Coordinator, PBF LGA, Adamawa)

"They didn't buy our service was the day of our strike and the strike lasted for almost that quarter, June to September 14th, so that quarter, there was nothing to write about because we didn't perform" (IDI, OIC, PBF LGA, Nasarawa)

In one particular case, the respondent considered that they were sanctioned unfairly because the patient that the verifiers were tracing had changed residences.

"They said, there was a fraudulence practice, but later on, we now discover that the fraudulence they were talking about was not a fraud, the person concern was not living at that premises or the house number he gave, he has already change from that building, they later discover the person was living in the building before, but has relocated. That was what I heard about the fraudulence, later on, they discover the person, you understand." (IDI, 2nd Health Provider, PBF LGA, Ondo)

Low Functionality of Indigent Committee

The presence of Indigent Committees was not so pronounced in some of the communities, though there existed some form of a committee saddled with various

responsibilities across the facilities. These Committees were given the responsibilities of mobilizing community members for health programs like immunization, ANC and utilization of health facilities in the various communities. The Committees were called various names across the states, some which included "Mama to Mama," Imburu Clinic Committee and "Dan Uwa" in Adamawa State. In Ondo State, the Committees were called "Itogbe" or Olopa Ilu". However, the presence of the indigent committees was highly palpable in the communities where they were in existence.

Question: Have you ever heard of any organisation or committee in this town that supports poor people to access free healthcare from this hospital?

Chorus: There's no such thing in this place

(FGD – Women, PBF LGA, Adamawa).

"Actually, we don't have that. The ones we have are the ones that render material help to the hospitals. There is a age group committee with regards to that which meets monthly and contribute money to provide something for the hospital." (FGD - Men, DFF LGA, Adamawa).

"As far as I am concern, there is no official committee on that, because if there is any committee we do meet in primary school to discuss some issues. So I am not aware of such committee." (FGD - Men, DFF LGA, Adamawa).

Lack of Program Knowledge among Junior Cadres of Health Providers

In general, the lower cadres of health providers appeared to be less aware of various procedures and mechanisms of NSHIP. Among those interviewed, most had not attended the direct training on PBF and DFF provided to their OICs or other senior colleagues. Many of them were also not aware of the process of developing the business/activity plans and hence were not included in the priority-setting exercises. A few of them also mentioned not understanding the formula through which their performance bonus payments were calculated.

"We have not seen the formula used by the present in-charge but the former one just distributes without formula. Nobody knows how it is calculated. But we don't know how this new in-charge will distribute the bonus because we are yet to finish the quarter with her. She is straight forward in what she does but every staff is supposed to know how his/her bonus I calculated." (IDI, 2nd Health Provider, PBF LGA, Nasarawa)

I: So do you develop a business plan in this facility?

I: I don't know, but I think there is one that some people develop.

(IDI, 2nd Health Provider, PBF LGA, Adamawa)

I: How often do you make an activity plan?

R: I am not among the decision makers, you asked me earlier and I told you the admin is the management.

(IDI, 2nd Health Provider, DFF LGA, Ondo)

Other Implementation Challenges

Apart from the abovementioned challenges pertaining to implementation of NSHIP, one respondent also talked about security issues in Adamawa state creating additional hurdles in providing health services:

"Well, the major challenges that we have in the state is the issue of security. You know in 2014, many of our LGA were sacked by Boko Haram, so security challenge has been our issue and the project has really helped us in reestablishing our health services in those security compromised areas and also the local vigilantes, the project helped in recruiting them, at the beginning, while the project supported them, gave the uniforms, sustained them for like two or three months like that." (KII, Adamawa State).

On a different note, a couple of other respondents expressed their concerns about not having incentives in place for community members who were a part of facility management committees or Ward Development Committees. They considered that these members were contributing valuable time to improve health services in their communities but were not being compensated for it.

"Honestly, you see, they don't have a salary. You see, sometimes, these are people who could be on their way to the market, then you say you need him to come and attend a meeting. So, he suspends all his activities to attend to you, and then at the end, he leaves without any compensation, not even a dime. You see, that is a little bit of a problem, to be honest." (IDI, 2nd Health Provider, PBF LGA, Adamawa)

Box 4: System-level dependencies: delay in receiving regular salaries

Among respondents from Adamawa, a common disgruntlement pertaining to delay in receving their regular salaries was often heard. In some cases, health workers had not received their salaries for 6-7 months. While in the case of PBF facilities, health workers were receiving some payment in the form of their performance bonus, those in DFF facilities had gone without any take home salaries for several months. Interestingly, one respondent considered that PBF was making the state government devoid of their responsibility of paying regular salaries as they were aware that health workers were receiving a bonus payment. On the other hand, another respondent considered that the entire service delivery of primary health care should be transferred to NSHIP such that there are no issues of delayed payments.

"The only thing I will appeal to them is to also help us in our salaries. I haven't received salary for several months now." (IDI, 2nd Health Provider, DFF LGA, Adamawa)

"If possible, if they can come into the situation of the state government, it will be very helpful because our salary is our right. No salary for 6 to 7 months, the issue of promotion, then what do we eat? So, this thing the NSHIP are doing is making the Adamawa state government to relax and feel that the NSHIP is providing us with token. If the government cannot pay, then we would love it if the NSHIP could pay our salaries." (IDI, OIC, PBF LGA, Adamawa)

"The NSHIP fund us coming even though sometimes with hiccups. But from the government side, let there be increase in funding apart from that of the NSHIP for us to sustain the quality of services, in case the PBF moves us to another state, I think the government should come and adapt the system of NSHIP in running PHCs. With that, everything will be possible." (IDI, LGA PHC Coordinator, PBF LGA, Adamawa)

"Another thing that NSHIP can do, is if the NSHIP will receive or will take over the payment of the staff. Because one of the challenges we're having in this clinic, not only in this clinic, in Primary Healthcare in general, in Adamawa State, is the issue of payment. Most especially...it's better the PBF clinic, because even if they're not paid, sometimes, they will get something because they buy their services. But the DFF, they don't buy their services. So, one of the challenges we are having is lack of payment. Like, last month, we've not been paid. Last August, we have not received salaries." (IDI, OIC, DFF LGA, Adamawa)

4.3.2 Perception of Excessive Workload in Absence of Adequate Staff

While all health workers interviewed acknowledged that NSHIP had many advantages and benefits, they perceived that it had severely increased their work load. In some cases, they narrated managing the excessive workload by hiring additional staff through the resources received through NSHIP. However, in places where facilities were not able to hire additional staff or were experiencing a much higher patient volume despite having extra staff, respondents complained of fatigue and stress. In some cases, they also considered that their base salary from the government was less relative to the amount of effort that they were expected to put in.

"We have less than 20 nurses in this hospital, we don't have enough sub staff to support the nurses, I am the only doctor in the facility. So it is over work." (IDI, OIC, PBF LGA, Adamawa)

"Staff workload has increased since the number of patients that are coming has increased, so workload has increased. We are having problem with personnel as to compare with the workload, no employment, so we have shortage of staff." (IDI, 2nd Health Provider, PBF LGA, Ondo)

"What I'm not happy about program is only the stress. We don't have time. Because sometimes I'll be tired, I will not have time at home to do anything. Once I get home, I just go and lie down. Maybe at night, they will call you again, "we have deliveries...ah, there is a sick person, we can't do it, come and assist us." That's what I can say that I do not like." (IDI, OIC, DFF LGA, Adamawa)

In some cases, health workers attributed the excess work load to record keeping. They were unhappy with the large volume of data that they had to record and the numerous registers that they had to complete.

"What I don't like about NSHIP is too much work [laughter]. Because the work is too much. They will bring this register, you will fill it, they will bring this register, the work is too much. Apart from the register, you'll do the service. Because there is some work that must be done by the in-charge." (IDI, OIC, DFF LGA, Adamawa)

"At times the work is too much for us unlike the other time, when we don't care about keeping records, but now have to, any work you do you must keep that record if not they will not come and but the services." (IDI, OIC, PBF LGA, Nasarawa)

4.3.3 Geographical Access to Health Facilities

Access to health care and facilities remains a critical challenge in some of the areas especially in the rural areas, where most of the community members and health workers complained of bad roads and lack of transportation. These constraints also had dire consequences in some states where participants reported that some lives were lost in the past in the process of moving women in labour from one place to another. Likewise, those who were referred to secondary facilities could not go due to bad roads in the rural areas. These narratives were common to both PBF and DFF LGAs across the three states.

"The roads are bad and full of potholes and water. They are also in the bush so transportation is a challenge." (FGD – Women, PBF LGA, Adamawa).

"The reason is that cottage hospital is the general hospital in the XX town and is relatively far away from our respective homes. That is why we take our wives to that hospitals which are closer. We are only referred to Cottage hospital if other hospitals cannot handle the problem." (FGD – Men, PBF LGA, Adamawa).

"When it comes to delivery, we usually have problem with accessibility to the facility because the various roads to the hospital are bad. Sometimes even when we are on the way bringing them, we sometimes have cases of death on the way. So the road is very bad, we don't have good access road way." FGD – Men, PBF LGA, Adamawa).

"Some of us don't even go for ANC most especially those of us from remote areas and the reason is due to lack of accessible roads." (FGD – Women, DFF LGA, Nasarawa).

"There are no good roads to this community for easy access by qualified health workers to the PHC thereby leaving us with the option to be taken our wife out for C-Section and sometimes they died on the road." (FGD – Men, PBF LGA, Nasarawa).

"One of the challenges is bad road especially for those who go into labour at midnight, bad road may cause delay in getting to the hospital at midnight, as this is peculiar to the people that are not mobile, they therefore give birth at home." (FGD – Women, PBF LGA, Ondo)

"So I didn't take her to Okitipupa. I calculated the money I have spent on transporting her around and I wondered what was wrong and why they were referring us about. So I decided to take her to the local midwives. So the midwives helped her deliver the baby. So on the 3rd day she was taken to the health centre." (FGD – Men, DFF LGA, Ondo).

4.3.4 Financial Access

Despite significant lowering of costs of services, some communities reported that the cost of services at NSHIP facilities remained quite were expensive for them thereby deterring their use. There was a reported case of a man who lost his child as a result of inability to pay for health services. Across the states, some of the community members reported that they were expecting health services to be free or at least more affordable in government hospitals but they were surprised to find that costs of health care in some of the hospitals were quite expensive. This was particularly the case in some facilities in Ondo State where the previous administration had run a free health care program to encourage maternal and child health. The expensive costs of health care therefore led to the patronage of alternative medical facilities like patent medicine vendors and consumption of local herbs. Some of the excerpts are below:

"We can say that there is no problem because they are doing their work as expected, except the health treatments here are very expensive, I brought my child yesterday I have to buy tablets for N3,500.00 and another N3,500.00 for blood tests. Therefore, I want to use this opportunity to call on the government to provide subsidy for health services." (FGD – Men, PBF LGA, Adamawa).

"I lost my child to malaria because I took him back home from the hospital since I didn't have what to pay for the services and he died." (FGD – Men, PBF LGA, Adamawa).

"The reason why women don't take their children to the hospital is that whenever one goes to the hospital, there'll need to conduct some tests and obviously, this is not without some expenses. This is the main reason why they do not go." (FGD – Women, PBF LGA, Adamawa).

"You know for some people is as a result of lack of money, some are willing to go to general hospital but they don't have money, so some ends up going to the chemist because they don't have the money (FGD – Men, DFF LGA, Adamawa).

"There is a problem with fund because some people visit the hospital thinking they will spend between #1000 and #2000 but by the time they are through with treatment or test, even the test cost as much as #1500, #1000, #700 which is too much and not affordable. Considering the way the economy is, there is no money at all, the government hospital bill is way too much considering the status of those of us visiting there for treatment." (FGD – Men, PBF LGA, Ondo).

"The experience I had of recent is that a child in my compound was sick, the child was then taken to general hospital Igbaraoke. All the services rendered there required a fee, unlike sometimes ago when treatment for children was free of charge, now even drugs require you paying a fee." (FGD – Women, PBF LGA, Ondo).

"Our major problem in accessing health services is finance to pay hospital bills. You know we are in the village and we don't do anything apart from faming activities which are seasonal. Until we harvest our produce sell them in the market we don't have money." (FGD – Women, PBF LGA, Nasarawa).

"We often come here because is a government hospital which we expect to be cheap and it is close to us but the problem of our people is they don't go to hospital for medical care until when the condition is worst especially on cases of children because of the financial involvement." (FGD – Men, DFF LGA, Nasarawa)

4.3.5 Perception of Poor Attitudes of Health Providers

While there were significant reports of positive changes in the behaviors of health care workers across the states, the study revealed that there were still some perceptions by community members of poor attitudes among some health workers. This was more common among health providers in the urban areas especially the general hospitals than the PHCs.

"We normally have a problem with females health workers that handled children immunization exercise. Sometimes they don't pay attention to our wives, instead of them to enlighten our wives how to take good care of their children they will allow our wives to wait for a long time before they attend to them. The worst part of it is that when a woman reached the age of forty (40) they will be calling her name like Mama and this is an insult to our wives. This also forced some of our wives to stopped bearing child even though they can do so and deliver their babies safely. So, these are challenges, they should be warning these health workers to stop maltreating and insulting those women and I am sure this will encourage them to finished their immunization in the hospital." (FGD – Men, PBF LGA, Adamawa)

"Some of them, yell at you. Every little thing, they scream. Something that doesn't even warrant that reaction. But in the PHCs, they are trying, they have pity. It's not like they too are perfect either." (FGD – Women, DFF LGA, Adamawa)

"If we go to the health Centre and tell them we came for treatment, especially if one is pregnant, they will abuse us for not coming early enough and then tell you you're late already. We will not meet more than two people there. Even if you are laboring, they will tell you to go that there is nobody to attend to you- that the doctor is not around. That is the problem with health Centre. If we get to private hospitals, they would attend to us at once and you will deliver (FGD – Women, DFF LGA, Ondo)

"Sometimes you go to the hospital when you are sick, and the cleaners yell at you, that you are dirtying the floor that they've cleaned. And they don't know what

condition brought you there. Nurses too, sometimes they don't fix your drip properly, leaving you with a swelling and problems." (FGD – Women, PBF LGA, Nasarawa)

"At other moment even if the health workers are called upon on emergencies they waste like 30 minutes to 1 hour before they come because most of them don't pass night here and some of them will be in their quarters but will refuse coming." (FGD – Men, DFF LGA, Nasarawa)

In addition to poor attitude of health workers, in a couple of instances community members also complained about the lack of doctors in health facilities, especially general hopsitals.

"There is problem with availability of a doctor. Most times a patient will be brought to the hospital but you can't find a doctor. I could remember a case of a pregnant woman that was taken to the cottage hospital but the baby came out without the doctor present, another one died before arrival of the doctor. There is also problem of human relation between the doctor and the patient." (FGD – Men, PBF LGA, Adamawa)

4.3.6 Social and Cultural Norms with Regard to Family Planning

Across the states, especially in the Adamawa and Nasarawa, the study revealed that there was still high preference for traditional methods of health care particularly with regards to family planning. The reasons adduced for non-uptake of family planning included cost, the desire to have more children, social and cultural beliefs, especially those who were of the opinion that family planning practices were attempts at hindering "God's work", lack of awareness, among others.

"Some people practice family planning while others don't. This because we are religious people here so if you bring the issue people will say Islam don't recognize it but people vast in modern education space their children." (FGD – Men, PBF LGA, Adamawa)

"There was a time my wife told me she wants to go for planning but I told her the children are not enough, she should wait until I have enough." (FGD – Men, PBF LGA, Adamawa)

"In my plan, I want to have about 10 children by the time I reach 40 years of age. This is because large population is associated with development." (FGD - Men, DFF LGA, Nasarawa)

"I am not ready for Family Planning yet; I don't have enough children yet. I only have 1 for now. I want 10 children first." (FGD - Women, DFF LGA, Nasarawa).

4.4 Differences across PBF and DFF LGAs

The common perception among respondents from facilities and LGAs as well as state and federal-level key informants was that PBF was a stronger intervention to bring about substantial changes in key health service delivery and outcome indicators in Nigeria. The basic premise for this perception was that PBF by virtue of providing financial incentives, in the form of performance bonus payments, was driving health workers to perform better.

"If you are not motivated, you cannot be committed. The PBF facilities have this built in them. The more they work, the more revenue they have." (KII, Federal-level)

On the other hand, some respondents believed that motivation derived intrinsically or from an enabling environment was often more powerful than extrinsic motivation. They considered that health workers in DFF facilities were often as motivated and as equipped as some PBF facilities and hence were potentially in a position to outperform them.

"In the few DFF health facilities I have been to, they have been strong on a structural basis and then motivation, even though they don't get financial motivation, they also have that intrinsic notion that we have better working experience. So in some LGAs you will see that they can come at par with some poor performing PBF LGAs due to the mismanagement and the weakness of the LGA authority. So some of their data could be better than that of PBF LGAs." (KII, Federal-level)

"Anybody working in the clinic and is given the necessary tools, he will be happy and discharge his responsibilities. You cannot complain of lack of materials, so you do your work happily. What they like about the program is the kind of discipline that is there and how the program also transformed the environment. And you see everybody is trying to be neat because the environment is neat. Most of my staffs are always wearing new uniforms now." (IDI, OIC, DFF LGA, Adamawa)

This study found a few qualitative differences across the two LGAs, namely that PBF facilities were more likely to provide additional incentives to communities to attract them to patronize their services, and experienced a more rigorous supervision and verification process. On the other hand, respondents from DFF facilities faced financial difficulties to a greater extent and expressed a desire to transition to PBF mechanisms. Some of these narratives are described below.

More incentives used by PBF facilities to attract patients to increase uptake of immunization and institutional deliveries

The study suggests that PHCs in PBF facilities used more incentives to attract and retain patronage of uptake of immunization and institutional deliveries. Observations and FGD showed that these facilities used various means such as promise of bonus to mothers who complete immunization rounds, gifts for deliveries in facilities, and various incentives for ANC attendance.

"In the past, they were not bothered by Immunization. But now they pay you to immunize your children. So, they have a lot of patients now. For us, we don't go because of the money, we always used to immunize our children but many go because of the money." (FGD - Women, PBF LGA, Nasarawa).

"We are very thankful to the government. In the past, after delivery, we didn't receive any gifts such as wrappers but now, once we deliver, they give us a whole roll of wrapper. They say we should back our babies with it. We are very grateful." (FGD - Women, PBF LGA, Adamawa).

Although, the narratives among community members about cost of drugs cut across the states, the DFF facilities had more of such narratives as most of the community members complained of non-availability of essential drugs in the facilities.

"We often come here because is a government hospital which we expect to be cheap and it is close to us but the problem of our people is they don't go to hospital for medical care until when the condition is worst especially on cases of children because of the financial involvement." (FGD - Men, DFF LGA, Nasarawa).

"If for example, you bring a child, they will ask you to do a test. If you do the test, and they find malaria and typhoid, you know, they'll write medicines. If they write the medicines...because, I once brought my child here, they wrote medicines and injections for us worth 2,000. (FGD – Women, DFF LGA, Adamawa).

For me, all my two children were born through CS. Also, when your wife gave birth in the hospital, before you go there are bills they usually give which comprises Dettol, soap, toilet roll etc. So, tell me how a poor person can afford all these. You brought your wife for help and you will be given extra bills apart from the one you will pay for the service (FGD – Men, DFF LGA,, Adamawa)

Perceptions of unresponsive attitude of health workers relatively higher among DFF facilities

Furthermore, there were relatively more narratives about unresponsive attitudes of some health providers among the DFF facilities, especially the general hospitals in the DFF LGAs.

"My own contribution is about the addition of health workers because when some of the workers are on call or duty, you can go and see that they are absent which if you continue waiting the patient will just keep suffering. Even if they take him to the ward, they will just go and keep him there. So such kinds of things use to annoy people who go to the hospital" (FGD – Men, DFF LGA, Adamawa).

"At other moment even if the health workers are called upon on emergencies they waste like 30 minutes to 1 hour before they come because most of them don't pass night here and some of them will be in their quarters but will refuse coming." (FGD – Men, DFF LGA, Nasarawa).

"When I got there, before they attended to me, it took time sir, it took time presenter. As she was on the floor shouting, they were not even bothered that she could be in danger" (FGD – Men, DFF LGA, Ondo).

More rigorous supervision and monitoring in PBF facilities

The intensity of supervision and monitoring described by respondents from PBF facilities seemed to be qualitatively higher than those in DFF facilities. This included the number of supervision visits per quarter, the verification processes and the data documentation that had to be carried out. This was also observed by a respondent from a DFF LGA as well:

"Yes, I think we have supervision it is thorough though but not as we have in PBF centres because we have friends in PBF centres where they will always write registers, do this and that and the thing is Nigerian mentality that if we are doing something and we are not giving incentives to what we are doing, we tend not to really work so hard to achieve much. So I just come to work and do my normal duty but for people that have incentives to what they do; they work better so DFF has thorough but not as much as we have in PBF facility."

Dissatisfaction with lack of performance bonus among DFF facilities

In many cases, particularly from Adamawa and Ondo, respondents from DFF facilities expressed a desire to join PBF instead. They considered that with PBF, they would receive additional monetary benefits, including an individual bonus, which would enable them to provide better quality services.

"*Let me be frank with you, they are not actually satisfied, when they see what their counterparts get in PBF facilities, they don't get anything and they are doing the same job, that motivation is not really there and I believe with motivation what they have been able to achieve they can achieve better*" (IDI, LGA PHC, Ondo)

"*Well like in this facility personally, if it is been transformed into PBF, we think it will go a long way to help the facility completely in doing so much for the community."* (IDI, OIC, DFF LGA, Adamawa)

"*Oliver twist will always ask for more. If they make more fund available I think that will help because we have DFF now we are saying that if we should be migrated to PBF because we have been encouraging our people because they look at some facility whatever they do they are being paid for it but everything they do here nothing they just look like we are doing services here their counterparts there is being paid whatever they are doing. What will improve it is that every DFF should be migrated to PBF*." (IDI, OIC, DFF LGA, Ondo)

4.5 Differences across Nasarawa, Adamawa and Ondo

On the whole, the three project states appeared to have experienced similar achievements and challenges since the inception of NSHIP. Interviews at the community levels suggested that all three states had seen a tremendous improvement in the physical structures at facilities and availability of manpower, as well as an increase in uptake of their services. Similarly, respondents across all three states had expressed their dissatisfaction due to poor geographic access to facilities. However, a couple of minor differences that emerged from these discussions appeared to be aligned with cultural norms around family planning. For example, respondents from Ondo were more open to the idea of using family planning methods as compared to those from Nasarawa and Adamawa. Additionally, in Ondo most of the community members were used to the free health care policy pursued by the immediate past administration to enhance maternal and child health. Hence, the reaction to the changes that they had to pay for health services in some of the hospitals was more adverse as compared to the other two states.

Among interviews at the health facility and LGA levels, the main narrative was similar across the three states. Health workers and LGA supervisors reported to be more committed and engaged to provide services to their communities due to financial and non-financial incentives made available to them. They also experienced better working environments, along with stronger management and supervision processes. On the other hand, expressions of fatigue and stress owing to additional workload also appeared to be common across the states. However, health workers and supervisors from Adamawa were more emphatic about this especially since they had not received their salaries for several months as described in Box 3. As a result, those belonging to PBF LGAs, considered bonus payments to bring them the much needed financial relief.

A couple of other differences also emerged from these narratives. While respondents from DFF LGAs in Adamawa and Ondo were quite emphatic about wanting to implement PBF in their respective facilities, these accounts were not heard among those in Nasarawa. A unique narrative was also heard from a respondent in Adamawa who claimed that the relative share of performance-based payments received by his facility was low due to excessive competition among PBF facilities in their LGA. It seemed that there were two PHCs, one Cottage Hospital and one private clinic all running PBF thereby competing with each other for clients from the adjoining communities.

Among interviews with key informants at the state and federal level, several other themes distinguishing the three states also emerged. One key informant considered that Adamawa despite having the most acute shortage of technical staff still had the most efficient management system in place for implementing NSHIP. Another key

informant considered that Nasarawa, at present, had the strongest political will for bringing about a structural reform in health service delivery and systems through NSHIP. The presence of doctors among senior leadership in Ondo also boosted various technical components of NSHIP in the state. Finally, one key informant considered that Nasarawa was more stringent in following the “stick approach” in PBF, and was consistent in sanctioning facilities that had committed fraud.

5 Conclusion

The main objective of this study was to bring forth achievements and challenges experienced by LGAs in implementing NSHIP, including both PBF and DFF modalities, across the states of Adamawa, Nasarawa and Ondo. Moreover, it aimed to understand better some of the reasons for these successes and continuing gaps by collating experiences of health facility providers, LGA supervisors, and other key informants involved in the project as well as members of communities that are likely to benefit from it.

As described above, NSHIP has brought about a transformation in terms of new and improved structures, availability of drugs and manpower, and reduction in cost of services making facilities more attractive to clients and hence improving service utilization of key maternal and child health services. These changes along with a new paradigm of management interventions has enhanced capacity, both ability and disposition to work, and engagement of health providers working in these facilities. In particular, the injection of additional monetary resources, both directly in the form of bonus payments or indirectly in the form of improving the work climate, led to increase motivation and commitment of health workers. Moreover, performance bonus payments received by individual health workers in PBF facilities reportedly improved their financial standing in society. However, findings from the study suggest that there still exist mixed opinions with regard to the adequacy of the amount of performance bonus relative to the additional work load as well as the fairness in its distribution across various staff members in the facilities.

On the other hand, challenges remained in improving geographical and financial access to health care for community members as well as bringing about behavioral changes for adopting modern methods of health care. In some cases, community members perceived health workers to demonstrate poor and improper attitudes towards them. It also seemed that the level of disgruntlement, on the whole, was higher with services at General Hospitals than at PHCs. On the facility side, the study found some perceived gaps in implementation, including delays in receiving quarterly payments, reduction in unit costs of services and mismatch of expectations from verification process by health providers. Health workers, across the board, also expressed their dissatisfaction with excessive workload. In addition, many complained about a systemic shortage of manpower as well as the need for structural expansion of their facilities beyond the scope of NSHIP.

While both PBF and DFF facilities gained tremendously from additional monetary resources, this study found a few qualitative differences across the two types of LGAs. For example, PBF facilities were more likely to provide additional incentives to communities to attract them to patronize their services, and experienced a more

rigorous supervision and verification process. On the other hand, respondents from DFF facilities faced financial difficulties to a greater extent and expressed a desire to transition to PBF mechanisms. In addition, differences across the three project states mirrored the broader socio-cultural and political context existing in them. For example, uptake of family planning services appeared to be higher in Ondo, shortages in technical staff and security concerns greater in Adamawa, and political leadership strongest in Nasarawa.

Thus, to conclude, NSHIP brought about a paradigm shift in health service delivery by providing much needed financial inputs into the Nigerian health system. In addition, it introduced new management principles and processes, for both PBF and DFF facilities enabling them to effectively prioritize resources, set goals and carry out implementation plans. Moreover, PBF increased motivation and commitment of health workers by providing individual performance bonus, as well as further opportunities for knowledge and skill enhancement. As it enters its next phase, NSHIP needs to work towards improving some of the existing challenges and gaps to further improve quantity and quality of service provision and continue to innovate to attract community members to use those services.

6 Annexure

6.1 Detailed Description of NSHIP Components – PBF and DFF

Key elements	Characteristic	PBF	DFF	Comment
Financing	Maximum amount of funds provided to Health Facility, per capita	$2	$1	• PBF: PBF facilities receive max **$2 per capita** based on its performance. Of it, $1 would be used for individual bonuses to health workers while the remaining $1 would be for operational costs[4]. • DFF: DFF facilities will receive maximum **$1 per capita** constantly for operational costs regardless of their performance.
	Funds can be used to provide bonuses to staff	Yes	No	DFF facilities will not be allowed to use their funds to pay bonuses to their staff.
Decentra-lized governance	Health Facility RBF Committee	Yes	No	• PBF facilities will have the **Committees** to review the performance of health facilities and advise for improvement, and sign checks for expenditures. • DFF facilities will not form RBF Facility Committees. They will use the **WDC** as the oversight structure. •
	Autonomy of the Health Facility	Yes	Yes	Same amount of autonomy in use of funds, HR function etc. except for bonuses to staff.
	Bank accounts managed by facility committee	Yes	Yes	PBF and DFF facilities will have bank accounts. RBF Facility Committee will be cosignatory on the PBF Facility Account. Two signatories from the DFF facility will sign on accounts.

[4] Per capita budget will be reviewed periodically.

Key elements	Characteristic	PBF	DFF	Comment
Planning at health facility	Development and implementation of business plan	Yes	No	• PBF: Develop a detailed **business plan** (Annex 4 (1)) that includes targets, analysis of barriers, and strategies to overcome barriers. Copies of this will be sent to SPHCDA and LGA PHC Department. • DFF: Develop a simplified **activity plan** (Annex 4 (2)) that specifies the use of money received (simple input-based table). Copies of this will be sent to SPHCDA and LGA PHC Department.
	Other PBF tools	Yes	No	Only PBF facilities use indice tool (Annex 5) and individual performance evaluation form to enhance individual motivation and manage finance.
Recording and Reporting	Use of standard HMIS forms	Yes	Yes	Required for both PBF and DFF facilities. Same government format will be used.
	Quarterly invoice	Yes	No	• PBF: Required **for PBF facilities** (condition of payment) • Data will be extracted from HMIS, and recorded every 3 months and reported to SPHCDA **by LGA** PHC Department through supervisory checklist.
Verification and supervision	Monthly quantity verification by SPHCDA	Yes	Yes (but lighter)	• PBF: TA firm and SPHCDA visit all health facilities monthly to verify quantity of services and provide detailed coaching on performance improvement. • DFF: Only SPHCDA visits sampled facilities every 6 months to verify quantity reported by LGA PHC Department •
	Quarterly quality supervision by LGA PHC Department	Yes	Yes	LGA staff will receive bonuses by conducting quality assessment for both PBF and DFF facilities. PBF-specific items will be replaced from the checklist for DFF facilities (e.g., business plan, indice tool, RBF committee)

Key elements	Characteristic	PBF	DFF	Comment
	3rd party verification of quantity	Yes	No	• PBF: TA firm will hire CSO to visit households to verify existence of patients for both PBF and DFF facilities to avoid over-reporting. • DFF: SPHCDA will check the existence of patients for randomly selected patients every 6 months.
	3rd party verification of quality	Yes	No	TA firm ensures conduct of independent quality assessments (e.g., use of mobile survey) for PBF facilities only.
Technical Assistance (TA)	1) Use of PBF process and tools 2) Problem solving to improve service uptake and quality 3) FM, waste mgt, drug mgt, reporting	Yes	No (Yes only for 3))	• TA firm will help PBF facilities use business plan, indice tool and health worker performance framework effectively. It will also advise on FM, waste management, drug management, reporting, HF RBF committee. • DFF facilities will not receive PBF related TA summarized in 1) and2). They can receive general TA summarized in 3).

Source: NSHIP Project Implementation Manual 2012

6.2 Selection of Study Sites

The following tables describe the monitoring data used for selecting PBF and DFF LGAs from each of the project states. A team from the National Primary Health Care Development Agency (NPHCDA) carried out these analyses. A larger team that attended the mid-term qualitative study training hosted by the Federal Ministry of Health did the final selection of LGAs. The LGA highlighted in dark green represent the final selection.

As per the study design, one high and one low performing PBF LGA and an average performing DFF LGA were selected from each state. The pre-pilot LGAs were purposively excluded from the selection as they had a much longer period of implementation. For example, in the case of Adamawa and Nasarawa, the highest performing LGA was indeed the pre-pilot LGA but these were replaced by the next highest performing LGA.

Table 6.2.1 Monitoring Data – Performance Scores for PBF LGAs in Adamawa

	QUALITY					QUANTITY					
LGA	2015 MPA Average	2016 MPA Average	2015 CPA Average	2016 CPA Average		2015 MPA Average	2016 MPA Average	2015 CPA Average	2016 CPA Average	Average Performance	Ranking
Fufore	59	73	68	77		46.0	76.0	1.3	3.0	50.4	1 Pilot LGA
Mayo Belwa	53	61	35	75		46.0	87.0	1.5	4.9	45.4	2
Yola South	39	44	37	30		42.0	79.0	38.5	43.5	44.1	3
Song	40	53	34	59		27.0	79.0	0.6	3.1	37.0	4
Mubi South	36	48	48	69		17.0	54.0	3.0	9.8	35.6	5
Maiha	49	47	28	56		27.0	59.0	2.5	4.3	34.1	6
Demsa	56	61	17	36		18.0	71.0	0.7	3.9	32.9	7
Gayuk	31	44	51	63		13.0	47.0	0.3	0.7	31.2	8
Girei	45	56									Incomplete data
Shelleng	24	38				19.0	75.0				Incomplete data
Madagali		15					0.8		15.0		Incomplete data

Table 6.2.2 Monitoring Data – Performance Scores for DFF LGAs in Adamawa

LGA	2015 MPA	2016 MPA	2015 CPA	2016 CPA	Average Performance
Ganye	4%	7%	1%	1.21%	3% (Random Balloting)
Hong	4%	8%	0%	0.46%	3%
Toungo	5%	6%	0.21%	0.33%	3%
Gombi	3%	7%	0%	0.53%	3%
Numan	3%	4%	1.08%	2.56%	3%
Jada	2%	5%	0.88%	0.54%	2%
Michika	0%	5%	0.34%	0.88%	2%
Mubi north DFF	6%	8%			
Yola North DFF	5%	7%			
Larmude DFF	4%	2%			
Gerei PBF	50%	84%			

Table 6.2.3 Monitoring Data – Performance Scores for PBF LGAs in Nasarawa

LGA	QUALITY				QUANTITY					
	2015 MPA Average	2016 MPA Average	2015 CPA Average	2016 CPA Average	MPA 2015 Average	MPA 2016 Average	CPA 2015 Average	CPA 2016 Average	Average Performance	Ranking
Wamba	73	67	73	74	177.0	309.0	0.5	0.6	96.8	1 Pilot LGA
Kokona	54	37	66	66	242.0	182.0	2.8	1.9	81.5	2
Akwanga	51	50	67	79	224.0	152.0	14.6	6.9	80.6	3
Toto	55	53	61	55	152.0	219.0	4.1	4.5	75.4	4
Doma	61	49	65	47	180.0	183.0	6.3	4.5	74.5	5
Karu	53	47	71	59	103.0	247.0	1.5	1.1	72.8	6
Nasarawa	53	47	59	53	158.0	73.0	4.4	3.0	56.3	7

Table 6.2.4 Monitoring Data – Performance Scores for DFF LGAs in Nasarawa

LGA	2015 MPA	2016 MPA	2015 CPA	2016 CPA	Average Performance
Awe	6%	8%	0.64%	0.25%	3.72%
Keana	8%	11%	0.10%	0.25%	4.84%
Keffi	8%	7%	0.22%	0.27%	3.87%
Obi	10%	12%	0.22%	0.22%	5.61%
Lafia	10%	20%			Incomplete data
Nasarawa Egon	5%	7%		0.44%	Incomplete data

Table 6.2.5 Monitoring Data – Performance Scores for PBF LGAs in Ondo

LGA	QUALITY					QUANTITY					
	2015 MPA Average	2016 MPA Average	2015 CPA Average	2016 CPA Average		2015 MPA Average	2016 MPA Average	2015 CPA Average	2016 CPA Average	Average Performance	Ranking
Akoko South-East	34	60	58	85		12.0	72.0	10.2	320.5	81.5	1
Ondo East	50	53	70	75		43.0	206.0	1.4	2.7	62.6	2
Ondo West	55	55	65	70		23.0	115.0	5.3	9.4	49.7	3
Ese Odo	48	47	41	48		35.0	145.0	1.5	3.6	46.1	4
Akoko South-West	48	60	58	92		16.0	41.0	11.7	27.3	44.2	5
Ile Oluji/ Okeigbo	54	46	72	82		29.0	57.0	1.1	1.1	42.8	6
Owo	49	56	58	72		28.0	50.0	10.5	11.1	41.8	7
Akoko North-West	54	66	62	81		13.0	33.0	3.4	12.2	40.6	8
Ifedore	64	55	71	82		15.0	26.0	1.4	2.8	39.7	9
Idanre						5.0	5.0		0.3		Incomplete data

Table 6.2.6 Monitoring Data – Performance Scores for DFF LGAs in Ondo

LGA	2015 MPA	2016 MPA	2015 CPA	2016 CPA	Average Performance
Akoko North-East	3.0%	5.0%	1.0%	1.1%	2.5%
Akure North	6.0%	8.0%	0.1%	0.1%	3.6%
Akure South	5.0%	6.0%	0.9%	0.7%	3.2%
Ilaje	6.0%	7.0%	0.1%	0.1%	3.3%
Irele	4.0%	6.0%	0.1%	0.1%	2.5%
Odigbo	4.0%	5.0%	0.3%	0.4%	2.4%
Okitipupa	3.0%	6.0%	0.5%	0.4%	2.5%
Ose	5.0%	7.0%	0.1%	0.1%	3.0%

6.3 Summary of Improvements in NSHIP - PBF and DFF

Improvements	PBF	DFF
High degree of implementation fidelity	High degree of implementation fidelity: new contractual procedures mandated by NSHIP's project design, trainings on PBF principles, creating new institutional arrangements such as management committees.	High degree of implementation fidelity: trainings on DFF, appropriate contractual arrangements, strengthening existing institutional structures.
Strengthening of management systems and processes	Use of business plans for setting goals and designing implementation strategies, common bank accounts to carry out all financial transactions, new guidelines outlined for data collection, collation and verification.	Use of activity plans for setting goals and designing implementation strategies, bank accounts for ensuring transparency in financial transactions, less emphasis on data verification mechanisms.
Reinforced supervision	Reported exponential increase in supervision visits, often in the form of surprise visits. Nature of supervision saw a shift from being an inspection to a coaching session using structured checklists.	Did not suggest the same degree of increase in supervision visits, but reported a significant improvement nonetheless. Similar experiences with nature of supervision.
Improvement in working conditions	Paramount improvements in structural quality of PBF facilities. Additional monetary resources enabled facilities to upgrade their infrastructure, procure drugs and supplies, and recruit manpower thereby filling in acute shortages of staff.	Reported similar degree of improvement in this domain.

Improvements	PBF	DFF
Performance bonus payments	Performance bonus payments received by individual health workers reportedly improved their financial status, and made them more punctual, motivated and committed to work. However, findings from the study suggest that there still exist mixed opinions with regard to the adequacy of the amount of performance bonus relative to the additional work load as well as the fairness in its distribution across various staff members in the facilities.	Not applicable to DFF facilities. However, in some instances health workers at DFF facilities expressed the desire to have PBF modalities in their facilities in order to earn additional bonuses.
Uptake of maternal and child health services	Community members reported to patronize services at PBF facilities, particularly for key maternal and child health services. They considered the facilities to be in a better position for delivering good quality services. In many cases, particularly among clients of PBF facilities, respondents mentioned receiving free items, such as soaps, clothes for babies etc, from the facilities free of cost. Most of the participants also observed that outreach activities had increased over the past two years and that health workers visited their hamlets and markets to immunize their children.	Community members reported to use services at DFF facilities, and also considered there to be significant improvements in structural quality as well as availability of staff. However, there were no narratives hear around receiving additional non-monetary incentives for use of services at DFF facilities.

6.4 Interview Guides

Mid-term Assessment of NSHIP: Qualitative Study

FOCUS GROUP DISCUSSION (FGD)

Guidelines for Focus Group Discussion - Men with Young Children (0-24 months)

Procedure of Selecting Participants

The FGD will be conducted in a hamlet, which can draw representation from all the socio-economic sections of the society. In villages where the hamlets are widely spread, care will be taken to select a hamlet, which can ensure proximity to most of the communities without being inhibitive to the poor households. The participants will be invited during a transect walk through the village and care will be taken on the following issues:

- The supervisors/recruiters will have to ensure that the participants should be representative of the village population.
- The focus group should be conducted with a group of
- 8-10 men from the village having the following criteria:
  - The men should be in the age group of 18-49.
  - The men should have at least one child in the age group of 0-24 months.
  - The group should have at least four men whose wives/partners had delivered their youngest child in a project (PBF or DFF) health facility and four who did not.

Instructions for Facilitators

- This Discussion Guide is simply a roadmap for the interview. The broad items suggest the areas that one has to explore. The sub-items under each broad item are possible probe questions.
- The facilitator is encouraged to keep a notepad for noting down personal observations and reflexive thoughts. On the same notepad, the moderator can draw a horseshoe indicating the seating arrangement of all the FGD participants. For personal reference and better note taking, names of each participant should be written down, against a cross mark, indicating his seating position.
- Do not prompt the answers to any of the questions, however if you observe that the discussion of the group is completely out of context, you may gently remind the group of the present topic of discussion.
- Start with some general discussion with the group. Discuss about their village and good things to see. Talk about their hobbies and what they all do during their leisure time. Then move on the following guidelines and let the group discuss.
- To the extent possible, carry out the discussion in a private setting such that interruptions from other members of the community are avoided.

I. Consent Form for FGD with Men with Young Children (0-24 months)

READ: Good morning/afternoon. My name is _____. I am working with the Federal Ministry of Health on a study on the health situations of members in your community, especially women and children. I would like to ask you some questions about health services available to and used by you and others in your family, especially services for pregnant women, children, family planning and the like. The purpose of the study is to obtain information needed to effectively manage the Nigerian health system and improve on its efficiency to enhance the health status of the population. The interview will take a short period. All the information we obtain will remain strictly confidential and your answers will never be identified.

This study has been reviewed and granted approval by the National Health Research Ethics Committee (NHREC), assigned number NHREC/01/01/2007, for the study period of 20 March, 2017 to 19 March, 2018.

Your opinions and experiences are important to us. We want you to be honest and truthful in answering our questions. Some of the questions I will ask might be considered too intrusive or too personal and thus may make you feel uncomfortable. Your participation is completely voluntary. You may decline to answer any single question that you don't want to or may leave this discussion whenever you would like. The benefit of your participation, however, is that you will contribute useful information that will help Government in planning to reduce maternal and under-five mortality in Nigeria.

At this time, do you want to ask me anything about the study? May I begin the discussion now?

Should you have any queries, feel free to call any of the following contact person(s):Study Contact Person: Dr E. Meribole, Email: meribole@yahoo.com. NHREC Contact Person: Desk Officer for NHREC, Email: deskofficer@nhrec.net; Phone: 08065479926

Signature of interviewer:_____ Date: _____

Signature/thumb print of respondent: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED . . . 1 -> ADMINISTER QUESTIONNAIRE

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 -> END

II. INFORMATION

NAME OF VILLAGE						
NAME OF WARD						
NAME OF LGA						
NAME OF CLOSEST GOVERNMENT HEALTH FACILITY						
TYPE OF CLOSEST GOVERNMENT HEALTH FACILITY						
NAME OF THE MODERATOR/ FACILITATOR						
NAME OF THE NOTE TAKER						
DATE OF INTERVIEW (IN DD/MM/YY FORMAT)	D	D	M	M	Y	Y
START TIME					HRS	
END TIME					HRS	

III. PROFILE OF PARTICIPANTS

#	**Name of the Respondent**	**Age of Respondent** IN COMPLETED YEARS	**Age of child 1** IN COMPLETED MONTHS	**Age of child 2** IN COMPLETED MONTHS	**Age of child 3** IN COMPLETED MONTHS	**Whether child delivered at any government health facility** YES/NO	**Highest education completed**	**Occupation**	**Religion**	**Ethnicity**	**Marital Status**	**No. of household members**
1												
2												
3												
4												
5												
6												
7												
8												

IV. SEMI-STRUCTURED QUESTIONNAIRE GUIDE

A. ACCESS TO AND UTILIZATION OF (GENERAL) HEALTH SERVICES

S.No	Guidelines	Probing Points
1.	**Ice-breaker**: According to you, what are the common health problems faced by members of your village/town? Have there been any changes in these conditions over the past two to five years?	
2.	What do members of your village/town generally do when they fall sick? Do they seek care from anywhere?	• **If YES**, from where/whom? Probe for name of facility/provider. • Why do they seek care from this particular facility or provider? • **If NO**, then why do they not seek care?
3.	What are the main problems that members of your village/town face while accessing health services?	• What are the problems associated with reaching the facility – condition of roads, transportation availability and costs? • What are the problems associated with availability of health providers, drugs, equipment, and services? Quality of services? • What are the problems associated with health provider behaviour and practices? • What are the problems associated with costs of health services?

A. ACCESS TO AND UTILIZATION OF (MATERNAL) HEALTH SERVICES

S.No	Guidelines	Probing Points
4.	Where did your wife/partner deliver the baby (home, someone else's home or a facility)? What were the reasons for this choice?	
5.	If delivered in a FACILITY, which one? Probe for name of facility. Can you describe the experience of your wife delivering the baby there? What were some of the challenges that your wife or you faced while delivering the baby at this facility? How satisfied were you with the services provided to your wife?	• Which type of health provider delivered your baby? • Were all required equipment and drugs available during your delivery? • What were the conditions of the labour room and the ward where your wife stayed during the delivery? • What was the attitude of the health providers during the delivery? • How long did you have to wait before your wife was attended to? • How much did your family spend on your wife's delivery? *Nawa ne kuka kashe akan haihuwan matan ka?*

C. ACCESS TO AND UTILIZATION OF (CHILD) HEALTH SERVICES

S.No	Guidelines	Probing Points
6.	What do you normally do when your child falls sick? Do you seek care from anywhere?	• **If YES**, from where/whom? Probe for name of facility/provider. • Why do you seek care from this particular facility or provider? • What were some of the challenges that you faced while taking your child to this faclity?? • How satisfied were you with the services provided to you? • How long did you have to wait before you met with the provider? • How much did your family spend for these services? • **If NO**, then why do they not seek care?
7.	Do parents in your community generally get their children immunized?	**IF YES,** where do the children receive their vaccines? What challenges did they face in getting their child immunized? **IF NO**, then why not?
8.	Do parents in your community generally get their child's weight and height checked?	**IF YES,** where do they get their child's growth monitored? Why from that facility? How often? What challenges did you face in doing so?

S.No	Guidelines	Probing Points
		IF NO, then why not?

D. ACCESS TO AND UTILIZATION OF (OTHER) HEALTH SERVICES

S.No	Guidelines	Probing Points
9.	Do people in your community generally use any methods for planning their families? Can you please describe any measures that you might have taken for planning your family in the last two to five years?	• **If YES**, from where/whom? Probe for name of facility/provider. • Why do you seek consultation from this particular facility or provider? • How satisfied were you with the services provided to you? • How long did you have to wait before you met with the provider? • How much did your family spend for these services? • **If NO**, then why do they not seek care?
10.	What preventive measures do you take against malaria? Have you received any bed nets from anyone?	• **IF YES,** from where/whom? Probe for name of facility/provider.

E.CHANGES OBSERVED IN NSHIP FACILITIES

S.No	Guidelines	Probing Points
11.	**Ask this question only if [NAME] facility has not been mentioned in any of the previous context.** In the past two years, have you visited [NAME] health facility in/near your village? Why did you visit this facility? What was your experience like?	• ASK FOR NARRATIVES AND EXAMPLES TO DESCRIBE THEIR EXPERIENCES.
12.	**Ask this question only if [NAME] facility has not been mentioned above in the context of a home visit.** Has anyone from [NAME] facility visited you or other members of your family at home during the past year?	• ASK FOR NARRATIVES AND EXAMPLES TO DESCRIBE THEIR EXPERIENCES.
13.	In general, do members of your village/town use the services provided at [NAME] facility? Why or why not?	• Probe specifically about geographic and financial access • Probe specifically about cost of services
14.	What changes have you noticed in [NAME] facility over the past one or two years?	• What changes have you observed in availability of services? • What changes have you observed in availability of drugs, equipment and infrastructure? • What changes have you observed in availability of manpower? • What changes have you observed in behaviour and practices of health providers? • What changes have you observed in the cost of services? ASK FOR NARRATIVES AND EXAMPLES TO DESCRIBE OBSERVED CHANGES.

S.No	Guidelines	Probing Points
15.	What is your perception about the quality of services provided to you at [NAME] facility? Do you consider whether there have been any changes in quality of services over the past two years?	ASK FOR EXAMPLES TO DESCRIBE THEIR PERCEPTIONS.
16.	According to you, what would make the services provided at [NAME] facility better?	ASK FOR EXAMPLES TO DESCRIBE THEIR RECOMMENDATIONS.
17.	Are there any groups or committees in your village/town that help you access health services in general? At [NAME] facility in particular? If YES, do you know what this committee is called? Can you describe any recent interaction with this group/committee with respect to accessing health services?	• Do you know whether there is an "indigent committee" in your village/town? What role does this committee play in helping your community?
18.	In general, how much does your family typically spend on accessing services from [NAME] facility per visit?	

Exit question: Is there anything else that you would like to tell us about any other topics?

FOCUS GROUP DISCUSSION (FGD)

Guidelines for Focus Group Discussion - Women with Young Children (0-24 months)

Procedure of Selecting Participants

The FGD will be conducted in a hamlet, which can draw representation from all the socio-economic sections of the society. In villages where the hamlets are widely spread, care will be taken to select a hamlet, which can ensure proximity to most of the communities without being inhibitive to the poor households. The participants will be invited during a transect walk through the village and care will be taken on the following issues:

- The supervisors/recruiters will have to ensure that the participants should be representative of the village population.
- The focus group should be conducted with a group of 8-10 women from the village having the following criteria:
  - The women should be in the age group of 18-49.
  - The women should have at least one child in the age group of 0-24 months.
  - The group should have at least four women who had delivered their youngest child in a project (PBF or DFF) health facility and four who did not.

Instructions for Facilitators

- This Discussion Guide is simply a roadmap for the interview. The broad items suggest the areas that one has to explore. The sub-items under each broad item are possible probe questions.
- The facilitator is encouraged to keep a notepad for noting down personal observations and reflexive thoughts. On the same notepad, the moderator can draw a diagram indicating the seating arrangement of all the FGD participants. For personal reference and better note taking, names of each participant should be written down, against a cross mark, indicating his seating position.
- Do not prompt the answers to any of the questions, however if you observe that the discussion of the group is completely out of context, you may gently remind the group of the present topic of discussion.
- Start with some general discussion with the group. Discuss about their village and good things to see. Talk about their hobbies and what they all do during their leisure time. Then move on the following guidelines and let the group discuss.
- To the extent possible, carry out the discussion in a private setting such that interruptions from other members of the community are avoided.

I. Consent Form for FGD with Women with Young Children (0-24 months)

READ: Good morning/afternoon. My name is _____. I am working with the Federal Ministry of Health on a study on the health situations of members in your community, especially women and children. I would like to ask you some questions about health services available to and used by you and others in your family, especially services for pregnant women, children, family planning and the like. The purpose of the study is to obtain information needed to effectively manage the Nigerian health system and improve on its efficiency to enhance the health status of the population. The interview will take a short period. All the information we obtain will remain strictly confidential and your answers will never be identified.

This study has been reviewed and granted approval by the National Health Research Ethics Committee (NHREC), assigned number NHREC/01/01/2007, for the study period of 20 March, 2017 to 19 March, 2018.

Your opinions and experiences are important to us. We want you to be honest and truthful in answering our questions. Some of the questions I will ask might be considered too intrusive or too personal and thus may make you feel uncomfortable. Your participation is completely voluntary. You may decline to answer any single question that you don't want to or may leave this discussion whenever you would like. The benefit of your participation, however, is that you will contribute useful information that will help Government in planning to reduce maternal and under-five mortality in Nigeria.

At this time, do you want to ask me anything about the study? May I begin the discussion now?

Should you have any queries, feel free to call any of the following contact person(s): Study Contact Person: Dr E. Meribole, Email: meribole@yahoo.com. NHREC Contact Person: Desk Officer for NHREC, Email: deskofficer@nhrec.net; Phone: 08065479926

Signature of interviewer:_____ Date: _____

Signature/thumb print of respondent: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED . . . 1 -> ADMINISTER QUESTIONNAIRE

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 -> END

II. BACKGROUND INFORMATION

NAME OF VILLAGE						
NAME OF WARD						
NAME OF LGA						
NAME OF CLOSEST GOVERNMENT HEALTH FACILITY						
TYPE OF CLOSEST GOVERNMENT HEALTH FACILITY						
NAME OF THE MODERATOR/ FACILITATOR						
NAME OF THE NOTE TAKER						
DATE OF INTERVIEW (IN DD/MM/YY FORMAT)	D	D	M	M	Y	Y
START TIME					HRS	
END TIME					HRS	

III. PROFILE OF PARTICIPANTS

#	**Name of the Mother**	**Age of Mother** IN COMPLETED YEARS	**Age of child 1** IN COMPLETED MONTHS	**Age of child 2** IN COMPLETED MONTHS	**Age of child 3** IN COMPLETED MONTHS	**Whether delivered at any government health facility for last pregnancy** YES/NO	**Highest education completed**	**Occupation**	**Religion**	**Ethnicity**	**Marital Status**	**No. of household members**
1												
2												
3												
4												
5												
6												
7												
8												

IV. SEMI-STRUCTURED QUESTIONNAIRE GUIDE

A. ACCESS TO AND UTILIZATION OF (GENERAL) HEALTH SERVICES

S.No	Guidelines	Probing Points
1.	**Ice-breaker**: According to you, what are the common health problems faced by members of your village/town? Have there been any changes in these conditions over the past two to five years?	
2.	What do members of your village/town generally do when they fall sick? Do they seek care from anywhere?	• **If YES**, from where/whom? Probe for name of facility/provider. • Why do they seek care from this particular facility or provider? • **If NO**, then why do they not seek care?
3.	What are the main problems that members of your village/town face while accessing health services?	• What are the problems associated with reaching the facility – condition of roads, transportation availability and costs? • What are the problems associated with availability of health providers, drugs, equipment, and services? Quality of services? • What are the problems associated with health provider behaviour and practices? • What are the problems associated with costs of health services?

B. ACCESS TO AND UTILIZATION OF (MATERNAL) HEALTH SERVICES

S.No	Guidelines	Probing Points
4.	During the months of your pregnancy, did you get any antenatal care? Why or why not?	• **If YES**, from where/whom? Probe for name of facility/provider. • **If NO**, then why did they not seek care?
5.	**If YES**, Can you describe your experience of the services that you received during the antenatal care visits? What were some of the challenges that you faced while getting these services? How satisfied were you with the services provided to you?	• How many times did you go for antenatal care visits? • Did anyone come to your home or village to provide you this care? • Did you get an injection in your arm? • Did you get your weight checked? • Did you receive IFA and Folic Acid tablets? • Do you get any medication to prevent malaria during pregnancy? • Were you tested for HIV/AIDS during any of the ANC visits? • How long did you have to wait before you were attended to? • How much did your family spend on getting antenatal care?

S.No	Guidelines	Probing Points
6.	Where did you deliver your baby (home, someone else's home or a facility)? What were the reasons for this choice?	
7.	If delivered in a FACILITY, which one? Probe for name of facility. Can you describe your experience of delivering your baby there? What were some of the challenges that you faced while delivering your baby at this facility? How satisfied were you with the services provided to you?	• Which type of health provider delivered your baby? • Were all required equipment and drugs available during your delivery? • What were the conditions of the labour room and the ward where you stayed during the delivery? • What was the attitude of the health providers during your delivery? • How long did you have to wait before you were attended to? • How much did your family spend on your delivery?
8.	Can you describe the kind of care you received after your delivery? What were some of the challenges that you faced while getting these services? How satisfied were you with the services provided to you?	• **If YES**, from where/whom? Probe for name of facility/provider. • Can you describe what all services and counseling you received during this postnatal care visit? • Did anyone come to your home or village to provide you this care?

C. ACCESS TO AND UTILIZATION OF (CHILD) HEALTH SERVICES

S.No	Guidelines	Probing Points
9.	What do you normally do when your child falls sick? Do you seek care from anywhere?	• **If YES**, from where/whom? Probe for name of facility/provider. • Why do you seek care from this particular facility or provider? • What were some of the challenges that you faced while taking your child to this faclity? • How satisfied were you with the services provided to you? • How long did you have to wait before you met with the provider? • How much did your family spend for these services? • Did anyone come to your home or village to provide you this care? • **If NO**, then why do they not seek care?

S.No	Guidelines	Probing Points
10.	Do parents in your community generally get their children immunized?	• IF YES, where do the children receive their vaccines? Facility or as outreach visits in the village? • What challenges did they face in getting their child immunized? • IF NO, then why not?
11.	Do parents in your community generally get their child's weight and height checked?	• IF YES, where do they get their child's growth monitored? Why from that facility? • How often? • What challenges did you face in doing so? • IF NO, then why not?

D. ACCESS TO AND UTILIZATION OF (OTHER) HEALTH SERVICES

S.No	Guidelines	Probing Points
12.	Do people in your community generally use any methods for planning their families?	• **If YES**, from where/whom? Probe for name of facility/provider. • Why do you seek consultation from this particular facility or

S.No	Guidelines	Probing Points
	Can you please describe any measures that you might have taken for planning your family in the last two to five years?	provider? • How satisfied were you with the services provided to you? • How long did you have to wait before you met with the provider? • How much did your family spend for these services? • **If NO**, then why do they not seek care?
13.	What preventive measures do you take against malaria? Have you received any bed nets from anyone?	• **IF YES,** from where/whom? Probe for name of facility/provider.

E. CHANGES OBSERVED IN NSHIP FACILITIES

S.No	Guidelines	Probing Points
14.	**Ask this question only if [NAME] facility has not been mentioned in any of the previous context. If it has been mentioned in only one or two contexts, then cross-check if they have used [NAME] facility for any other service.**	• ASK FOR NARRATIVES AND EXAMPLES TO DESCRIBE THEIR EXPERIENCES.

S.No	Guidelines	Probing Points
	In the past two years, have you visited [NAME] health facility in/near your village? Why did you visit this facility? What was your experience like?	
15.	**Ask this question only if [NAME] facility has not been mentioned above in the context of a home visit.** Has anyone from [NAME] facility visited you or other members of your family at home during the past year?	• ASK FOR NARRATIVES AND EXAMPLES TO DESCRIBE THEIR EXPERIENCES.
16.	In general, do members of your village/town use the services provided at [NAME] facility? Why or why not?	• Probe specifically about geographic and financial access • Probe specifically about cost of services
17.	What changes have you noticed in [NAME] facility over the past one or two years?	• What changes have you observed in availability of services? • What changes have you observed in availability of drugs, equipment and infrastructure? • What changes have you observed in availability of manpower? • What changes have you observed in behaviour and practices of health providers? • What changes have you observed in the cost of services?

S.No	Guidelines	Probing Points
		• ASK FOR NARRATIVES AND EXAMPLES TO DESCRIBE OBSERVED CHANGES.
18.	What is your perception about the quality of services provided to you at [NAME] facility? Do you consider whether there have been any changes in quality of services over the past two years?	• ASK FOR EXAMPLES TO DESCRIBE THEIR PERCEPTIONS.
19.	According to you, what would make the services provided at [NAME] facility better?	• ASK FOR EXAMPLES TO DESCRIBE THEIR RECOMMENDATIONS.
20.	Are there any groups or committees in your village/town that help you access health services in general? At [NAME] facility in particular? If YES, do you know what this committee is called? Can you describe any recent interaction with this group/committee with respect to accessing health services?	• Do you know whether there is an "indigent committee" in your village/town? What role does this committee play in helping your community?
21.	In general, how much does your family typically spend on accessing services from [NAME] facility per visit?	

Exit question: Is there anything else that you would like to tell us about any other topics?

IN-DEPTH INTERVIEW (IDI)

Guidelines for Interviews with Health Providers at Selected Health Facilities

I. Procedure of Selecting Participants

The IDI will be conducted in a purposively selected project (PBF or DFF) facility: a health center or a general hospital.

Two IDIs will be carried out per facility using this interview guide, with the following purposively selected respondents:

PHC

- The officer in-charge of the health center.
- Another technical health staff (Nurse, CHO, CHEW, JCHEW, Laboratory Scientists) of the selected facility, present at the time of the study.
  [USE THE STAFF ROSTER TO DETERMINE WHO IS PRESENT AT THE FACILITY AT THE TIME OF THE STUDY].
- If not present on the day of the team's visit, an appointment for another day/time will be sought.

General Hospital

- The Medical Officer In-charge/Superintendent of General Hospital.
- One nurse in the maternity ward selected at random. [USE LOTTERY TECHNIQUE TO SELECT AT RANDOM].
- If not present on the day of the team's visit, an appointment for another day/time will be sought.

II. Instructions for Facilitators

- This Interview Guide is simply a roadmap for the interview. The broad items suggest the areas that one has to explore. The sub-items under each broad item are possible probe questions.
- However, in some cases, as indicated in the guide itself, all probe points should be asked.
- The facilitator is encouraged to keep a notepad for noting down personal observations or reflexive thoughts.
- Do not prompt the answers to any of the questions, however if you observe that the discussion is completely out of context, you may gently remind the respondent of the present topic of discussion.

- Start with some general discussions with the respondent to build a rapport. Discuss about their village and good things to see. Talk about their hobbies and what they all do during their leisure time. Then move on the following guidelines and let the respondent discuss.
- Carry out the interview in a private setting i.e. a separate room where no interruptions are likely.
- Do not disturb the health provider in case he/she is attending to patients. Wait for them to complete their consultation and then approach them for the interview.

III. Consent Form for Health Provider

Instructions for the Interviewer*: The following is to be read verbatim to the client prior to the consultation and interview. If the subject then agrees to participate, you must sign on the line marked "Witness to Consent Procedures" at the end of this form. Also mark the date on the appropriate line.*

Purpose of research: The purpose of the study is to better understand the implementation of NSHIP in the pilot states. We will ask you some questions about your experiences of implementing NSHIP at your facility. This information will help the Government and its partner organizations to identify aspects of NSHIP that have performed well as well as those which require further improvements.

Study Investigators: This study is being conducted by the Federal Ministry of Health and the World Bank. This study is sponsored by the World Bank, Washington DC, USA.

Expected duration of research and of participant(s)' involvement: This interview will take approximately an hour of your time to complete.

Risks/discomforts: There is no risk in participating in this study. You may feel uncomfortable by the presence of outside observer.

Costs to the participants: Your participation in this research will not cost you anything in money terms.

Benefit(s): You or others participating in this study will not be paid for being in this study. There is no immediate or direct benefit to you for participating in the study. However, the information collected through the study will help the Government and other organizations to further improve the implementation of NSHIP across health facilities.

Confidentiality: Your personal information will not be shared with anyone other than the persons involved with this study. Any report or publication from the study will provide summary information and you will not be identified in any reports or publications by any means. The honesty of your answers is very important.

Voluntariness: Your participation in this study is voluntary and you may decide not to participate. You have the right to discontinue participation at any stage during this interview. Your decision will not result in any penalty or loss of benefits in any way.

This interview will be audio recorded to help the research team analyse the data in

detail. The recordings will be kept in a safe location and only the research team will have access to them. However, you can ask for the recording to be stopped at any time during the interview.

Questions: If you have any questions, please feel free to ask the interviewer at any time during the interview.

Do not agree to be in this research unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

This study has been reviewed and granted approval by the National Health Research Ethics Committee (NHREC), assigned number NHREC/01/01/2007, for the study period of 20 March, 2017 to 19 March, 2018.

Should you have any queries, feel free to call any of the following contact person(s): Study Contact Person: Dr E. Meribole, Email: meribole@yahoo.com. NHREC Contact Person: Desk Officer for NHREC, Email: deskofficer@nhrec.net; Phone: 08065479926

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

Statement of person giving consent:

I have read the description of the research or have had it translated into and/or read to me in a language I understand. I understand that my participation is voluntary. Based on the information about the research, I have decided to participate in the study. I understand that I may freely stop being a part of this study at any time.

DATE: _____ SIGNATURE: _____

IV. BACKGROUND INFORMATION

1. State:
2. LGA:
3. Ward:
4. Name of health facility:
5. Type of health facility:

---

6. Age:
7. Sex:
8. Marital Status:
9. Highest level of education completed:
10. Type of provider:
11. Designation at the current health facility:
12. Length of time working at current health facility:
13. Length of time working in the sector:

---

14. Name of Facilitator:
15. Name of Recorder:
16. Date of Interview:
17. Start time of Interview:
18. End time of Interview:
19. Time taken to reach facility from LGA Secretariat:

V. Semi-structured Interview Guide

A. Background and current job description

No.	Guidelines	Probing points
1.	**Icebreaker**: Can you please tell me a little bit about yourself? Why did you decide to join this profession?	• Where did you grow up? • Where did you study? • Where did you work before? • Do you also live here? Where is your family?
2.	Can you please describe a typical day of yours at this facility?	• What services do you provide? • What outreach services do you provide? • How many patients do you typically see? • How long do you typically work for? • What are your interactions like with your colleagues/supervisors?
2a.	**For General Hospitals ONLY**: Can you please describe the management of the hospital?	• Who constitutes the management of the hospital? • Who makes the important management decisions for the hospital?

B. Introduction of NSHIP at the health facility

No.	Guidelines	Probing points
3.	Is your facility a part of the NSHIP (PBF/DFF) program? Can you please explain why it was introduced in your facility?	• How long has it been in operation? • What is the objective behind it? • What indicators does it seek to improve?
4.	Can you please describe how this program initially started at your facility?	• Were you consulted before the program started? • Did you receive any training? What training did you receive? From whom? What was your experience of the training? • Did you or your facility enter into any contract for this project? If yes, what did the contract include? Who was this contract with? • Did you receive any funds at the start of the program? How much? For what purpose? • Did you receive any handover note about NSHIP when you took over? (in case officer in-charge was not present when NSHIP started)
5a.	Can you please describe how this program is implemented at your facility?	• How do you decide what services to prioritize as a part of this program? • Do you make a business plan? How often? What is in the business plan

	ASK FOR A DETAILED DESCRIPTION COVERING ALL OF THE PROBING POINTS	for the last quarter? • How do you go about achieving the objectives laid out in the business plan? • How do the financial transactions take place? Who pays the facility? How often? How much? ○ ***For PBF only***: How are incentive payments calculated for the facility? For individual health providers? • How do you spend the money earned through this program? • What outreach services do you provide as a part of this program? • How are various activities under this program monitored? Internally and externally? • What data are collected from this facility as a part of this program? How often? Where is it sent? • What is the process by which quantity and quality scores are verified? • Who provides you with the support and guidance for implementation of this program? • Have you sub-contracted any other health facility? For what services

		and why?
5b.	Can you please describe the user fees charged for various services, such as for ANC, deliveries, outpatient consultations, provided at your facility?	• How were these prices decided for these services?

C. **Changes brought about with NSHIP: Organisational-level**

No.	Guidelines	Probing points
6.	What changes have you experienced at this facility ever since the NSHIP (PBF/DFF) program began? ASK FOR A DETAILED DESCRIPTION COVERING ALL OF THE PROBING POINTS	• Facility structures and inputs? • Additional monetary resources/bonus? Process of financial transactions? Delays in receiving funds? • Management processes? • Supervision and monitoring? • Use of records/registers for decision-making? • Autonomy to make decisions? OR Process by which they make decisions? • Staff relations?

		• Staff knowledge? • Patient volume? Community responsiveness? • Workload? • Improvement in health output indicators?
7.	Can you please rank the three most important changes in your opinion? Why do you consider these three to be the most important?	
8.	**For PBF Only**: Over the last two years (or ever since NSHIP started in your facility), were there any quarters when you did not receive incentives for any particular indicator? What do you consider to be the main reasons for these achievements/shortcomings?	• What efforts did you make to improve upon these missed indicators?
9.	Do you think the NSHIP (PBF/DFF) program has changed the way you work as a team at this health facility? Why or why not?	• How does the staff at your facility make important decisions? For example, how does the staff decide to spend the additional funds?

10.	Can you describe the role that the RBF health facility committee (for PBF)/ward development committee (for DFF) has played in the implementation of this project?	• What is their role in this project? • How often do they meet? • What typically happens during these meetings? • How useful do you think this is for your work? • What are the gaps in the support that you are currently receiving?
11.	**For PBF Facilities only**: Can you describe the role that the "indigent committee" has played in the implementation of this project?	• What is their role in this project? • How often do they meet? • What typically happens during these meetings? • How useful do you think this is for your work? • What are the gaps in the support that you are currently receiving?
12.	How would you describe your interactions with the LGA PHC Department/Hospital Management Board for this program? **For PBF Only**: Are you a member of the LGA	• What is their role in this project? • How often do you meet or speak to them? • What typically happens during these meetings?

	RBF Steering Committee? What is the role of this committee?	• How useful do you think this is for your work? • What are the gaps in the support that you are currently receiving?
13.	How would you describe the support that you are receiving from the state authorities (SPHCDA, SMOH) for this program?	• What is their role in this project? • How often do you meet or speak to them? • What typically happens during these meetings? • How useful do you think this is for your work?
14.	What are your thoughts on the effects of this program on the community? Why?	• What have been the challenges in getting the community to use the services at this facility?
15.	According to you, what further changes in the program design and/or implementation will improve (i) service delivery and quality, (ii) utilization of services by the community, at your facility? Why?	• What are your thoughts on the unit prices of services (charged by the purchaser (SPHCDA))?

D. Changes brought about with NSHIP: Individual-level

No.	Guidelines	Probing points
16.	How has the NSHIP (PBF/DFF) program affected your personal experience of working at this facility? Have any aspects of the program motivated you to perform better? Which ones? Why or why not?	• What have you liked about this program? Why? • What have you learnt from this program? • What has made you discontent with this program? Why?
17.	How do you think this program is affecting your co-workers?	• What do you think they have liked about this program? Why? • What do you think they have learnt from this program? • What do you think has made them discontent with this program? Why?
18.	**For PBF only**: What are your thoughts on the amount of performance-based bonus payments distributed to you?	• Do you consider that the amount is adequate given your workload? Why or why not? • Do you consider that the amount is fairly distributed among all your co-workers? Why or why not?
19.	What changes in the program design and/or implementation will help you perform better?	

20.	**For Facility In-charge only**: How do you provide leadership to your staff for implementing and managing this program? **For the second health provider**: How does the in-charge of this facility/hospital provide leadership to you and others in the staff for implementing and managing this program?	
21.	**For Facility In-charge only**: Do you consider that this program has changed your capability as a manager of this facility? How so?	

IN-DEPTH INTERVIEW (IDI)

Guidelines for Interviews with LGA Primary Health Care (PHC) Department and Hospital Management Board (HMB) Supervisors

I. Procedure of Selecting Participants

The IDI will be conducted in a purposively selected project LGA, covering all project health centers and the general hospital.

Two IDIs will be carried out using this interview guide, with the following purposively selected respondents:

- PHC Coordinator, LGA Primary Health Care (PHC) Department
- In-charge, Hospital Management Board (HMB)

In case not available during the entire length of the team's stay in the LGA/State, then the interview will be carried out with the deputy in-charge of the LGA PHC Department/HMB.

II. Instructions for Facilitators

- This Interview Guide is simply a roadmap for the interview. The broad items suggest the areas that one has to explore. The sub-items under each broad item are possible probe questions.
- However, in some cases, as indicated in the guide itself, all probe points should be asked.
- The facilitator is encouraged to keep a notepad for noting down personal observations or reflexive thoughts.
- Do not prompt the answers to any of the questions, however if you observe that the discussion is completely out of context, you may gently remind the respondent of the present topic of discussion.
- Start with some general discussions with the respondent to build a rapport. Then move on the following guidelines and let the respondent discuss.
- Carry out the interview in a private setting i.e. a separate room where no interruptions are likely.

III. Consent Form

Consent Form for LGA PHC Department/Hospital Management Board Supervisors

Instructions for the Interviewer*: The following is to be read verbatim to the client prior to the consultation and interview. If the subject then agrees to participate, you must sign on the line marked "Witness to Consent Procedures" at the end of this form. Also mark the date on the appropriate line.*

Purpose of research: The purpose of the study is to better understand the implementation of NSHIP in the pilot states. We will ask you some questions about your experiences of implementing NSHIP at your facility. This information will help the Government and its partner organizations to identify aspects of NSHIP that have performed well as well as those which require further improvements.

Study Investigators: This study is being conducted by the Federal Ministry of Health and the World Bank. This study is sponsored by the World Bank, Washington DC, USA.

Expected duration of research and of participant(s)' involvement: This interview will take approximately an hour of your time to complete.

Risks/discomforts: There is no risk in participating in this study. You may feel uncomfortable by the presence of outside observer.

Costs to the participants: Your participation in this research will not cost you anything in money terms.

Benefit(s): You or others participating in this survey will not be paid for being in this study. There is no immediate or direct benefit to you for participating in the survey. However, the information collected through the survey will help the Government and other organizations to further improve the implementation of NSHIP across health facilities.

Confidentiality: Your personal information will not be shared with anyone other than the persons involved with this study. Any report or publication from the study will provide summary information and you will not be identified in any reports or publications by any means. The honesty of your answers is very important.

Voluntariness: Your participation in this study is voluntary and you may decide not to participate. You have the right to discontinue participation at any stage during this

interview. Your decision will not result in any penalty or loss of benefits in any way.
This interview will be audio recorded to help the research team analyse the data in detail. The recordings will be kept in a safe location and only the research team will have access to them. However, you can ask for the recording to be stopped at any time during the interview.

Questions: If you have any questions, please feel free to ask the interviewer at any time during the interview.

Do not agree to be in this research unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

This study has been reviewed and granted approval by the National Health Research Ethics Committee (NHREC), assigned number NHREC/01/01/2007, for the study period of 20 March 2017 to 19 March 2018.

Should you have any queries, feel free to call any of the following contact person(s):SEP Study Contact Person: Dr E. Meribole, Email: meribole@yahoo.com. NHREC Contact Person: Desk Officer for NHREC, Email: deskofficer@nhrec.net; Phone: 08065479926

Statement of person obtaining informed consent:

I have fully explained this research to_____and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

Statement of person giving consent:

I have read the description of the research or have had it translated into and/or read to me in a language I understand. I understand that my participation is voluntary. Based on the information about the research, I have decided to participate in the study. I understand that I may freely stop being a part of this study at any time.

DATE: _____ SIGNATURE: _____

IV. BACKGROUND INFORMATION

1. State:
2. LGA:
3. Name of LGA PHC Department/HMB:
4. Designation at the LGA PHC Department/Hospital Management Board:

---

5. Age:
6. Sex:
7. Highest level of education completed:
8. Length of time working in current role:
9. Length of time working in the sector:

---

10. Name of Facilitator:
11. Name of Recorder:
12. Date of Interview:
13. Start time of Interview:
14. End time of Interview:

V. Semi-structured Interview Guide

C. Background and Current Job Description

No.	Guidelines	Probing points
1.	**Icebreaker**: Can you please tell me a little bit about yourself?	• Where did you grow up? • Where did you study? • Where did you work before?
2.	What are your main roles and responsibilities in your current role at the LGA PHC Department/Hospital Management Board?	• How many health facilities/hospitals come under your supervision? • How often do you visit each health facility/hospital under your supervision per month/quarter? • Who do you work with? Report to?

E. Introduction of NSHIP

No.	Guidelines	Probing points
3.	Is your LGA/State a part of the NSHIP (PBF/DFF) program? Can you please explain why it was introduced in your LGA/state?	• How long has it been in operation? • What is the objective behind it? • What indicators does it seek to improve?

4.	Can you please describe how this program initially started in your LGA/State?	• Were you consulted before the program started? • Did you receive any training? What training did you receive? From whom? What was your experience of the training? • Did you or your department/board enter into any contract for this project? If yes, what did the contract include? Who was this contract with? • Did you receive any funds at the start of the program? How much? For what purpose?
5.	Can you please describe the main role of the LGA PHC Department/HMB in this project? Can you describe the role that you have played in this project over the past two years? ASK FOR A DETAILED DESCRIPTION COVERING ALL OF THE PROBING POINTS	• How do you prepare the business plan/activity plan for the LGA PHC Department/HMB? Who do you submit it to? • How often do you conduct supervision at the facilities under you? • How do you conduct this supervision? What kind of feedback do you provide? • Do you conduct any other meetings with the facilities under you? How often? For what purpose? • Do you provide any training to the providers? How often? For what purpose?

		• Who do you send the results of the supervision to? And how? • How is the performance of the LGA PHC Department/HMB evaluated? How often? • How are performance-based financing payments calculated for the LGA PHC Department/HMB? • How are funds disbursed to the LGA PHC Department/HMB? How often? • FOR PBF LGAs only: Do you attend LGA Steering Committee Meetings? How often? • Who provides you with the support and guidance for implementation of this program?

D. Changes brought about with NSHIP: Organisational-level

No.	Guidelines	Probing points
6.	What changes have you observed in the facilities under your supervision ever since the NSHIP (PBF/DFF) program began? Why do you think these changes have taken place?	• Facility structures and inputs? • Additional monetary resources/bonus? Process of financial transactions? Delays in receiving funds?

	ASK FOR A DETAILED DESCRIPTION COVERING ALL OF THE PROBING POINTS	• Management processes? • Supervision and monitoring? • Use of data for target setting? • Autonomy to make decisions? • Staff relations? • Staff knowledge? • Patient volume? Community responsiveness? • Workload? • Improvement in health output indicators?
7.	Can you please rank the three most important changes in your opinion? Why do you consider these three to be the most important?	
8.	Can you describe which facilities are doing the best/worst as per key project indicators? Based on your experience, can you explain the reasons behind the variation in performance?	• Which services have improved more than others? Why?

9.	What can you say about changes in individual health workers' motivation and performance in the facilities under your supervision? Why do you think this is so?	• Can you please give some examples of changed behaviors among health workers? • How do you think health workers are dealing with the additional workload? • How satisfied do you think the health workers are with the individual bonus payments? Changes in management and institutional processes?
10.	Now, can you describe the changes that you have noticed in the LGA PHC Department/HMB ever since this project was introduced? Why do you think these changes have taken place? ASK FOR A DETAILED DESCRIPTION COVERING ALL OF THE PROBING POINTS	• Management processes? • Supervision and monitoring frequency? • Use of data for target setting? • Autonomy to make decisions? • Staff relations? • Staff knowledge for carrying out supervision?
11.	In the past two financial years, how has the performance of this LGA PHC Department/HMB been in terms of achieving its quarterly performance payments? What do you consider to be the main reasons for	• What indicators were routinely/commonly missed? Why was this the case? • What efforts did you make to improve upon these missed indicators?

	these achievements/shortcomings?	
12.	How have you spent the incentive payments achieved by your LGA PHC Department/HMB over the past two years?	
13.	How would you describe your interactions with the state authorities (SPHCDA) for this program?	• How often do you meet or speak to them? • What typically happens during these meetings? • How useful do you think this is for your work? • What are the gaps in the support that you are currently receiving?
14.	**For PBF Only**: Are you a member of the LGA Steering Committee? If yes, can you describe the role this committee plays in this program?	• How often does it meet? • What typically happens during these meetings? • How useful do you think this committee is for your work? • What are the gaps in the support that you are currently receiving from this committee?
15.	How are data collected and collated by you verified by higher/external agencies?	• How often does this happen? • What happens in cases where discrepancies are found?
16.	What are your thoughts on the effects of this	• What have been the challenges in getting the community to use the services of this

	program on the community? Why?	program?
17.	According to you, what further changes in the program design and/or implementation will improve (i) service delivery and quality at the facilities, (ii) utilization of services by the community, at the facilities?	• What are your thoughts on the unit prices of services?

E. Changes brought about with NSHIP: Individual-level

No.	Guidelines	Probing points
18.	How has the NSHIP (PBF/DFF) program affected your personal experience of working at this LGA PHC Department/HMB? Have any aspects of the program motivated you to perform better? Which ones? Why or why not?	• What have you liked about this program? • What have you learnt from this program? • What challenges have you faced in your work because of this program? • What has made you discontent with this program?
19.	How do you provide leadership to your staff for implementing and managing this program?	
20.	Do you consider that this program has changed your capability as a manager of this LGA PHC Department/HMB? How so?	
21.	What changes in the program design and/or implementation will help **you** perform better?	

VI. Checklist for Information on LGA PHC Department/Hospital Management Board

1. Staff Composition

No.	Designation	Main Responsibility	Carries Out Supervision of NSHIP Facilities (Yes/No)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

2. Number of rooms for official use by LGA PHC Department Staff:

3. Number of vehicles available for staff use:

4. Number of vehicles available specifically for carrying out supervision:

5. Number of computers available and functional for staff use:

6. OBSERVE AND PROVIDE DESCRIPTION OF THE OFFICE SPACE:
   - Please describe the furniture, equipment (TV, AC, etc) available in each of the rooms, their condition, the overall appearance of the office
   - Please ask to see whether an "Activity Calendar" for the Month is available in the office

KEY INFORMANT INTERVIEWS (KII)

Guidelines for Interviews with Key Informants

I. Procedure of Selecting Participants

The KIIs will be conducted with purposively selected respondents at the State and Federal levels, namely:

- State Project Coordinator at the State Program Implementation Unit (PIU) or any one designated by him/her to participate on his/her behalf
- Executive Secretary, State Primary Health Care Development Agency (SPHCDA) or any one designated by him/her to participate on his/her behalf
- Representatives from National Primary Health Care Development Agency
- Representatives from RBF-TA at the Federal and State levels

II. Instructions for Facilitators

- This Interview Guide is simply a roadmap for the interview. The broad items suggest the areas that one has to explore. The sub-items under each broad item are possible probe questions.
- However, in some cases, as indicated in the guide itself, all probe points should be asked.
- The facilitator is encouraged to keep a notepad for noting down personal observations or reflexive thoughts.
- Do not prompt the answers to any of the questions, however if you observe that the discussion is completely out of context, you may gently remind the respondent of the present topic of discussion.
- Start with some general discussions with the respondent to build a rapport. Then move on the following guidelines and let the respondent discuss.
- Carry out the interview in a private setting i.e. a separate room where no interruptions are likely.

III. Consent Form

Purpose of research: The purpose of the study is to better understand the implementation of the Nigeria State Health Investment Project (NSHIP) in the pilot states. We will ask you some questions about your experiences of project implementation. This information will help the Government and its partner organizations to identify aspects of NSHIP that have performed well as well as those which require further improvements.

Study Investigators: This study is being conducted by the Federal Ministry of Health, Nigeria in collaboration with the World Bank.

Expected duration of research and of participant(s)' involvement: This questionnaire will take approximately an hour of your time to complete.

Risks/discomforts: There is no risk in participating in this study. You may feel uncomfortable by the presence of an outside observer.

Costs to the participants: Your participation in this research will not cost you anything in terms of money.

Benefit(s): There is no immediate or direct benefit to you for participating in the study. However, the information collected through the study will help the Government and other organizations to further improve the implementation of NSHIP.

Confidentiality: Your personal information will not be shared with anyone other than the persons involved with this study. Any report or publication from the study will provide summary information and you will not be identified in any reports or publications by any means. The honesty of your answers is very important.

Voluntariness: Your participation in this study is voluntary and you may decide not to participate. You have the right to discontinue participation at any stage during this observation. Your decision will not result in any penalty or loss of benefits in any way.

Questions: If you have any questions, please feel free to ask the interviewer at any time during the interview. OR contact:

Do not agree to be in this research unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

This study has been reviewed and granted approval by the National Health Research Ethics Committee (NHREC), assigned number NHREC/01/01/2007, for the study period of 20 March, 2017 to 19 March, 2018.

Should you have any queries, feel free to call any of the following contact person(s):Study Contact Person: Dr E. Meribole, Email: meribole@yahoo.com. NHREC Contact Person: Desk Officer for NHREC, Email: deskofficer@nhrec.net; Phone: 08065479926

Statement of person obtaining informed consent:

I have fully explained this research to_____and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

Statement of person giving consent:

I have read the description of the research or have had it translated into and/or read to me in a language I understand. I understand that my participation is voluntary. Based on the information about the research, I have decided to participate in the study. I understand that I may freely stop being a part of this study at any time.

DATE: _____ SIGNATURE: _____

IV. BACKGROUND INFORMATION

1. Current Designation:
2. Federal/State Agency:
3. Age:
4. Sex:
5. Highest level of education completed:
6. Length of time working in current role:
7. Length of time working in the sector:

V. Semi-structured Interview Guide

A. Background and current job description

No.	Guidelines	Probing points
1.	**Icebreaker**: Can you please tell me a little bit about yourself?	• Where are you from? • Where did you study? • Where did you work before?
2.	Can you please describe the main role of your organization (SPIU/SPHCDA/NPHCDA/RBFTA) in NSHIP? How has it evolved over time? Can you describe the role that you have played in this project over the past two years?	• Purchasing services and contracting? • Collating and approving of business/activity plans? • Verification and counter-verification of quality and quantity? • Providing training, mentoring, supervision? • Disbursing funds? • Strengthening institutional structures?

B. Experiences of NSHIP Implementation

No.	Guidelines	Probing points
3.	What has been your experience of implementing NSHIP? Implementation with regard to the following: • Purchasing and contracting?	• What have been the main achievements? • What have been the main challenges? • What has been the main learning so far? • How has the experience been different for PBF and DFF LGAs?

	• Collating and approving of business/activity plans? Verification and counter-verification of quality and quantity? • Providing training, mentoring, supervision? • Disbursing funds? • Strengthening institutional structures?	
4.	How would you describe your interactions with other institutional structures and authorities at the state (SPIU/SPHCDA/SMOH/HMB) and federal (NPHCDA) levels for this program?	• Who provides you technical and administrative support? How?

C. **Changes brought about with NSHIP**

No.	Guidelines	Probing points
5.	According to you, what are the main changes that have taken place at the *facility* level? How do they differ between PHCs and General Hospitals? How do they differ for PBF and DFF LGAs?	• Which services have improved more than others? Why? • What are the main changes in institutional processes? • What are the main changes in health provider knowledge, practice and behaviors?

6.	According to you, what are the main changes that have taken place at the *LGA* level? How do they differ for PBF and DFF LGAs?	• Management processes? • Supervision and monitoring frequency? • Use of data for target setting? • Autonomy to make decisions? • Staff relations? • Staff knowledge for carrying out supervision?
7.	According to you, which PBF LGA has performed the best/worst? Why? According to you, which DFF LGA has performed the best/worst? Why?	• How are they able to assess performance?
8.	According to you, what are the main changes that have taken place at the *organisational and institutional* level as a whole?	• New institutional structures? • Management processes? • Use of data for target setting? • Transparency and accountability mechanisms? • Additional resources? • Capacity building?
9.	In the past two financial years, how has the performance of the state(s) been in terms of achieving their DLI payments for LGAs and the state? How was the performance assessed? What do you consider to be the main reasons for these achievements/shortcomings?	• What indicators were missed? Why was this the case? • What efforts were made to improve upon these missed indicators?
10.	What are your thoughts on the effects of this	• What have been the challenges in working with the community for this program?

	program on the community? Why? How do they differ for PBF and DFF LGAs?	
10a.	What have been the noted discrepancies at the facility and LGA levels? What actions were taken? What changes have been observed in the performance of those facilities and LGAs since?	•

D. **Future vision for NSHIP**

No.	Guidelines	Probing points
11.	According to you, what further changes in the program design and/or implementation will improve (i) service delivery and quality at the facilities, (ii) utilization of services by the community, at the facilities (iii) institutional and management mechanisms?	
12.	According to you, what is the vision for NSHIP among stakeholders in your state? What are your thoughts about its sustainability (both financial and institutional) after the pilot phase? What dialogue has taken place, if any, to address the issue of sustainability?	