Whose Accountability?

Participation and Partnership in a Disabling Environment

Sam Unom*

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1 Introduction

This article reviews the development of community participation and accountability under the auspices of a donor-funded basic health services project in Benue State, Nigeria. It is divided into four main sections. In the first section, we revisit the key features of the disabling environment in which the three-year Benue Health Fund Project had to take forward the notion of participation. This is vital background information within which to situate the project's work. It is also important because a major theme of the article is the centrality of context to participation and partnership. In the second section, the purpose, outputs, structure and modus operandi of the Benue Health Fund Project are introduced. Certain thoughts about health sector partnerships as found in the original document are teased out to indicate the project's perspective on the subject. The third section focuses on some of the strategies and mechanisms the BHF has been using to develop partnership. The strategies are analysed in terms of their relevance to strengthening representation, enhancing capacity of community actors, ensuring inclusion and re-orienting policymakers. In the fourth section, the experience of the project is reviewed in terms of the lessons that might be learnt for future work.

2 Poverty, Community and Health in Benue State

2.1 Context of poverty and policy

Benue, an agrarian state in Nigeria's North Central zone, is among the poorest of the country's 36 states. Sixty-five percent of the 3.5 million citizens is poor (live on less than $0.27 per day); over 25% of the population lives in extreme poverty (live on

*As the DFID-Benue Health Fund Project's Stakeholder Liaison and Co-ordination Officer, the author was a member of the Social Development-PHC core team responsible for facilitating community participation in the planning and management of health and health care services in Benue State, Nigeria. He is currently Project Officer for the DFID-funded Good Governance Project of the British Council in Nigeria. The Project is working with Nigerian governments and civil society groups to strengthen accountability, human and people's rights, democratic practices and the place of women in public life.

E-mail: sam.unom@BC-Abuja.bc.org

less than $0.02 per day). Overall human development standards are at or below national average. Nearly 70% of adults have not been to school. Only 10% of the population have access to clean water. As at 1996, poverty-related health indicators were among the worst in the country. Forty-six percent of rural dwellers live more than 10 km. from the nearest health facility (and roads covered with asphalt serve only 10% of the population). Benue has the highest number of citizens per doctor in Nigeria.[1]

This state of poverty, of course, is itself largely explained by the prolonged absence in Nigeria, under unstable and corrupt military rule, of an enforceable contract specifying rights and responsibilities between the government and the governed.[2] Citing the need 'to bring government closer to the people', successive military rulers changed the country's federal structure from the three regions at independence to 36 states and 774 local government areas (LGAs). But as most of these are not economically viable and have not been able to raise their own revenue, both states and LGAs have depended for their budget on their statutory share from the federation account. This dependence was seized upon by the centralised high command to limit the autonomy of state military administrations and the appointed local authorities under them.

As for the people to whom government was being brought closer, there were severe limitations even on civil and political rights and no provision for holding officials to account over their actions or inaction. Hence the appropriateness of the question 'whose accountability?' There were no representative institutions and no avenues for popular participation at any level. The series of LGA creation exercises did not make local authorities any less unresponsive or unaccountable, owing their mandate, such as it was, to state military administrators. Until the democratic transition, most of the state civil servants deployed to head the LGAs were not even local people; yet they were responsible for formulating and implementing development policies in these areas.

Benue was particularly vulnerable to the policy failures and instability in Nigeria under military rule. There have been fourteen different administrations since the state was created in 1976. Soldiers have headed eleven of these administrations, all but one of whom came from outside the state. At the LGA level the fact that BHF has had to work with four sets of LGA chairmen since 1997 is indicative of similar discontinuity. Two sets of chairman were in fact unelected state civil servants sent in from other places.

For the Benue Health Fund Project the situation had practical implications for the attempt to develop partnership. As the recent DFID/WB Participatory Poverty Assessment (PPA) in the country has shown[3], Nigeria's poor increasingly interpret their poverty as an 'overwhelming denial indicated by social and personal isolation and powerlessness'. For this reason they (as many of the non-poor) have now come to completely distrust external interventions.[4] Individuals as well as whole communities increasingly came to rely completely on their own means for their survival. Given this absence of trust and the breakdown in relations between the people and the government it would have been foolhardy to expect that public services and officials *in any sector* will feel any pressure to be accountable.

2.2 The health sector

Public-sector health care development in Nigeria is the joint responsibility of all three tiers of government. The Federal Ministry of Health (FMoH) developed the National Health Policy in 1988. Under its provisions State Ministries of Health (SMoHs) are responsible for secondary health care policy and planning, based on national guidelines. The LGAs have responsibility for primary health care (PHC), with technical support from the National Primary Health Care Development Agency (NPHCDA) through the PHC directorates of the SMoHs.

Health care financing at both secondary health care (SHC) and PHC levels depends on the states and LGAs' statutory share from the federation account. Internal revenue generation has remained unviable over time, as we have noted, and as oil revenues fluctuated these tiers of government found themselves increasingly unable to resource their health care services. Annual per capita health expenditure in Benue state is estimated at $1.3, compared with the target of $13 per capita set by the World Bank's Better Health Initiative in Africa.

At the inception of the BHF, formal health care services were skeletal, of very poor quality and for most people inaccessible (cost-wise and physically). Seventy-five percent of services was provided by the voluntary sector (notably missions), with the remaining 25% split between public and private sector services. However, there was little coordination in policy and programmes between these sectors. Communication and coordination across the different levels of the service were poor and data for planning and management sparse. Roles, responsibilities and powers of the organisations involved in health care were not clearly defined. An irrational pattern of services emerged wherein competition was rife.

In addition, the highly centralised management systems precluded service centres from decision–making and control over the most routine of matters at both the PHC and SHC levels. The Hospitals Management Board (HMB), the SMoH parastatal, ran the eight state hospitals from the state capital until a new edict was enacted in the course of the project design in 1995. The situation with the voluntary sector was not significantly different. The NKST (see note 11) and the Catholic hospitals had their Management Committees, but they were only advisory and not representative.

In the LGAs, chairmen and perhaps senior professional staff decided policy and determined management.[5] Despite the fact that many of the LGA-run PHC centres had been built by communities, local people had little say in how these were run. Interaction between staff and local people did not develop beyond service provision and the passing on of notices regarding annual immunisation campaigns.

This centralisation and 'professionalisation' of decision-making and management left little room for the development of an accountable health care service. Users had no facility for questioning service providers where professional behaviour was directed from the top and where health 'knowledge' was the exclusive preserve of professionals. As both supervision and supplies were irregular and spurious, induced only by the prospect of personal gain, staff were practically abandoned to run their own show as they found expedient. The consequence of all these was the collapse of the formal health system, as people turned to unregulated options or simply went without health care.

2.3 Community organisation and health-related decision-making

The state is inhabited predominantly by the Tiv (72%) and Idoma (27%) ethnic groups. The Tiv tend to live in scattered homesteads while the Idoma live more in nucleated villages. The basic unit of social organisation for both groups is the household, comprising a man, his wife or wives, their children and the wives and children of his sons. Households are linked to each other through patrilineal descent. Communities are formed by groups of households whose heads trace their descent through the male line to a common ancestor. These may or may not live in the same settlement. A community might therefore extend beyond a single settlement in the same way that several communities might inhabit a settlement.

Poverty manifests at the household and community levels. Disparities across communities relate to such factors as poor soil fertility, lack of nearby services and infrastructure and the absence of viable local institutions and leadership. Within the household, poverty is related to age, gender and education of household head, the ratio of wage earners to dependants, and the distance of the household from markets, schools and potable. The poorest and most vulnerable are the socially isolated, who are unable to earn an income and have no one to count on for support in times of personal crisis.[6]

Benue communities tend to have a single, central local level organisation, formally called Community Development Associations (CDAs) but often known to community members as 'meeting'. These meetings are run by committees comprised of men (including tax collectors and traditional rulers) nominated from the constituent households, lineages, kindreds or clans. The CDAs spearhead community initiatives in building and running schools, clinics and rural infrastructure. There are other economic and cultural organisations formed by or inclusive of women, youths, age grades, widows, church members and migrants, but these have relatively little influence in deciding key sociopolitical issues. This is despite the fact that their members contribute labour for communal tasks (construction of roads, bridges, buildings, etc.).

The men are also responsible for decision-making at the household level. Thus, while women care for sick household members and are responsible in practical terms for the general well-being of the household, it is men who control household budgets. The men take decisions on treatment seeking, including where and with what assistance women give birth.[7]

2.4 The influence of the setting

It is accepted that community involvement in health CIH, as a basic principle of health development, relates to and is influenced by extant political and economic conditions. Four such 'environmental preconditions' have been noted, viz.:

- Political commitment to CIH and to participation in general
- A process of bureaucratic re-orientation in favour of delegation to local authorities
- Capacity development to enable people to take responsibility for the process
- The existence of a minimum structure for health.[8]

From what we have seen here all of these conditions were absent. To this we will also add the problems of social capital as reflected in the collapse of extra-community relations and cultural limits imposed on participation within the communities. All these elements constrained the BHF as an externally driven project aiming to introduce such fundamental changes as those described below.

3 Project Background and Description

The Department for International Development (DFID) (then ODA – Overseas Development Agency) has been exploring options for supporting health services in Benue state since 1991. At first the plan was to rehabilitate selected hospitals in partnership with the State Ministry of Health. Later, emphasis was placed on strengthening PHC with the aim of supporting improvements in quality, management and funding of PHC services in selected LGAs in line with the Bamako Initiative approach. This would be complemented by the rehabilitation of the referral SHC facilities serving these areas. But the initial design of the SHC component was seen as too elaborate and unaffordable for the Benue state government, and it was not until October 1995 that a team of consultants submitted a re-designed proposal.

The project originally proposed to support secondary health care in partnership with the SMoH. A Project Steering Committee comprised of senior health professionals and managers under the overall direction of the SMoH Director-General was to have a planning and monitoring role. However, DFID later emphasised the need to strengthen the PHC component as well, wherein the LGAs were also brought on board. However, following the adoption of the EU's Common Position on Nigeria in 1995, DFID could no longer enter into direct partnership with the state military government. Hence the project's abnormal formal partnership with the Hospitals Management Board (HMB) as a parastatal and not the SMoH.[9]

The Benue Health Fund Project was started on the basis of this abnormal partnership in January 1997. Its goal was 'to protect the health status of the population of Benue State (pop. 3.5m), especially its poor and vulnerable groups.' To achieve this, the project would seek 'to improve the coverage, utilisation and quality of basic health services in seven local government areas (pop 1.2m) of the State and to develop a blueprint for replication elsewhere.'

The project had five outputs[10] at the onset, around which its work was organised. These aimed to:

- Establish a Health Fund, with a representative management committee, to resource health institutions
- Enhance PHC services in the seven local government areas
- Refurbish, re-equip and improve services at five SHC hospitals
- Ensure efficient management of human, financial and physical resources in all participating institutions
- Empower communities to plan and manage improvements in their own health care.

A Project Advisory Committee (PAC) comprised of representatives of the major institutional stakeholders and chaired by the project manager oversees the allocation of project resources from the Health Fund. Institutional stakeholders include the:

- National Primary Health Care Development Agency (NPHCDA)
- SMoH
- HMB
- Five hospitals (three government and two mission hospitals) serving as secondary referral centres for people in the seven target LGAs
- NKST mission[11]
- Seven LGAs and the PHC centres in these LGAs
- School of Health Technology which provides basic training to PHC-level workers and lab technicians.

The PAC considers proposals by stakeholders against a set of criteria agreed by them. A Project Manager who is a DFID SHC specialist runs the project in conjunction with other specialists in PHC and social development. They and their local counterparts constitute the PAC Secretariat, which reviews sub-projects in advance of the quarterly full PAC meetings.

Neither the 33 'focal' communities (communities empowered to access the fund for special sub-projects supportive of community health or health care), nor the remaining 130 communities, where BHF works through the PHC facility, are directly represented on the PAC. This has been a bone of contention throughout the life of the project.

Major work undertaken to date (which we shall be referring to in this article) includes:

- quantitative and qualitative baseline surveys (using PRA)
- The establishment of PHC and HMC committees and capacity development for community members and health providers and managers
- The establishment of drug revolving funds,
- refurbishment of the five hospitals
- Piloting of payment deferrals and exemptions schemes (at both PHC and SHC levels)
- quality of care training for health workers
- Initiation of health promotion and adolescent sexual health programmes.

The first phase of the Benue Health Fund Project was scheduled to end in December 1999. Following a review, a 27-month extension has been approved. The project's social development, PHC and SHC core teams worked with stakeholders and a visiting team to review progress and draw plans for the extension period.

3.1 The BHF approach

While Output 5 clearly states the objective of community empowerment, there is no single statement of purpose regarding the project's strategy for partnership development. However, both the design document and the criteria set for access to the Health Fund provide for:

- Ensuring community involvement in planning and decision-making
- Ensuring community participation in the generation, analyses and dissemination of health-related information
- Enhancing community-level action planning for health supported by increased decentralisation of planning
- Strengthening linkages between empowered community organisations and health providers and managers at all levels.

It is obvious from these targets that the project's approach is consistent with what the WHO describes as community involvement in health (CIH). In distinguishing the concept of participation from CIH, a WHO Study Group notes that the latter is 'broader and more action-oriented'. It conceives CIH to mean, among other components, 'a partnership between individuals, groups, organisations, and health professionals, in which all parties examine the roots of health development processes, and in which all the participants come together to discuss issues and feasible solutions and to agree upon a course of action.'[12]

4 Facing the Challenge

The challenge the project has faced, we have seen, was to develop a functional health care system out of the wide range of overlapping and often conflicting health services on offer. A major component of this challenge was the need to re-introduce the notion of rights to health and thereby ensure community involvement in health care planning and management.

In the study cited above, the WHO identified a number of support mechanisms that need to be developed for effective CIH. These include:

- Strengthening representation on all decision-making bodies
- Developing the capacity of the newly empowered decision-makers
- Ensuring an inclusive process of sub-project planning and implementation
- Re-orienting policymakers, professional health managers and staff towards working with communities.

The following review is structured in terms of progress made in developing these mechanisms.

4.1 Strengthening representation

We have already noted that a new HMB edict was required to free the hospitals from direct state control. The hospitals then signed a charter that assigned responsibility for local management to a representative Hospital Management Committee (HMC). The charter, which was discussed and agreed at a workshop, stipulated that HMCs would:

- Set fees
- Draw budgets covering operations and management costs[13]
- Establish financial management
- Establish appropriate staffing arrangements
- Have a baseline audit of systems.

At the PHC level, each participating LGA signed a Memorandum of Understanding agreeing to have a PHCMC comprising representatives of the stakeholders, and below it, VDCs (in accordance with national guidelines), which will be responsible for health care planning and management at those levels.[14] Concerning the VDCs, it was stipulated that 'there should be members that represent women (at least two) and the youth of the community' and that the committee must be 'acceptable to the community as whole, not just a small section of it'.

Three Community Resource Persons (CRPs) comprising one opinion leader or community elder, one woman leader, and one youth leader, have also been identified in each community to work with various groups in developing fundable proposals for improving health. Similarly, the management committees (MANCOMs) raised for the community-based deferrals and exemptions schemes include old and young men and women, as well as a representative of the poor and vulnerable.

The PAC comprises representatives from the PHCMCs, HMCs, the NKST, HMB and the SMoH.

4.2 Developing capacity for participation

Initial capacity development efforts focused on ensuring that the newly empowered groups had the interest, trust and capacity to exercise their right to participate. Their interest in participation was established during both the 10-day qualitative baseline survey visits and the 1-day rapid appraisals, when project teams would work with various groups of people using a range of PRA/PLA tools over a day period.

As to the trickier question of trust, the project benefited from the fond memories held by local elders of the efficiency of white missionaries. The involvement of the 'white man' (a term also used for Britons specifically), and the presence in the survey team of a trusted local person)[15] provided a point of entry. What was now required was consolidation.

Promoting participation

The main vehicles used in the initial period to promote the idea of community involvement were community visits, community drama and 'night halts'. These promoted the idea of community ownership of the process. Using community drama as a major tool, community members (this time including women, youths and the disabled) during night halts analysed the causes of previous failures of the formal health care system, including the collapse of clinical care. They invariably determined that reform must provide for community involvement and that they were willing to take responsibility for the process.

They also understood community involvement to mean that communities would plan and manage improvements in their own health care through their VDCs. The functions of the VDC were specified to include managing the PHC centres, planning and implementing health projects in the community and ensuring the access of all community members to health services irrespective of their ability to pay. It was particularly stressed that 'the community must feel that it will be possible for them to monitor and reprimand the committee (VDC) should there be any financial impropriety.' On the other hand the VDC have oversight of the

clinic staff, whom they are to evaluate regularly. The essence of the dispensation was captured in the song which emphasised that the drugs were the property of the community (and not the LGA or BHF) and that the community would not allow anyone to interfere with them.[16] They understood community ownership to mean that the VDC had overall responsibility for health care development in the community.

Training

A programme of training was developed to skill the PHCMCs to support the participation and also to equip the VDCs to assume their responsibilities. On the basis of this programme the project organised a series of participatory training workshops. The first series of PHCMC workshops focused on the objectives, structure, approach and modalities of the BHF, as well as the tools, attitudes and behaviour required for participatory development. In the second series, a sub-group of five PHCMC members, known as 'the outreach group', were further strengthened in those respects to enable them work with the focal communities in designing, planning and monitoring community-level sub-projects.

The project also ran a series of training workshops to develop the capacity of the VDCs to perform their functions. The first workshops focused on building the skills of VDC members in managing the DRF. A lot hung on the success of the DRF. One lesson suggested from the baseline surveys was that utilisation levels had dropped because drugs had either been unavailable, ineffective or expensive. It was important, therefore, that the clinics become associated with the availability of potent and affordable essential drugs. This would also go on to further establish trust. The initial training, therefore, focused on DRF management and clinic development. Six key members of each VDC participated, along with relevant LGA staff.

The CRPs also received training in community mobilisation and PRA attitudes and techniques for participatory sub-project development, specifically towards identifying health and health care development projects. The groups use a number of PRA/PLA tools selected for their relevance to the context and their user-friendliness (see Appendix). Together with their shadows, they have been supported by the VDCs (logistics and mobilisation) and outreach groups (technical) to identify sub-projects and develop plans and budgets for implementation. They have since submitted proposals from various community groups, including widows, other women and the disabled.

As for ensuring access to health services, the Deferrals and Exemptions MANCOMs from the six communities in which D&E schemes are being piloted have since received training and have assumed their functions. The training focused on sustainable funding, record-keeping, planning and management, community mobilisation, wealth ranking and liaison with those listed by their communities for exemptions. Each five-person MANCOM includes men and women, a youth leader and a representative of those too poor to pay (invariably one of those on the exemption list). The communities fund the scheme with only an initial one-off matching grant from BHF.

At the SHC level, the Project has trained HMCs in planning, budgeting, monitoring and supervision.

Research

Participatory action research has been conducted regarding community experiences in the two priority areas of need, namely, malaria control and environmental hygiene. An IEC programme is being developed on the basis of the research and is to be implemented jointly with local people. It is envisaged that the IEC will improve health awareness and increase knowledge among community members. Community members should improve their ability to question their providers. On-going user surveys will also provide information for inputting into quality of care and then also for the community sentinel monitoring that is planned for the extension phase.

All three institutions – VDC, CRP and MANCOM – are directly answerable to the community. However, they work in close collaboration. In addition, at least one CRP and one MANCOM member of each community also sits on the VDC, as part of an arrangement to strengthen linkages and coordination. VDC representatives and one CRP per community attended the MANCOM training.

4.3 Ensuring inclusion in sub-project planning and implementation

The guiding principle of the sub-project approvals process is that projects are not only justified in terms of their impact on health, but that beneficiaries include the poor and vulnerable. Community involvement and impact on the poor and vulnerable are among the eleven criteria used to assess applications. Also, applications are encouraged from women, widows and the disabled. Community-based sub-projects are planned by the communities and implemented with their counterpart contribution (in cash and in kind). Community members must state that they are satisfied before contractors and BHF sign off.

4.4 Re-orientation of policymakers, professional health managers and staff

LGA officials, PHCMCs and professional staff have been sensitised via workshops and example towards working with communities in a new partnership that goes beyond passing down notices about immunisation to community-led planning and management. Advocacy workshops have been organised for top LGA officials, while several partnership development training events have been held for PHCMC members and the outreach groups.

5 Appraisal

Although the BHF approach as outlined above is enshrined in various project papers, participation, community involvement and partnership have remained contested concepts.[17] Hence project partners and staff do not necessarily share the same understanding and appreciation of the value of community involvement.

Some project staff see CIH as a means to an end, in this case as an instrument towards achieving a specific output. Following this interpretation community involvement is only one element in the overall objective of the project, an objective that is essentially medical. Others see community involvement as an end in itself, wherein it is understood that people participate because it is their right. Some confuse participation with consultation; others see little value in it. These variations in interpretations have their methodological implications, and as far as achieving project purpose is concerned the divergent views are an important disabling factor.[18] It is therefore important that team members themselves have a shared understanding of the approach and strategy before setting out to develop CIH.

The Benue Health Fund Project has nevertheless made considerable progress towards meeting most of its targets for CIH. The project has gone a long way in strengthening representation on the decision-making bodies. However, progress still needs to be made in ensuring that powerful local leaders do not manipulate nomination onto these bodies. In a number of cases exclusive caucuses of elderly men have selected women and youth representatives. Also, community representatives on the HMCs and PHCMCs are often appointed and therefore do not come through a process of democratic selection. The lesson the project has learned is that quotas are by themselves not enough to encourage democratic representation. One experimental response has been to try to work with the various constituencies directly to develop a shortlist of their preferred representatives, which is then discussed with community leaders or at the community meeting. This approach has been tried with some success in the selection of CRPs.

Most of the community-based institutions have been effective in taking on the responsibility of community involvement. VDCs have generally been successful in managing the DRFs and overseeing the clinics. The VDCs have also been managing the clinic renovation funded by the project. Following technical assessment and a process of consulation with the VDCs, funds have been allocated to the VDC to administer as required. In some areas there have been doubts about the cost and quality of purchases being made by the VDC, but as the programme is not planned with the direct involvement of community members it is difficult for them to question its implementation.

In a few cases VDC supervision of staff has not been as close as envisaged in the reforms. Some VDCs have asked for further training, pointing out that their limited understanding prevents them from effectively monitoring stock level vis-à-vis utilisation. Moreover, community input into quality of care training and standards has not been fully developed, and so local people do not know what

questions to ask and what standards to expect. The idea of rights in health has not quite settled among community members, although few expect an instant transition from the breakdown in relations with the state.[19]

The fear is that in some instances VDCs and other community members have somehow been intimidated by their limited understanding of technical matters. In other instances, staff have accused the VDCs of not adequately fulfilling the promises made during workshops, namely, to encourage staff by providing them with farmlands and accommodation near the clinic. In any case not all VDCs are completing the monthly staff appraisal forms.[20]

Perhaps there is a lesson here about the sequencing of reform components. Is it possible that community-led health promotion, informed by local people's experiences, and quality of care standards, set through a participatory process, are important at the beginning to ensure a shared understanding of acceptable standards? Without this, communities have been unable to monitor effectively the performance of their health workers. Staff have attended the VDC workshops; it might be useful to allow the VDCs to return the favour. This will enhance a shared understanding of the issues and bridge communication gaps that might later arise in the course of VDC–staff relations.

CRPs have been facilitating sub-project development in the focal communities with PLA tools (see Appendix). The project has received over 100 proposals initiated through this system (about a third of which have been approved for funding), an average of three per community. These tend to be requests to improve physical and financial access to clinics/hospitals and markets as well as water and sanitation. The words for health in both Tiv and Idoma convey the idea of well being. Communities apparently rely on this broad understanding of the meaning of health. But reviews have determined these to be outside the scope of the project, and communities are now being encouraged to focus on health care sub-projects. The project has been flexible enough to accommodate the communities in the first phase while planning a re-orientation of CRPs ahead of the second phase. DFID also continues to fund agricultural and water and sanitation projects in the state and is currently exploring another project to strengthen LGA systems and capacity so that this tier of government can do what is after all its job. However, the divergence of perspectives between the project and its primary stakeholders has been a sore point in project-community relations, and is indicative of problems that arise with inequality between partners.

Community participation in PHCMCs and HMCs, though formally provided for, is undermined in certain instances by the infrequency of meetings. Members of one PHCMC have failed to meet for nearly a year after being trained. HMCs have fared better, but they have not had much interaction with community members. Many members of these bodies are very busy people. Perhaps the lesson here is that representation is better enhanced where non-professional committee members are actually democratically elected from their constituencies, in which case they will have to answer to their electorate. Perhaps this would also ensure that only those interested and available will sit on the committees.

Linkages are being developed between community-based institutions and increasingly between this level and the LGAs. Linkages will be developed between the CDAs/CBOs and policymakers and managers at the PHC and SHC levels in the extension phase of the project. Referral links will also be strengthened in the areas of clinical services as well as D&E and supervision. These links will improve community input into the development and monitoring of quality and standards at all levels. Without such direct community involvement with policymakers and providers participation at the community-level may not result in improved accountability.

Finally, it is important in a context as disabling as the one in which the project has had to work that the partnership development process should be consolidated at the policy level at the earliest opportunity. There is no basis to expect a model of partnership and accountability in a disabling environment such as described here. Such an environment places a premium on opportunism and planning for diversity, which makes strategic planning very difficult. In such circumstances only opportunism can be considered a model. The point is well made that participation and accountability

are not stand-alone processes and must be supported by an enabling environment. The new state government's official development plan acknowledges the role of BHF and notes that some aspects of its work might be replicated straight away. The project will be facilitating the strategic planning process in collaboration with the SMoH, hence the new Output 1. The process of joint analysis and planning, it is hoped, will be marked by active discussion and engagement between users and providers at all levels and across all sectors. The findings will be summarised into briefing papers for political leaders, and further disseminated through the media and at community meetings. It is envisaged that this process of engagement will open up the system to all stakeholders and engender greater involvement. This should result in greater accountability of policy makers, managers and providers, in the broader context of the development of democracy and transparency.

Notes

1. Sources: *Nigeria Poverty Profile 1980–1996*, FOS, Abuja, 1999; *1998 Nigeria Human Development Report*, UNDP, New York, 1999; Graham Gass *et al.*, Findings of the BHF Qualitative Baseline Survey, BHF, Makurdi, 1998 (unpublished)
2. It has been suggested that it is possible for autocratic regimes to engineer socioeconomic and political change. This might be true in other regions, but Nigeria's military led the field of self-serving Sub-Saharan dictatorships.
3. Benue was one of the study sites.
4. All BHF qualitative assessments have found that local people consider trustworthiness a critical precondition, not only in the choice of health provider, but also in deciding their partnerships. See for e.g. Graham Gass *et al.*, *op.cit.*; Anyebe *et al.*, *Poverty, Practices and Preferences: Deferring and Exempting Payment for Health Care in Rural Benue*, BHF, 1999; for the World Bank/DFID study, see *Consultations with the Poor: Nigeria PPA Country Report, 1999*; for an earlier assessment see also Paul Francis *et al.*, *State, Community and Local Development in Nigeria*, World Bank, Washington, 1994.
5. It might be argued that LGA officials, where they are elected, are representatives of the people. In this case they were mostly appointed, or in any case without a forum for continued consultation with the people.
6. Gass *et al.*
7. It is the husband who decides if the wife will deliver by herself, use a TBA, or go to the clinic.
8. See Peter Oakley, *Projects With People*, ILO, 1994.
9. The idea of a Steering Committee became untenable for the same reason.
10. The project's outputs have been updated for the extension phase, with a new output on strategic planning in place of outputs 1 and 4 and another on M&E.
11. The abbreviation stands for Church of Christ in the Sudan among the Tiv, a Protestant denomination formerly run by the Sudan United Mission. The NKST runs a large health service across Tivland.
12. *Community Involvement in Health: Challenging the Health Services*, WHO, 1989
13. Staff at government-owned facilities are on the central payroll.
14. The mission set-up was to be similarly re-structured.
15. This is a respected academic and consultant who was not associated with corruption while in government.
16. Even though the seed stock was provided by the BHF with only token community contribution, the community had responsibility for its sustainable mangement, as BHF made no provision for its recapitalisation.
17. See WHO, pp. 10–11 for the spectrum of interpretations, ranging from conventional planning with blank spaces for local input to an approach which advocates open space on which the community will draw.
18. One example: among sub-project funding criteria is the stipulation that communities must make a counterpart contribution on all their sub-projects, as a way of enhancing ownership and sustainability. But the clinic renovation programme is wholly funded by BHF because the communities are adjudged too poor to pay!
19. Community members are reluctant to approach the LGA for counterpart funding of community sub-projects because they feel it is futile. The situation should improve when the elected governments start to deliver on their promises of partnership made at the advocacy workshops.
20. Until the democratic transition it did not matter anyway, as staff could still pull strings back at the LGA, whereas VDCs could not. Thus, even the most vigilant VDC could only hope that its appraisal of health staff would not be thrown into the wastebasket.