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Summary Report
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Nigeria

Demonstration social audit (multi stakeholder surveillance): Cross River state 2006

CIET Trust

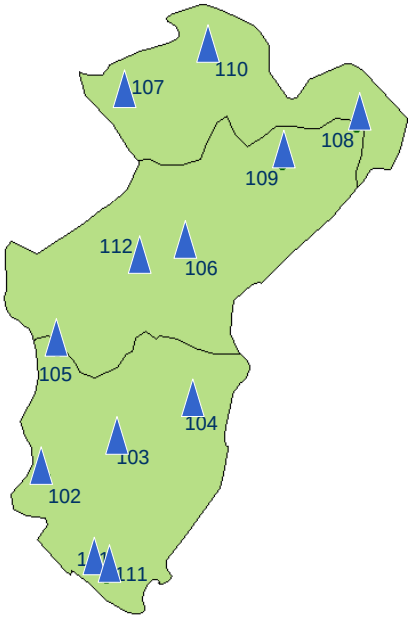
SUMMARY

Cross River State

Multi Stakeholder Surveillance Demonstration

Participants

Locally trained researchers interviewed a total of 1576 households in 12 sites in Cross River State, including a sample of 7623 people. Some 48% (748/1576) were female. Some 62% (987/1576) were rural. The sampling drew randomly from rural and urban areas in order to give findings representative of the state.



Methods

As the 12 sites spoke no less than eight languages, the demonstration did not permit full translation and testing of the survey instruments/questionnaires. This will be an important provision in any rollout. In addition to obtaining general information about overall and recent usage of health services, interviewers also asked about health care related to specific events such as deliveries in the last two years (n=496) and fever episodes (n=641) since January 2006. To enhance household perspectives, the field teams completed a community profile with the village chief/head and visited a nearby government health facility to interview the health worker present (12 key informant interviews). Within two weeks of conducting household interviews, trained facilitators returned to the same communities to hold focus group discussions.

Usual sources of medical treatment

Source of medical treatment	Cross River N=1575
Government	48.4%
Private	13.0%
Traditional	2.9%
Pharmacy	23.4%
Church	2.0%
Self	10.3%

Findings

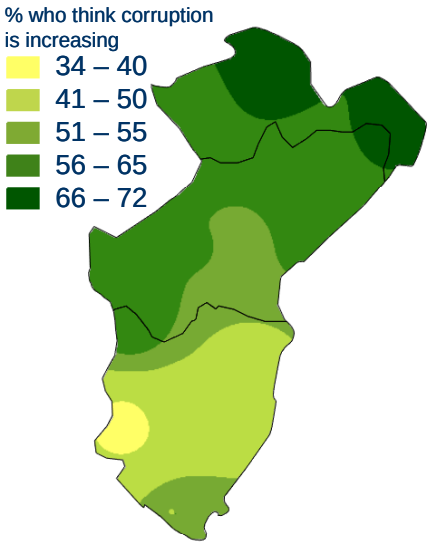
Access to services: Nearly half 48% (753/1575) of the households reported going to a government facility for medical care while 41% went when they were last ill. Yet some 67.9% (1036/1574) said they would use government services in the future to treat a case of pneumonia. Respondents also consulted pharmacies (23.4%), private clinics (13%) and treated themselves at home (10.3%).

Alternate source of treatment used when last sick by those who would normally use government services

Source of treatment last sought	Cross River N=190
Private	19.3%
Traditional	4.1%
Pharmacy	24.5%
Church	0.8%
Self	51.3%

Proportion saying they were satisfied with the service received at last visit

Facility used when last sick	Cross River
Government	88%
Private	91%
Traditional	90%
Pharmacy	89%



Vulnerability Index: The MSS demonstration began the process of identifying and characterizing vulnerable households. Its analysis found such households characterised by several aspects, including level of education of the household head, food supply, type of housing and the length of time occupants had lived in the area. A vulnerability index is only relevant, however, in its ability to predict certain practical disadvantage, like lack of access to services, more obligations to make unofficial payments or worse attitudes of health workers. Evolution of this approach is a necessary part of the rollout.

Satisfaction with services: Six out of ten 66% (459/699) regular government service users were satisfied or very satisfied with government health services. When rating their most recent experience in a government health facility, 88% (482/550) expressed satisfaction, indicating that respondents could be generally unsatisfied with government services yet remain positive about their own experience. Some 74% of the dissatisfied users were still satisfied with the treatment received at their last visit. Respondents suggested changes such as reducing the cost of health services (36%) increasing the variety and type of medications (29%) and improving the physical plant (26%). This indicates a “public view” of public services that could be addressed if clearly understood.

*Corruption***:** Only 3% (51/1572) of households reported making an unofficial payment. Yet when asked whether they thought government corruption was increasing or decreasing, some 68% (879/1295) said that it was increasing. Respondents identified the main forms of corruption as patronage 20% (307/1574) and asking for money/bribes 39% (597/1574). Opinions about corruption in government services overall and episodes of personally experienced corruption do not appear to match. The focus groups confirmed these early findings. While participants were adamant that they did not make unofficial payments it emerged that often they did not know what they should be paying for treatment. Focus group discussion also revealed valuable descriptions of how charges are justified (for example, requesting 2000 naira for gas to bring

the doctor). In a larger cycle it will be extremely useful to convert this newly learned corruption terminology into survey questions that can quantify the real rate of corruption in health services and the ways in which it occurs.

Average cost of services quoted by service providers in Naira

Service	Cross River
Card	111
ARVS	438
Leprosy	2000
Immunization	8
Childbirth	784

Cost information: It is clear that cost of services relates directly to access. The MSS demonstration revealed discrepancies between service provider costs and user cost quotes for delivery. This warrants a more detailed examination. Current cost information does not allow for quantifying unofficial payments as neither CIET nor the respondents have any way of knowing the "correct" charge for services. It would also be incorrect to assume that that the average cost quoted by health providers in the institutional review is "correct". It is more likely a standard rate that deviates with any unusual situation. A goal in a larger study would be to separate actual cost from unofficial cost.

Cost of delivery in government facility: comparing cost given by household and institutional review

Cost of delivery	Cross River
Av cost from household interview	**5106**
Av cost from institutional review	784

Feedback sessions to date

National: Abuja hosted a national feedback session on May 18th with participants from both Cross River and Bauchi states. The presentation highlighted the methodology used in MSS and gave an overview of findings in Cross River State.

Cross River State: A feedback session in Calabar on June 18th was also part of a larger consultation with stakeholders in Cross River compiling similar information about their data collection efforts. Sessions between national counterparts and the DSS research team indicated ways in which MSS can complement their efforts.

Next steps

The impending elections (April 2007) highlight the need for partnering with permanent government positions/departments at each level of government. CIET has consulted with NEHSI partners, government authorities and educational institutions to consider who will use the data and how to integrate it into curriculum. Consultations to date have provided an overview of potential data users at

the different levels of government, among NEHSI partners as well as the educational institution(s) which will eventually house an evidence based management curriculum.)

Interviewer conducted household surveys: In the pilot cycle, in keeping with time and budget constraints, the survey instruments were designed in a scannable format. In the course of a larger project the surveys would be completed in writing by an interviewer, allowing for more detailed responses and clarification where required. A larger cycle would use non-scannable questionnaires for manual entering and validation.

Increased access: A first step must be reversal of the current filters that seem to discourage the most vulnerable from using the government services. A more detailed appreciation of the access filters could lead to re-inclusion of these groups. An appreciation of household cost is pivotal, as is understanding of the links between government and private systems (including traditional and self-medication).

Reasonable expectations of and satisfaction with behaviour of health workers: Largely overshadowed by cost concerns, health worker attitudes also need to be revisited. Monitoring what people think of health workers will allow the state government to monitor how the public views public services and their level of engagement. This is a two way street. It will also be necessary to monitor how health workers feel about their work (for example, using a proQol instrument), so that changes come *from* the health workers, rather than being imposed on them.

Reduced out of pocket payments: An early step is to adapt the survey lexicon from conventional corruption terminology, to quantify both system leakage and passing the costs of public health services to the users. This will permit closer monitoring of unofficial charges as a major parameter of a strengthened health system. As attention is drawn to the issue, out of pocket payments should decline. For this to be sustainable public expenditure would need to be tightened in a decisive way and new modalities of financing developed.