

SCAPP National Stakeholders Meeting



The SCAPP Project National Stakeholders' Engagement Meeting

"The SCAPP Experience: Building Accountable PHC Systems from the Ground Up"

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Venue: Belmont Hotel, Abuja, Nigeria

Organised by: Health Sector Reform Coalition (HSRC) and BudgIT

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About BudgIT

BudgIT is a civic organisation that uses creative technology to simplify public information, stimulate a community of active citizens, and enable their right to demand accountability, institutional reforms, efficient service delivery, and an equitable society.

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List of Acronyms

ANC	Antenatal Care
BHCPF	Basic Health Care Provision Fund
CBO	Community-Based Organization
CCSI	Centre for Communication and Social Impact
CHO	Community Health Officer
CSO	Civil Society Organization
CSOs	Civil Society Organizations
DFF	Decentralized Facility Financing
DRF	Drug Revolving Fund
ES	Executive Secretary
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FMoHSW	Federal Ministry of Health and Social Welfare
HERFON	Health Reform Foundation of Nigeria
HMIS	Health Management Information System
HR	Human Resources
HSRC	Health Sector Reform Coalition
IDP	Internally Displaced Person
KADMAM	Kaduna State Accountability Mechanism for Maternal, Newborn and Child Health
KSPHCB	Kaduna State Primary Health Care Board
LGA	Local Government Area
LGHA	Local Government Health Authority
MPDSR	Maternal and Perinatal Death Surveillance and Response
NPHCDA	National Primary Health Care Development Agency
OIC	Officer-in-Charge
PATHS 2	Partnership for Transforming Health Systems Phase II
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PLA	Planning, Learning and Action
SCAPP	Social and Citizen Accountability for Primary Health Care Performance
SMoH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
UHC	Universal Health Coverage
USSD	Unstructured Supplementary Service Data
WDC	Ward Development Committee
WHO	World Health Organization

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Background

The Social and Citizen Accountability for Primary Health Care Performance (SCAPP) Project is a two-year initiative implemented by BudgIT in collaboration with HSRC and KADMAM supported by Gates foundation. Operating across all 23 LGAs in Kaduna State, the project covers 200 BHCPF-supported PHC facilities in 200 wards. It works through two core mechanisms: the PHC Tracka digital platform (multi-channel citizen and patient feedback with geo-tagged, anonymous reporting) and KADMAM-led community engagement and WDC capacity building across all LGAs. HSRC provides supervisory and analytical support and evidence-based advocacy at state and national levels.



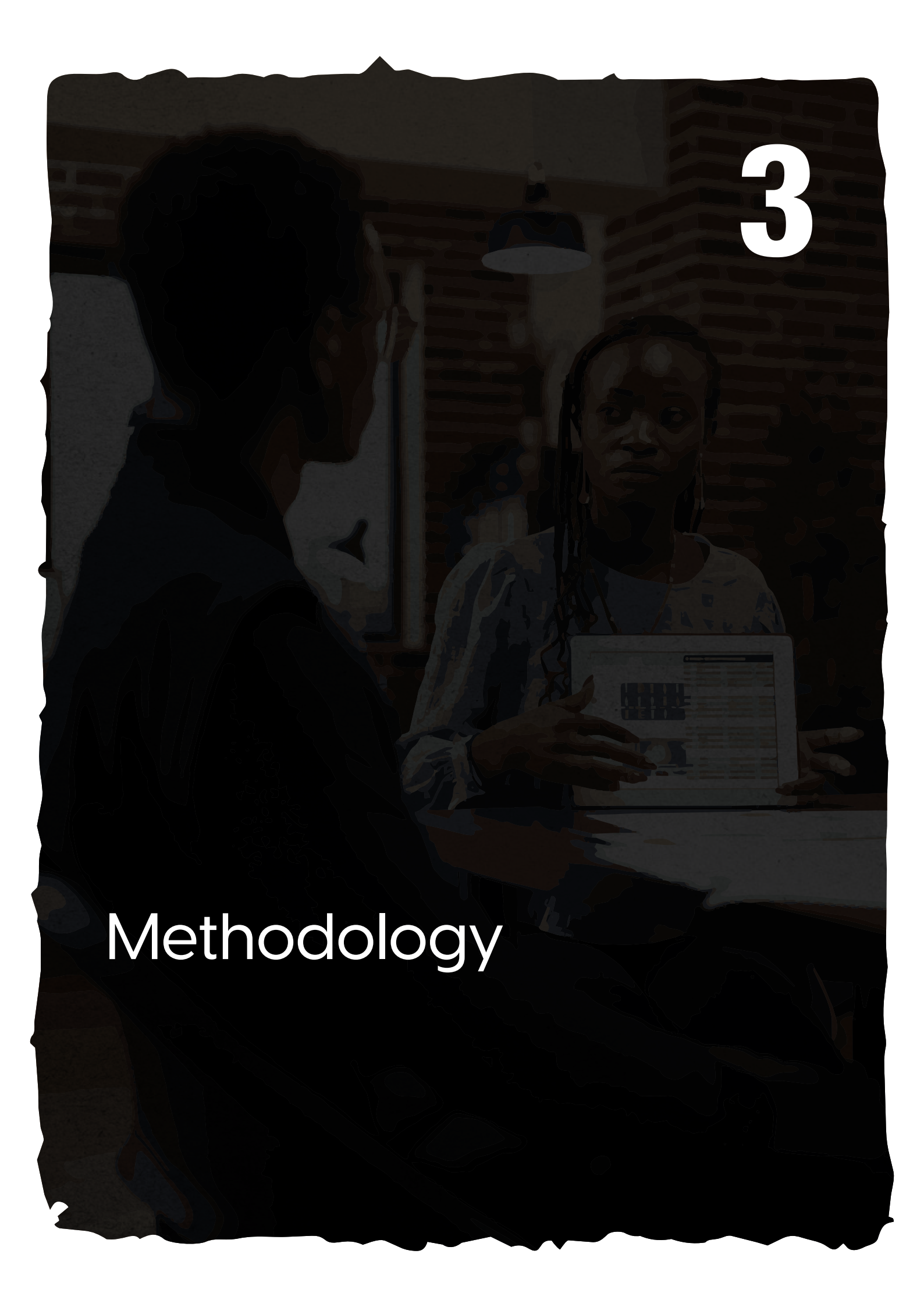
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Objectives



The National Stakeholders' Engagement Meeting was convened at the one-year mark to showcase evidence, lessons and impact from the SCAPP Project, while creating a platform for dialogue, policy alignment, and collective action to strengthen social accountability mechanisms in PHC service delivery nationwide. Specific objectives of the meeting included.

- Present the key findings, outcomes and lessons from the SCAPP implementation in Kaduna State
- Highlight the roles and limitations of WDCs and community structures in PHC accountability and performance
- Facilitate dialogue between government, civil society organizations, and development partners on strengthening citizen-led accountability mechanisms
- Identify policy, institutional, and operational actions required to scale and sustain social accountability
- Build consensus on priority reforms to address systems and gaps in PHC service delivery, including human resources, medicines, infrastructure and governance



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Methodology

3.1 Meeting design

The meeting was structured around a deliberative forum model. The meeting involved:

- Assembling multi-level stakeholders in the same room.
- Evidence sharing through technical presentation sessions.
- Structured deliberation through discussion of technical sessions, panel discussions, and questions and answer sessions.
- Commitment generation following deliberations.

The meeting was designed to move beyond information dissemination towards collective sense-making and commitment generation.

3.2 Meeting participation

The engagement had a total of 103 participants across all levels of

Nigeria's PHC governance architecture. They included representatives of the Federal government (FMoH, NPHCDA, Office of the Special Adviser to the President on Health), Kaduna State Government (SMoH, KSPHCB, LGHAs from all three senatorial districts), WDC chairpersons, PHC Officers-in-Charge, traditional and religious leaders, CSOs (BudgIT, HSRC, KADMAM, DGI Consult, Vaccine Network, CCSI, HERFON), media organisations, and community representatives.

3.3 Meeting Documentation

Documentation of the meeting was supported by rapporteur note-taking, audio recordings, presentation materials, attendance registration, and the meeting agenda to ensure accurate capture of discussions, key decisions, stakeholder contributions, and commitments.



A photograph of three women seated at a table, likely during a panel discussion or conference. The woman on the left is wearing a brown hijab and glasses, holding a microphone and a piece of paper. The woman in the center is wearing a patterned dress and a lanyard, looking towards the right. The woman on the right is wearing glasses and a patterned dress, also holding a microphone. The background is dark and out of focus. The image has a dark, textured overlay.

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Opening Session And Technical Presentations

4.1 Commencement and Protocol

The meeting opened with the national anthem at 9:20 AM. Following which formal recognition of participants was conducted by Prof. Clara Ladi Ejembi (HSRC).

4.2 Welcome Addresses

Two welcome addresses were delivered in succession. The first address was given by Dr Biobele Davidson, Health Systems Strengthening Lead at BudgIT, on behalf of BudgIT who oversees the SCAPP project. The second was delivered by Prof Clara Ladi Ejembi, HSRC Vice Chairman, Health Systems Strengthening and HSRC-SCAPP Project Coordinator, on behalf of Dr Mustapha Lecky, Chairperson of the Health Sector Reform Coalition, who was absent from the meeting.

Dr. Biobele Davidson (BudgIT) welcomed participants, noting the project's expansion from 75 facilities across five states to over 200 in Kaduna State alone, and described the SCAPP model of community-led accountability through a field anecdote. She called on all participants to engage actively, share openly and contribute meaningfully.

Prof. Clara Ejembi (HSRC) noted that this meeting is the first in a series of planned meetings where stakeholders will come together to explore how Primary Health Care can be strengthened. She contextualised SCAPP within HSRC's mandate to drive health sector reform, noting that HSRC was central to passage of the National Health Act 2014, the legislative foundation for BHCPF. She described SCAPP as going beyond participation to foster genuine community ownership of PHC and outlined the meeting's five formal objectives. She called for open, truthful contributions throughout the day, reminding participants that there

are no right or wrong answers, and that the collective purpose is to chart a common path that moves the trajectory in the right direction.

4.3 Opening Remarks

Dr. Salamatu Anas Ibrahim (Special Adviser to the President on Health and meeting Chairperson) delivered substantive opening remarks, affirming PHC as the only pathway to UHC and emphasising that the gap between policy and community experience reflects accountability failure, not policy absence. She cited concrete examples of procurement and staffing accountability failures observed as Commissioner of Health in Borno State and Gombe, argued for a shift from federal-level procurement to strengthening subnational procurement systems, and called for institutionalisation of accountability at every governance level.

4.4 Goodwill Messages

Goodwill messages were delivered by members of different stakeholder groups present at the meeting: KADAMAM (Alhaji Garba Muhammad) — appreciation for stakeholder support; NPHCDA (Dr. Nana Tanko) — describing the meeting theme as the “missing link” to quality PHC; Kaduna SMOH (Dr. Aisha Abubakar Sadiq) — reaffirming Kaduna's commitment to UHC and situating SCAPP challenges as national; Vaccine Network (Ms. Chika Ofor) — calling for truth-telling and describing BHCPF as the catalytic steppingstone for PHC; Sarkin Tsibiri (Alhaji Shehu Abbas) — citing Drug Revolving Fund transparency and 90% ANC uptake in his community; a Christian leader (Rev. Joshua Haruna) — describing SCAPP as a game changer that improved maternal and child health outcomes; and a Muslim leader (Mallam Sabitu Ashiru) — prayers for the success of deliberations.

4.5 Technical Presentations

Five technical presentations were delivered by HSRC and BudgIT team members.



Citizens and Patients as Agents of Change (Dr. Biobele Davidson, BudgIT):

The presentation highlighted how citizen and patient feedback can drive accountability and improve primary health care performance. Drawing on evidence from the PHC Tracka platform across 200 facilities in Kaduna State, it demonstrated that structured community feedback mechanisms can identify critical service delivery gaps, inform local action, strengthen community ownership of PHC, and enhance responsiveness by health authorities. The session emphasized the importance of institutionalizing feedback systems, strengthening community participation, and integrating citizen-generated data into health planning and decision-making to sustain improvements in PHC service delivery.



WDCs as Drivers of Change (Prof. Clara Ejembi, HSRC):

Drawing on evidence from a rapid assessment of 200 WDCs, focus group discussions, and 11 months of monitoring data, the presentation assessed the effectiveness of WDCs as mechanisms for community participation and PHC accountability. While many WDCs reported high levels of functionality and engagement, the evidence revealed significant gaps in community awareness, inclusiveness, and financial oversight, particularly regarding BHCPF implementation. The findings highlighted a disconnect between reported performance and community experiences, with WDCs often filling service delivery gaps created by systemic weaknesses rather than exercising effective accountability. The presentation underscored the need to strengthen WDC governance, gender representation, financial oversight capacity, and institutional support to enhance their role as drivers of accountable and responsive primary health care systems.



The Last Mile Test (Dr. Ndaeyo Iwot, HSRC):

Drawing on evidence generated through SCAPP implementation, the presentation examined the key barriers preventing PHC facilities from delivering quality and accessible services. Findings showed that gaps in human resources, infrastructure, medicines, and affordability continue to undermine service utilization and community confidence. The presentation demonstrated how citizen feedback and strengthened WDC engagement can help bridge these gaps and support more responsive and accountable health services.



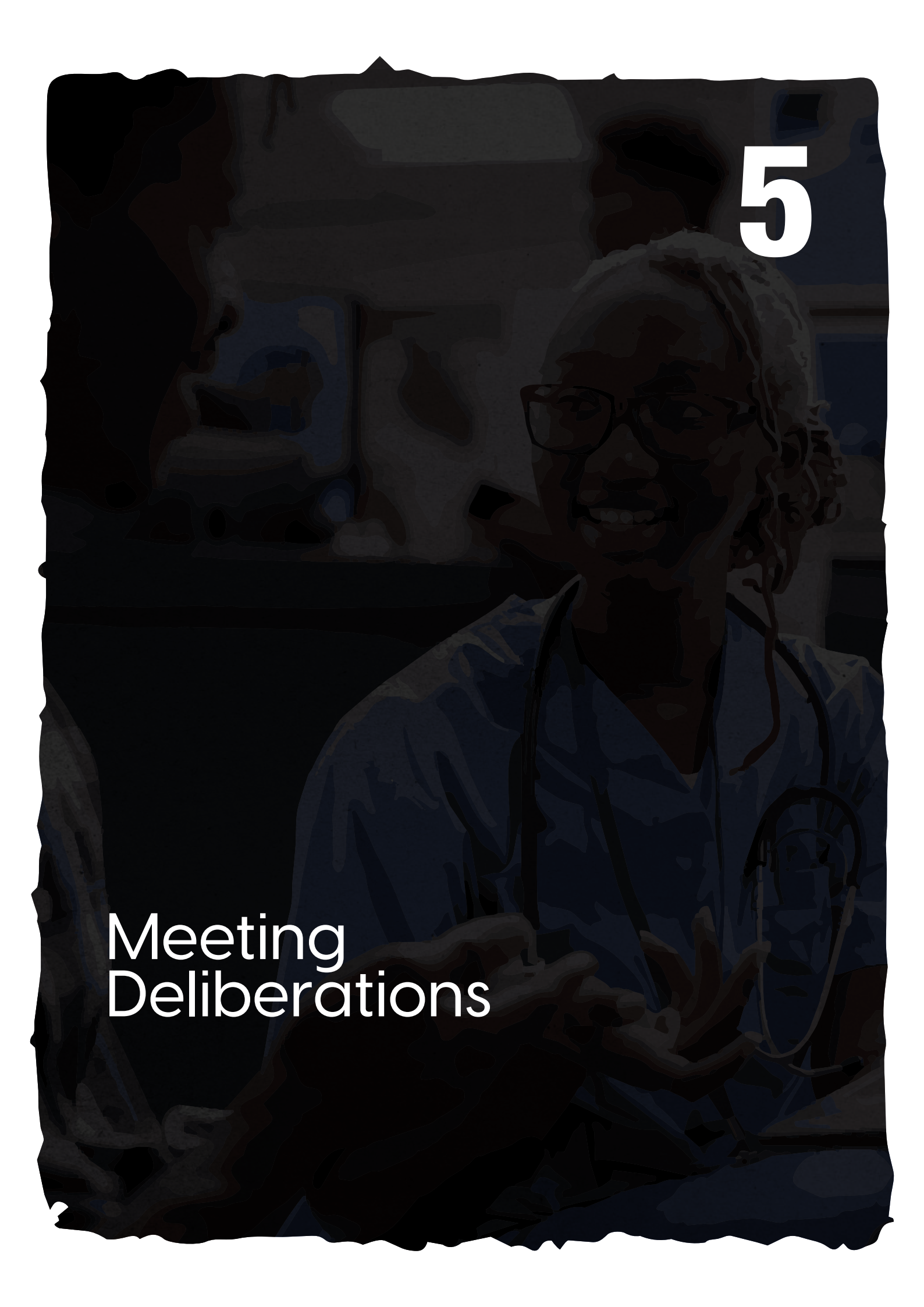
BHCPF Financing and Accountability (Dr. Suleiman Usman for Dr. Mustapha Lecky, HSRC):

The presentation revealed that evidence from WDC meetings and monitoring activities showed that community structures remain largely disconnected from BHCPF financing and accountability processes. The presentation emphasized the need to institutionalize community participation in financial oversight, improve access to BHCPF information, and strengthen WDC capacity to monitor the use of PHC funds and support better service delivery outcomes.

From Kaduna to Nigeria (Ms. Roseline Nyong, BudgIT):

Presented PHC Tracka's national scale-up potential, characterising it as the mechanism for bridging Nigeria's PHC accountability gap through mobile-friendly anonymous reporting, real-time state dashboards and structured community dialogues. Called for adoption across Nigeria's 36 states as a mechanism converting community voices into structured policy intelligence.



A dark, artistic photograph of a healthcare professional, likely a nurse or doctor, smiling and gesturing with their hands. They are wearing a stethoscope and scrubs. The image has a high-contrast, almost silhouette-like quality with some highlights on the face and hands. A large white number '5' is positioned in the upper right corner.

5

Meeting Deliberations

5.1 Discussion of Technical Presentations

Following the five technical presentations and the tea break, two designated discussants provided structured commentary before the floor was opened for questions and answers.

5.1.1 First Discussant — Dr. Aisha Abubakar Sadiq, Permanent Secretary, Kaduna State Ministry of Health.

Dr. Abubakar Sadiq opened her discussant remarks by summarising each technical presentation and drawing out their interconnections. Her key observations are recorded below.

than foundational requirements. She named the interconnected triad of human resource shortages, infrastructure deficits, and drug and commodity challenges as the defining constraints.

- **On the PHC Tracka presentation:** the evidence showed that, contrary to widespread perceptions, 90.8% of patients rated their facilities at or above the average benchmark. This was characterised as a positive sign of change arising from stakeholder engagement and feedback systems. She emphasised the main actionable conclusions: scale up PHC Tracka; embed it in state planning; institutionalise town hall meetings; and disseminate accountability scorecards.
- **On the WDC presentation:** she highlighted the importance of citizen participation, community oversight and the significance of town hall meetings not just as gatherings but as structured accountability mechanisms. She noted that most town halls documented did not discuss the BHCPF. She drew on Prof. Ejembi's analysis to observe that community capacity to compensate for systemic weaknesses demonstrates grassroots potential but also underscores that such potential is being exercised in response to deficit rather than institutional strength.
- **On the last-mile presentation:** she emphasised the concept of “lack of system enablers” — utilities such as electricity, water and security — that are routinely treated as luxuries rather
- **BHCPF presentation:** she explained the two pathways for BHCPF fund access (capitation and decentralised facility financing) and underlined the recommendation for Kaduna State to domesticate national WDC guidelines. She highlighted the need for quarterly WDC alliance meetings, capacity building, and formalisation of complaints and finding escalation pathways.
- **On the national scale presentation:** she commended its brevity and focus on community-level feedback. She cited a specific example of a shared borehole between a PHC and a community that had become a source of conflict until community dialogue produced a structured sharing arrangement, as an illustration of how social accountability mechanisms can resolve operational challenges at the facility level.
- **On human resources:** she observed that the challenge is not merely the number of health workers but the appropriate skill mix, competence and character. She described an experience in Kaduna of an Environmental Health Officer seeking transfer whose basic professional competencies were found to be inadequate, illustrating the need for quality assurance in recruitment beyond numerical targets.

5.1.2 Second Discussant — Dr. Mike Egboh, Board Member, HSRC.

Dr. Egboh delivered a frank reflection that challenged participants on several fronts. He opened by noting that most of the issues raised in the technical presentations have been known for twenty (20) or more years, and asked participants to identify, if they could, any single issue that they were hearing for the first time. He framed his remarks around several systemic concerns rather than repeating the presentations.

Dr. Egboh cited the Jigawa and Kano State experiences under the Partnership for Transforming Health Systems Phase II (PATHS II) project as models demonstrating that PHC accountability gains can be sustained.

In Jigawa State, which was among the lowest-performing states when PATHS II commenced, the state now

has a functioning drug procurement system and no longer depends on external funding for drug purchases. In Kano State, the Kano State Drug Agency has grown to a point of generating its own revenue and supporting the Ministry of Health's infrastructure. The PATHS 2 "Ask Nigeria" platform gave citizens the ability to publicly air concerns about PHC services, including an incident in Enugu where a community member reported a nurse cooking in a health clinic, which led to the nurse's termination after the governor heard the broadcast.

He posed pertinent questions: "If Professor Ransome-Kuti were to wake up today, would he be happy with how far we have gone?" and "We talk about output. Nobody is talking about the outcome."



Recommendations

- 1 Community involvement is the most important factor for sustainability; ownership must precede sustainability.
- 2 Traditional and religious leaders must step up their roles in PHC governance.
- 3 Politicians can be engaged strategically; they will associate themselves with visible community development even without genuine commitment, and this can be leveraged.
- 4 Evaluations should focus on outcomes — actual changes in people's lives — not merely project outputs.
- 5 Attitude is a critical but under-discussed factor in accountability; success is tied to the moral disposition of individuals in the system.
- 6 The sector should revisit what has worked in other initiatives before creating new projects or acronyms.



5.1.3 Questions and Answers

Following the discussant presentations, the floor was opened for questions, comments, and reflections from participants. The session generated lively and interactive discussions between the panelists and stakeholders, focusing on practical challenges and opportunities for strengthening primary health care service delivery. Key issues raised included human resources for health, the functionality and governance of Ward Development Committees (WDCs), accountability and transparency mechanisms, equity and inclusion, and health workforce development. The exchanges provided an opportunity for stakeholders to seek clarification on issues emerging from the presentations, share field experiences, and collectively explore strategies for improving PHC performance and accountability. For ease of presentation, the discussions have been organized under the following thematic areas: Human Resources for Health; WDC Functionality and Governance; Accountability and Transparency; Equity and Accessibility; and Health Workforce Recruitment and Capacity Development.

1

Human Resources for Health: Participants raised concerns about the shortage of qualified health workers, particularly doctors, in PHC facilities and its implications for achieving Universal Health Coverage. Responses highlighted the role of the Task Shifting and Task Sharing Policy, ongoing recruitment efforts, and the need for structured refresher training for community health workers and other frontline personnel.

2

WDC Functionality and Governance: Discussions explored ways to strengthen WDC effectiveness through the domestication of operational guidelines, clearer governance structures, improved documentation systems, and stronger collaboration between WDCs and facility managers. Participants also emphasized the importance of orienting PHC staff on WDC roles to enhance cooperation and reduce institutional friction.

3

Accountability and Transparency: Questions focused on political interference in WDC membership selection, community oversight of PHC activities, and mechanisms for reporting concerns such as absenteeism and drug diversion. Responses emphasized adherence to transparent guidelines, the ongoing domestication of WDC policies in Kaduna State, and the development of an anonymous QR code-based feedback platform to strengthen accountability and protect whistleblowers.

4

Equity and Accessibility: Participants discussed the inclusion of internally displaced persons and persons with disabilities in PHC services. Stakeholders highlighted ongoing outreach services to IDP settlements and the need to improve facility accessibility through disability-friendly infrastructure such as ramps and appropriate signage. Health Workforce Recruitment and Retention: Questions were also raised regarding the recognition of volunteer health workers during recruitment processes. It was noted that while volunteer service should be considered, recruitment must continue to prioritize required qualifications to maintain service quality and professional standards.

5.2 Panel Discussion

5.2.1 Introduction to panel discussion

The panel discussion, themed “Voices, Systems, and Accountability: Driving PHC Performance in Nigeria,” was moderated by Dr. Amina Mohammed Baloni, former Commissioner of Health, Kaduna State.

The session brought together a diverse panel comprising Dr. Nana Tanko, Director of Community Health Services at the National Primary Health Care Development Agency (NPHCDA); Dr. O. Ogbe, Special Adviser to the Coordinating Minister of Health and Social Welfare on BHCPF; Hajiya Nafisah Isah, Director of Community Health Services at the Kaduna State Primary Health Care Board (representing the Executive Secretary); Comrade Muhammed Yusuf Nadabo, WDC Chairman of Banawa Ward in Kaduna South LGA; Esther Oju of DGI Consult (representing Dr. A. Gafar); and Mr. Godwin Ochigbo, Officer-in-Charge of

Gwantu Ward PHC in Sanga LGA.

Drawing on perspectives from government, health facilities, community structures, and development partners, the panel examined lessons from the SCAPP project and their implications for strengthening primary health care accountability and performance in Nigeria. Discussions focused on community participation, health system governance, PHC financing, accountability mechanisms, and the role of Ward Development Committees (WDCs) in improving service delivery and responsiveness. Through moderator-led exchanges and audience engagement, panellists identified key challenges, shared experiences, and proposed practical actions for advancing social accountability and sustainable PHC reforms. The abridged responses of the panellists are presented below under the relevant thematic areas.



5.2.2 Panellist Contributions

**Dr. Nana Tanko — Director of
Community Health Services,
NPHCDA**

Question 1:
*From a national perspective,
what does an accountable
PHC system look like in
practice, and why do gaps
persist between national
policies and community
experience?*

Dr. Tanko described the NPHCDA's mandate to provide guidelines for PHC development with clearly defined service standards and accountability assignments across every level (federal, state, LGA, facility and community). On what an accountable system looks like in practice, she framed it around a central question: do we have the right people doing the right things at the right time with the right resources and, critically, with the right attitude? She emphasised that attitude determines outcomes and that the focus must shift from outputs to outcomes.

On why gaps persist, she identified interconnected reasons: (i) domestication and implementation failures at subnational level, where states and LGAs vary widely in how they contextualise national guidelines; (ii) variable implementation capacity across states and LGAs; (iii) blurred accountability lines, noting that “what is everybody’s business becomes nobody’s business;” and (iv) the unresolved question of whether gaps are from the guidelines themselves or from implementation failures.

She noted national-level actions including deployment of performance and financial management officers across all 774 LGAs and constitution

of quality improvement teams with a mentorship programme at each facility. She also raised the observation that most recommendations placed emphasis on the state and primary health care board taking action, with relatively little attention to with the LGA, arguing that more responsibilities should be decentralised to the LGA level given its proximity to communities and the recent development of LGA autonomy.

Question 2:
*Are national guidelines
developed in a top-down
manner? How is co-creation
with states and LGAs
addressed?*

Dr. Tanko acknowledged the validity of the moderator’s challenge that calling state participants to validate what has already been drafted is not the same as co-creation. She noted that policy formulation typically begins with evidence gathering at community and PHC levels, and that programmes increasingly involve structured engagement at community, LGA and state levels before implementation. On policy shifts required, she outlined four priorities: institutionalise community accountability and make transparency non-negotiable at every level; strengthen national leadership and enforcement to ensure roles in guidelines are fulfilled; digitalise and simplify monitoring for faster corrective action; and invest in supportive supervision cascading from state to LGA to ward level, which she identified as a critical area requiring strengthened investment.

**Dr. O. Ogbe — Special Adviser to
the Coordinating Minister of Health
and Social Welfare**

Question 1:
*How is the BHCPF currently
designed to support
accountability at facility and
community level, and to what
extent are communities
aware of BHCPF funds?*

Dr. Ogbe situated the BHCPF within its historical context and drew a deliberate distinction between organic mechanisms built into the original BHCPF design and non-organic mechanisms introduced more recently.

Organic Mechanisms: First, the funding pathway itself was deliberately routed through states rather than directly to facilities, while it would have been technically simpler to pay facilities directly, the routing carries a message of responsibility at each stage. Second and most central is the quarterly business plan: the OIC and WDC are mandated to develop it jointly, with the WDC co-signing before it can be approved. Dr. Ogbe noted that the day's presentations had shown WDCs are often expected simply to sign plans they did not participate in developing, which defeats the purpose entirely. Third, the fund retirement process: after expenditure, facilities must retire funds before the next round of funding is released, creating a structured accountability chain from facility level to NPHCDA nationally.

Non-organic mechanisms: First, deployment of performance and financial management officers to BHCPF facilities to monitor financial utilisation with acknowledged mixed results but clear cases where funds going amiss were identified. He cautioned against these officers becoming purely supervisory, noting the goal is to marry transparency with support. Second, digitalisation of the financial management system across 14 states, through which a business plan cannot be submitted until the WDC has reviewed and approved it, generating an authorisation code as a

technical prerequisite for submission, a significant design improvement making WDC participation structural rather than discretionary.

On community awareness of BHCPF funds, Dr. Ogbe identified this as a critical unresolved gap: communities cannot hold facilities accountable for funds they do not know about. OICs and WDC signatories have little incentive to proactively disclose fund amounts. Closing this gap requires empowered community-based CSOs who will demand and disclose this information regardless of institutional preference.

On the Fundamental Challenge — WDC Formation: Dr. Ogbe argued that the deepest accountability gap is not in capacity building or training. It is in how WDCs are formed. Both the quarterly business plan and the digital platform require WDC participation, but if WDC members are political appointees rather than genuine community representatives, their participation becomes performative. He recalled Planning, Learning and Action (PLA) processes, where communities identified who could genuinely represent community interests, a practice largely replaced by appointments made by LGA chairmen or state PHC boards. He illustrated with a direct analogy: go to an illiterate woman in a village who sells provisions, deposit N200,000 with her, and tell her twelve different people will come to bring foodstuff. She will not make a mistake and will not let anyone steal from her twice. The issue is not capacity; it is ownership.

Question 2:
*What policy or operational
changes are needed to make
the system more accountable
and more effective?*

Dr. Ogbe was direct: Nigeria has sufficient policies and guidelines. The singular gap is effective implementation. Quoting directly: "We don't need new policies and guidelines; we just need to implement them." He identified three practical

priorities:

- (i) reconstitute WDCs through community-driven processes, ensuring members are brought forward by their communities;
- (ii) hold local governments accountable for defined roles of supportive supervision, monitoring and instant redress, noting LGAs will soon receive operational BHCPF funding and that national reviews reach only 30–40 of 200 PHCs while the LGA which can provide instant local redress is not being sufficiently engaged; and
- (iii) balance accountability with recognition alongside calling out poor performance, high-performing facilities, health workers and WDCs must be visibly recognised and showcased to give others the courage to do good.

**Hajiya Nafisah Isah — Director
Community Health Services,
KSPHCB (representing ES Prof.
Jamoh)**

Question 1:
*What is your experience
working with WDCs and
community feedback
systems?*

Hajiya Nafisah affirmed that WDCs remain one of the most important community structures for strengthening accountability, ownership and utilisation of PHC services in Kaduna State. She described their contributions across four areas: community mobilisation resulting in measurable increases in women accessing immunisation, family planning and maternal and newborn health services; oversight of BHCPF utilisation, including escalation of concerns about commodity availability, renovation quality and financial accountability that “land on her table before reaching the Executive Secretary;” reporting staffing and commodity gaps that prompted direct government action,

including recruitment of over 1,500 health care workers with annual recruitment at this scale intended for the next five years; and improvements in community feedback mechanisms including dialogue sessions, complaint mechanisms and community scorecards not previously in place.

She cited a concrete example from the previous week: a WDC from Kagarko LGA escalated that women were dying at a facility during delivery. Before the end of that same day, the Executive Secretary constituted a committee through the Community Maternal and Perinatal Death Surveillance and Response structure to visit the facility, inspect it, interact with management and gather community testimony. She used this to illustrate that prompt response is possible for concerns requiring immediate action, while acknowledging that others, particularly those involving procurement of equipment or human resources, require escalation before a response can be given.

Question 2:
*What are the biggest barriers
to making accountability
work at scale?*

Hajiya Nafisah identified four principal barriers:

- (i) lack of institutionalisation of WDC guidelines — the primary driver of political interference, most intrusions stem directly from this gap;
- (ii) lack of operational funding constraining WDC activities;
- (iii) delays in government response that risk demoralising WDC members who have escalated in good faith; and
- (iv) limited data to substantiate complaints — without documented records, it is difficult to compel action.

Question 3:
***What will the SPHCDA
specifically do to ensure
feedback loops are closed?***

Hajiya Nafisah explained that the KSPHCB has begun integrating community feedback mechanisms into the BHCPF accountability structure, aligning facility bank accounts, financial reporting, fund retirement timelines, routine supervision and performance monitoring within the BHCPF framework. She acknowledged the moderator's challenge directly: accounting for BHCPF while leaving other fund flows outside the accountability framework creates parallel systems that undermine the whole. A broader, integrated accountability framework covering all funds flowing into the facility is needed.

Closing Commitment: Kaduna State will domesticate the WDC operational guidelines within six months.

**Comrade Muhammed Yusuf
Nadabo — WDC Chairman,
Banawa Ward, Kaduna South LGA**

Question 1:
***How does community
participation improve PHC
services in Barnawa? What
challenges do you face in
holding the system
accountable?***

Comrade Nadabo situated the WDC's role clearly: it is a link between the clinic and the community, not a clinical or management body. WDCs do not administer drugs, hire or fire staff; their mandate is to ensure that ward-level funding is well utilised for the benefit of the people the facility serves.

On challenges, he described an active and at times combative accountability role, including championing the redeployment of staff whose conduct was undermining the facility and facing pushback from within local

government for being a WDC chairperson who refuses to sign anything without proper scrutiny. He framed this refusal as the core of the WDC's accountability function. He described his personal financial commitment: since taking chairmanship he had invested over N200,000 of his own resources as incentives, and in the two weeks before the meeting had spent approximately N400,000 out of pocket to address storm damage to the facility roof. He framed this not as exceptional generosity but as patriotism, drawing comparisons with India's social health activists and Cuba's street-level doctor outreach as models of genuine community ownership. He also cited a concrete accountability intervention: an OIC had been overcharging patients N6,500 for services; the WDC investigated and successfully intervened to reduce the charge to N3,000.

Question 2:
***What support do you need
from the government and the
system for the WDC to be
more effective?***

Comrade Nadabo's answer was direct: prompt, responsive action. When a WDC raises a concern and escalates it to the KSPHCB, the government must respond. He called for training and retraining of WDC members, so they understand their roles clearly, and for the system to give WDCs sufficient authority to act when they identify problems. The moderator reframed his description of bureaucratic bottlenecks pointedly: it is not bureaucracy that is the obstacle, it is will. The BHCPF already has funds earmarked for infrastructure and commodity shortfalls. She commended Comrade Nadabo for leading by example and noted that WDC chairpersons should feel empowered to withhold their signature when transparency is absent, not pressured to sign simply because a stipend is being released.

**Esther Oju — DGI Consult
(representing Dr. A. Gafar)**

Question:
What has SCAPP taught us about what works in social accountability? What has it revealed about community-level oversight of BHCPF?

Ms. Oju identified three conditions that must be present simultaneously for social accountability to function:

- (i) structured community participation mechanisms, consistent community structures that citizens can recognise, trust and use as platforms, not ad-hoc engagement;
- (ii) systems to receive and act on feedback as voice without response is not accountability, it is consultation at best and tokenism at worst; and
- (iii) data — citizens can only advocate effectively if they have access to facts, as documented records convert a complaint into a case.

On community awareness and oversight of BHCPF, she was direct: community awareness remains critically low and is one of the most significant barriers to meaningful oversight. Citizens cannot ask questions about funds they do not know exist. She connected this to the broader point about transparency: transparency does not automatically produce participation, but the absence of transparency guarantees its absence. Dialogue is the mechanism through which information becomes ownership.

Closing Commitment: Social accountability must be institutionalised and embedded in the health system as a permanent feature, not treated as a project-cycle activity that exists while funding lasts and disappears when it ends.

**Mr. Godwin Ochigbo — OIC,
Gwantu Ward PHC, Sanga LGA**

Question:
How does community feedback affect your work at the facility level? What are your biggest constraints in delivering quality care?

Mr. Ochigbo was direct: community feedback helps address real-time gaps. He described two concrete situations. The first arose in 2025 during a mosquito net distribution exercise: his ward was removed from the distribution list without prior notification, and community members threatened to reject all future health interventions including routine immunisation. The facility moved quickly into community dialogue mode, engaging traditional leaders to manage the situation. He used this to illustrate a point the Permanent Secretary reinforced: the exclusion was a systemic failure originating at the national level, arriving too late for any logistical correction, with the facility and community bearing the consequences.

The second situation involved conflict between security staff and community members over access to the facility borehole at night. The WDC, working with traditional leaders, convened a mediation process and established a structured time-sharing arrangement that resolved the conflict — a direct demonstration of the WDC functioning as a conflict resolution and community-facility dialogue mechanism.

When asked to name his single most important request to the KSPHCB, Mr. Ochigbo did not hesitate: staff retention. Sanga LGA is one of the most remote LGAs in Kaduna State, and newly posted health workers consistently leave shortly after arrival.

The moderator proposed enforceable appointment conditions: postings to hard-to-reach LGAs should carry a legal clause making the posting a condition of employment, with failure to remain constituting automatic forfeiture of the appointment.

5.2.3 Additional Floor Contributions to Panel Discussion

The floor discussion further enriched the dialogue by highlighting practical challenges affecting accountability, governance, and service delivery at the community level. A field officer raised concerns that WDCs are often expected to oversee PHC renovation projects without being provided access to contract terms of reference, limiting their ability to assess contractor performance or challenge poor-quality work. In response, state PHC authorities acknowledged the challenge and encouraged WDCs to escalate unresolved concerns through established channels, including direct engagement with the Kaduna State Primary Health Care Board where necessary.

A WDC representative from the Federal Capital Territory (FCT) provided a comparative perspective, describing a structured system of WDC elections, defined tenure periods, and formal induction processes. He expressed concern over reports that some WDC chairpersons in Kaduna State had remained in office for extended periods without clear tenure limits. The discussion reinforced the importance of domesticating and institutionalizing WDC operational guidelines to ensure consistency,

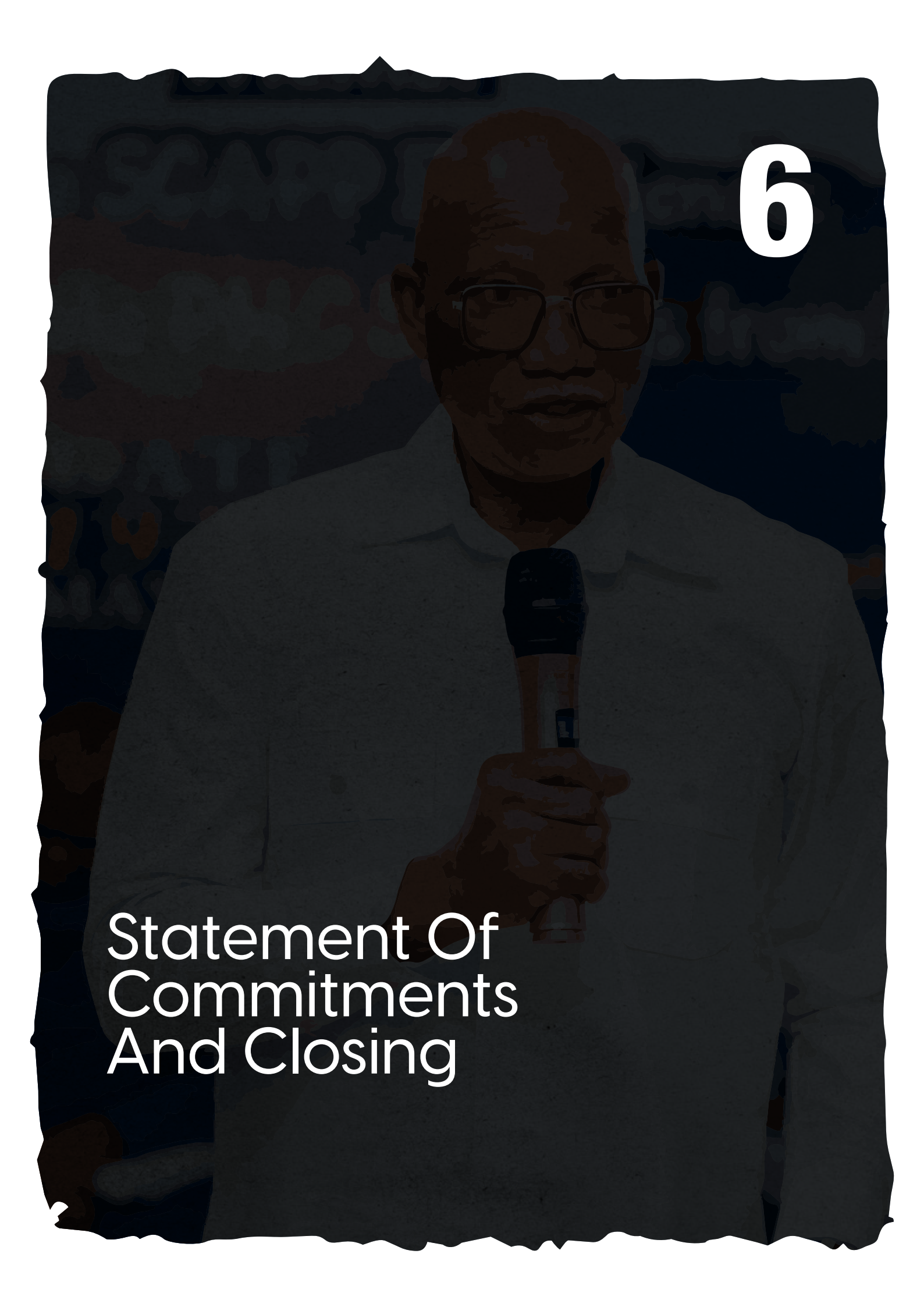
transparency, and accountability in WDC governance across the state.

Additional reflections from the State Ministry of Health highlighted the importance of timely communication and coordination between national, state, and local actors. Using the example of a mosquito net distribution exercise, it was noted that delayed communication regarding programme changes created challenges for community engagement and implementation at facility level. The contribution underscored the need for better information flow and advance notification to subnational actors to prevent avoidable disruptions and loss of community trust.

The discussion also revisited the persistent challenge of deploying and retaining health workers in hard-to-reach areas. Participants noted that while recruitment efforts are ongoing, retention remains a major concern, particularly in remote LGAs. Stronger policy measures, including enforceable posting conditions and incentives for service in underserved areas, were suggested as potential approaches for ensuring a more equitable distribution of the health workforce.

5.3 Closing Commitments from All Panellists

- **Comrade Nadabo:** structured training and retraining of WDC members; enforcement of accountability for health workers who overcharge patients.
- **Esther Oju (DGI Consult):** social accountability must be institutionalised and embedded as a permanent health system feature, independent of external project cycles or donor funding.
- **Dr. Ogbe:** documentation and domestication of clear guidelines on how WDCs should be recruited and constituted; effective implementation of existing BHCPF guidelines by all actors.
- **Mr. Ochigbo:** government must establish mechanisms for rewarding good-performing staff and penalising poor performance.
- **Dr. Nana Tanko:** engage relevant NPHCDA departments to develop a transparency package — a clear, accessible statement of services guaranteed, key funding inflows and their purpose — so WDCs and communities have information for meaningful oversight; strengthen feedback loop closure mechanisms within national guidance.
- **Hajiya Nafisah:** Kaduna State will domesticate the WDC operational guidelines within six months.



6

Statement Of Commitments And Closing

6.1 The Seven Commitments as Read by Dr. Biobele Davidson

#	Commitment	Attribution
1	To institutionalise community accountability without compromising transparency.	Collective
2	To advance the digitalisation of monitoring and accountability mechanisms.	Collective
3	Kaduna State Government to domesticate the WDC operational guidelines within six months.	Kaduna State Government
4	To develop and implement a state policy on the right human resource profile for PHC facilities.	Kaduna State Government
5	To strengthen capacity on identified accountability gaps.	Kaduna State Government with support from partners-BudgIT other GF partners and CSO's
6	To address last-mile service delivery gaps as a priority.	Kaduna State Government with support from partners
7	To strengthen government oversight of PHC systems and processes.	Collective

6.2 Closing Remarks and Vote of Thanks

Prof. Clara Ejembi delivered closing remarks on behalf of Chairperson Dr. Salamatu Anas Ibrahim, acknowledging the quality of the day's discussions and reaffirming the shared commitment of all stakeholders to a functional, transparent and accountable PHC system. Dr. Clement Woje (HSRC) delivered the vote of thanks. The meeting was declared closed at approximately 4:20 PM.



7

Key Learnings

Key learnings from all sessions are organised into six thematic clusters.

7.1 The System Context

1

WDC formation is the root of the accountability problem. Where members are political appointees rather than genuine community representatives, every mechanism built on top of them becomes performative. Until WDC formation returns to community-driven processes, structural reform will remain cosmetic.

2

WDCs are functioning as system substitutes, not accountability institutions. Communities are financing electricity, water, repairs and staffing support that are the state's institutional responsibility. Celebrating community initiative must not substitute for holding the state accountable for its obligations.

3

The absence of domesticated WDC guidelines is a structural vulnerability. Without a state-specific operational framework, political discretion fills the institutional vacuum.

4

Financial oversight is the weakest WDC function and the most important. Procurement monitoring was almost entirely absent from WDC meeting records across 200 facilities.

5

Procedural accountability without substantive resolution is a system failure. The documented response pattern of "follow up, write a letter and advocate" has become a ritual that absorbs community energy without producing change.

7.2 Community Structures

1

WDC formation is the root of the accountability problem. Where members are political appointees rather than genuine community representatives, every mechanism built on top of them becomes performative. Until WDC formation returns to community-driven processes, structural reform will remain cosmetic.

2

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3

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4

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5

Procedural accountability without substantive resolution is a system failure. The documented response pattern of "follow up, write a letter and advocate" has become a ritual that absorbs community energy without producing change.

7.3 Financing and Accountability

1

BHCPF engagement by WDCs is critically and structurally insufficient. Only 11.6% of 862 WDC meetings discussed BHCPF, driven by information asymmetry, lack of template mandate for financial reporting, and absence of WDC enforcement authority.

2

Community awareness of BHCPF is too low for meaningful oversight. Without structured transparency packages specifying fund flows, community oversight remains nominal regardless of how many meetings are held or forms signed.

3

Information asymmetry operates at every level and undermines accountability throughout. What is required is a transparency architecture making key information — fund flows, service entitlements, contract terms, expenditure retirements — accessible to every level as a non-negotiable institutional standard.

7.4 Human Resources, Commodities and Infrastructure

1

Retention, not recruitment, is the real human resource crisis. Recruitment without retention is a revolving door. Legal obligation — legally enforceable posting conditions with automatic forfeiture for non-compliance — changes the calculus in a way that allowances and appeals to duty do not.

2

Skill mix, competence and character matter more than headcount. Recruitment frameworks must move beyond numerical targets to incorporate skill mix analysis, competency assessment and character evaluation.

3

Federal procurement of state and LGA inputs perpetuates dependency and erodes local accountability. The Federal Government's role is to strengthen subnational procurement systems, not substitute for them.

7.5 Accountability Culture

1

Feedback without response destroys accountability culture. Failure to close the feedback loop is culturally corrosive. A structured, tiered response framework with defined timelines for different categories of concern must be systematised.

2

Attitude and moral compass are accountability variables the system consistently ignores. Structural improvements alone will not close the accountability gap if the people operating within improved structures do not bring the right orientation to their work.

3

Recognition is as important as sanction in building accountability culture. A balanced accountability narrative is more likely to shift behaviour than a framework functioning purely as a mechanism of blame and sanction.

7.6 Sustainability and Scale

1

Sustainability requires institutionalisation, not project dependency. Every activity, structure and capacity built through SCAPP must transfer ownership to communities and institutions before the project ends, with state budget lines, domesticated guidelines and institutionalised processes that function independently of external funding.

2

Community ownership is the non-negotiable foundation — and must be earned, not assumed. Ownership must be earned through consistent responsiveness. Every unresolved concern and every unchanged condition erodes community ownership incrementally, until participation becomes performance and accountability becomes ritual.





Appendix 1: Meeting Agenda

Scheduled Time	Activity	Responsible Person/Chair
8:00 – 9:00 AM	Registration	Secretariat
9:00 – 9:40 AM	Opening: National Anthem/Prayer; Introduction; Welcome Addresses; Chairperson's Opening Remarks; Goodwill Messages	Dr. B. Davidson; Dr. M. Lecky; Dr. Salamatu Anas Ibrahim
9:40 – 10:00 AM	Technical Presentation 1: Community Feedback and Accountability Systems	Dr. Biobele Davidson
10:00 – 10:20 AM	Technical Presentation 2: Powering Accountability — WDCs as Drivers of Change?	Prof. Clara Ejembi
10:20 – 10:40 AM	Technical Presentation 3: The Last Mile Test: Fixing Service Delivery Bottlenecks	Dr. Ndaeyo Iwot
10:40 – 11:00 AM	Technical Presentation 4: Financing and Accountability (BHCPF) and Beyond	Dr. Mustapha Lecky
11:00 – 11:20 AM	Technical Presentation 5: From Kaduna to Nigeria: Social Accountability for PHC Impact and Sustainability	Ms. Roseline Nyong
11:20 – 11:50 AM	Tea Break	—
11:50 AM – 12:30 PM	Discussion of Technical Presentations	Dr. Mike Egboh; Dr. Aisha Abubakar Sadiq
12:30 – 2:30 PM	Panel Discussion: Voices, Systems, and Accountability: Driving PHC Performance in Nigeria	Moderator: Dr. Amina Mohammed Baloni
2:30 – 3:20 PM	Closing Session: Statement of Commitments/Communiqué; Closing Remarks; Vote of Thanks	Dr. B. Davidson; Dr. Salamatu Anas Ibrahim; Dr. Clement Woje
3:20 – 4:00 PM	Lunch	—

Note: The above times are from the draft agenda as circulated prior to the meeting. Actual session timings as recorded by rapporteurs differed from the scheduled times and are used throughout the main body of this report. Agenda-listed times are provided here for reference only.

Appendix 2: Attendance List

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
1	Mr. Sadiq Malami	AHBN		FCT Abuja	Civil Society / Development Partner Participant
2	Prince Mustapha	AMAC, Ward Development Committee, Abuja	WDC Chairman AMAC	FCT Abuja	Community / Facility Stakeholder Participant
3	Ms. Uba Oluchukwu Francisca	ASII		FCT Abuja	Civil Society / Development Partner Participant
4	Dr. Terfa Kene	Association of Public Health Physicians of Nigeria (APHPN)	President	FCT Abuja	Civil Society / Development Partner Participant
5	Mr. Benjamin Samson	Blueprint Newspapers Limited		FCT Abuja	Media Representative
6	Ms. Belinda Edo	BudgIT Nigeria		FCT Abuja	Project Partner / Organiser
7	Ms. Roseline Nyong	BudgIT Nigeria	Programme Officer, BudgIT	FCT Abuja	Technical Presenter
8	Mrs. Comfort Onechojo Ogbaje	BudgIT Nigeria		FCT Abuja	Project Partner / Organiser
9	Dr. Biobele Davidson	BudgIT Nigeria	Health Systems Strengtheni ng Lead	FCT Abuja	Co-host / Welcome Address; Technical Presenter
10	Mr. Olayemi Aboduni	Centre for Citizens Advocacy and Social Impact (CCSI)		FCT Abuja	Civil Society / Development Partner Participant
11	Mr. Akintola Oluseyi	Centre for Citizens Advocacy and Social Impact (CCSI)		FCT Abuja	Civil Society / Development Partner Participant
12	Mr. Paul Dasimeokun	Centre for Social Justice		FCT Abuja	Civil Society / Development Partner Participant
13	Ms. Chiamaka L. Benedict	Chiben International Service Limited		FCT	Civil Society / Development Partner Participant
14	Mr. Idalla Goerge Charlie	Community — Abuja (FCT)		FCT Abuja	Community / Facility Stakeholder Participant
15	Mr. Monday Gyubok	Community — Jaba Local Government Area	Youth Leader	Jaba	Community / Facility Stakeholder Participant

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
16	Mr. Douglas J. Bako	Community — Jemaá Local Government Area	Religious Leader, Kubau	Jemaá	Community / Facility Stakeholder Participant
17	Mallam Musa Philibus	Community — Kubau Local Government Area		Kubau	Community / Facility Stakeholder Participant
18	Mr. Zakious D. Barau	Community — Lere Local Government Area		Lere	Community / Facility Stakeholder Participant
19	Mr. Mohammed Sani Maiwada	Community — Shika, Giwa Local Government Area		Shika, Giwa	Community / Facility Stakeholder Participant
20	Mr. Ibrahim Atta	Community-Based Women and Children Initiatives (C-WINS)		FCT Abuja	Project Partner / Organiser
21	Mr. Abdullahi Sani	CREAP Africa Initiative		FCT Abuja	Civil Society / Development Partner Participant
22	Ms. Ajayi Precious Tolulope	DGI Consult		FCT Abuja	Civil Society / Development Partner Participant
23	Ms. Victoria David	DKT International		Kaduna	Civil Society / Development Partner Participant
24	Ms. Esther Ojo	DW Consult		FCT Abuja	Panellist
25	Mrs. Mary Igbinoss	EEBHUB		FCT Abuja	Civil Society / Development Partner Participant
26	Dr. Ekam Ethel	Federal Ministry of Health	Special Adviser to the Coordinating Minister of Health and Social Welfare on the Basic Health Care Provision Fund (BHCPF)	FCT Abuja	Government Representative Participant
27	Mr. Gabriel Baba Dickson	Federal Ministry of Health and Social Welfare		FCT Abuja	Government Representative Participant
28	Dr. O. Ogbe	Federal Ministry of Health and Social Welfare		FCT Abuja	Panellist
29	Mr. Dakum Loyid Boji	Federal Ministry of Health and Social Welfare		FCT Abuja	Government Representative Participant

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
30	Ms. Elizabeth Abesoye	Federal Ministry of Information and National Orientation		Kaduna	Government Representative Participant
31	Mr. Daniel Adejo	Federal Radio Corporation of Nigeria (FRCN)		FCT Abuja	Media Representative
32	Mr. Salam Abdulrahman	Grassroots Voice Nigeria		FCT Abuja	Civil Society / Development Partner Participant
33	Mr. Jimoh Owolabi	Haavees Technologies		FCT	Civil Society / Development Partner Participant
34	Ms. Opeyemi Adeosun	Health Reform Foundation of Nigeria (HERFON)		FCT Abuja	Civil Society / Development Partner Participant
35	Mrs. Nmachukwu Gloria Ihegworu	Health Reform Foundation of Nigeria (HERFON)		FCT Abuja	Civil Society / Development Partner Participant
36	Ms. Rita Gambo	Health Sector Reform Coalition (HSRC)	Field Officer, HSRC SCAPP Project, Jemaá	Jemaá	Project Partner / Organiser
37	Mr. Abaya Sunday Usman	Health Sector Reform Coalition (HSRC)	Field Officer, HSRC SCAPP Project, Igabi	Kaduna	Project Partner / Organiser
38	Dr. Clement Woje	Health Sector Reform Coalition (HSRC)	Zonal Coordinator, HSRC SCAPP Project	Kaduna	Project Partner / Organiser
39	Dr. Musa Wakawa	Health Sector Reform Coalition (HSRC)	Field Officer, HSRC SCAPP Project, Zaria	Zaria	Official meeting rapporteur
40	Dr. Henry Julius	Health Sector Reform Coalition (HSRC)	Field Officer, HSRC SCAPP Project, Giwa	Zaria	Official meeting rapporteur

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
41	Dr. Mark David Anthony	Health Sector Reform Coalition (HSRC)	Zonal Coordinator, HSRC SCAPP Project	Kaduna	Project Partner / Organiser
42	Mr. Ado Zakari Mohammed	Health Sector Reform Coalition (HSRC)	Zonal Coordinator, HSRC SCAPP Project	Zaria	Project Partner / Organiser
43	Dr. Juliette Ango	Health Sector Reform Coalition (HSRC)		FCT Abuja	Master of Ceremony
44	Ms. Nike Punshak	Health Sector Reform Coalition (HSRC)	Field Officer, HSRC SCAPP Project, Kudan	Zaria	Project Partner / Organiser
45	Dr. Suleiman Usman	Health Sector Reform Coalition (HSRC)	Data Analyst, HSRC SCAPP Project	Zaria	Project Partner / Organiser; Technical Presenter on behalf of Dr Mustapha Lecky, Chairperson HSRC
46	Ms. Bisan Shekari	Health Sector Reform Coalition (HSRC)		Zaria	Project Partner / Organiser
47	Mrs. Akaoma Onyemelukwe	Health Sector Reform Coalition (HSRC)	Business Development Advisor	FCT Abuja	Master of Ceremony
48	Dr. Mike Egboh	Health Sector Reform Coalition (HSRC)	Board Member, HSRC	FCT Abuja	Discussant
49	Prof. Clara Ladi Ejembi	Health Sector Reform Coalition (HSRC)	Vice Chairman, Health Systems Strengthening; SCAPP Project Coordinator	Kaduna	Co-host / Welcome Address; Closing Remarks
50	Mr. Punshak Watle Matawal	Health Sector Reform Coalition (HSRC)	Admin, HSRC SCAPP Project	Zaria	Project Partner / Organiser
51	Mr. Onoja Ambassador	Health Sector Reform Coalition (HSRC)	Financial Secretary	Makurdi	Project Partner / Organiser

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
52	Mr. Musa Muhammad Danmusa	Health Sector Reform Coalition (HSRC) / Community-Based Women and Children Initiatives (C-WINS)	General Secretary	FCT Abuja	Civil Society / Development Partner Participant
53	Mr. Collins Nyong	HSC		FCT Abuja	
54	Mr. Ibrahim Ibrahim	HSDF		Kaduna	
55	Dr Ndaeyo Iwot	HSRC			
56	Dr. Amina Mohammed Baloni	Independent (Former Commissioner of Health, Kaduna State)		Kaduna	
57	Ms. Temitope Joseph	ISMPH	Former Commissioner of Health, Kaduna State	FCT Abuja	Civil Society / Development Partner Participant
58	Chief (Mrs.) Moji Makanjuola	ISMPH		FCT Abuja	Civil Society / Development Partner Participant
59	Mrs. Ijeoma Charity Ogbo	ISMPH		FCT Abuja	Civil Society / Development Partner Participant
60	Mr. Lawrence Adeniji	Justina Lawrenzo Foundation		FCT Abuja	Civil Society / Development Partner Participant
61	Ms. Roseline Abu Awaje	Justina Lawrenzo Foundation, Nasarawa State		Nasarawa	Civil Society / Development Partner Participant
62	Mr. Abu Promise	Justina Lawrenzo Foundation, Nasarawa State	Co-Chair, Advocacy Sub-Committee, KADMAM	Nasarawa/Karu	Civil Society / Development Partner Participant
63	Mrs. Mariam J. Ahmad	Kaduna State Mechanism for Accountability for Maternal Health (KADMAM)		Kaduna	Project Partner / Organiser
64	Alhaji Garba Muhammad	Kaduna State Mechanism for Accountability for Maternal Health (KADMAM)		Kaduna	Project Partner / Organiser
65	Mr. Bello Abdullahi	Kaduna State Mechanism for Accountability for Maternal Health (KADMAM)		Kaduna	Project Partner / Organiser

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
66	Dr. Aishatu Abubakar Sadiq	Kaduna State Ministry of Health	Permanent Secretary	Kaduna	Discussant
67	Dr. Joseph Sunday	Kaduna State Ministry of Health	Director, Planning, Research and Statistics	Kaduna	Government Representative Participant
68	Mr. Abubakar Sadiq Idris	Kaduna State Ministry of Health		Kaduna	Government Representative Participant
69	Hajiya Nafisat Musa Isa	Kaduna State Primary Health Care Board	Director, Community Health Services	Kaduna	Panellist
70	Mr. Isah Yushau	Kaduna State Primary Health Care Board		Kaduna	Government Representative Participant
71	Mr. Ralph Pepple	LEA		FCT Abuja	Civil Society / Development Partner Participant
72	Ms. Esther M. Tanko	Local Government Health Authority, Jemaá		Jemaá	Government Representative Participant
73	Ms. Hindatu Adamu	Local Government Health Authority, Kajuru		Kajuru	Government Representative Participant
74	Dr. Hauwa M. Mahmud	Local Government Health Authority, Zaria LGA	Health Secretary	Zaria	Government Representative Participant
75	Mr. Kenechi Bernard	M.H.W.I		FCT Abuja	Civil Society / Development Partner Participant
76	Mallam Sabitu Ashiru	Malikachi Mosque, Ikara, Kaduna State	Imam, Malikachi Mosque	Ikara	Community / Facility Stakeholder Participant
77	Mrs. Shifau Shehu	Nadeiza Ventures		FCT Abuja	Civil Society / Development Partner Participant
78	Mrs. Lateefah Ometere Shehu	Nadeiza Ventures		FCT Abuja	Civil Society / Development Partner Participant
79	Dr. Nana S. Abubakar	National Primary Health Care Development Agency (NPHCDA)	Director, Community Health Services	FCT Abuja	Panellist
80	Ms. Upundu Uzoamaka	NDITDA		FCT Abuja	Civil Society / Development Partner Participant

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
81	Mr. Iheanicho Chigbo	News 24 Extra	Special Adviser to the President on Health	FCT Abuja	Media Representative
82	Mr. Sheriff Gbadamosi	Nigeria Health Watch		FCT Abuja	Civil Society / Development Partner Participant
83	Ms. Aisha Ndakun	NYII		FCT Abuja	Civil Society / Development Partner Participant
84	Dr. Salma Ibrahim Anas	Office of the Special Adviser to the President on Health (OSAP-H)		FCT Abuja	Chairperson of the Occasion; Closing Remarks
85	Ms. Audu Hadiza Bui	Office of the Special Adviser to the President on Health (OSAP-H)		FCT Abuja	Government Representative Participant
86	Mrs. Maryam Umar Abdullahi	Primary Health Care Facility — Hunkuyi	Officer-in-C harge, PHC Hunkuyi	Hunkuyi	Community / Facility Stakeholder Participant
87	Mr. Saidu Danlami	Primary Health Care Facility — Igabi Local Government Area	Officer-in-C harge, PHC Igabi	Igabi	Community / Facility Stakeholder Participant
88	Mr. Ochigbo Godwin Augustine	Primary Health Care Facility, Gwantu Ward, Sanga Local Government Area	Officer-in-C harge, Gwantu Ward Primary Health Care Facility	Sanga	Panellist
89	Mr. Ajemobi Kayode	R & T	Sarkin Tsibiri	FCT Abuja	Civil Society / Development Partner Participant
90	Ms. Thereza N. Okafor	Tessy Beads Company		FCT	Civil Society / Development Partner Participant
91	Mr. Nzor Ernest	The Guardian Newspapers		FCT Abuja	Media Representative
92	Mr. Michael Olabode	ThisDay Newspapers		FCT	Media Representative
93	Alhaji Shehu Abbas	Tsibiri Community, Shika Ward, Giwa Local Government Area, Kaduna State		Shika, Giwa	Community / Facility Stakeholder Participant
94	Mr. Olusegun Emmanuel	TV360 Nigeria	Sarkin Tsibiri	FCT Abuja	Media Representative
95	Mr. Emeka Amakor	TV360 Nigeria		FCT Abuja	Media Representative

S/N	Name (Title Inclusive)	Organisation (Full Name)	Role in Organisation	Location	Role in Engagement Meeting
96	Mr. Nduka Gold	UTN		Kaduna	Civil Society / Development Partner Participant
97	Ms. Chika Nwankwo	Vaccine Network		FCT Abuja	Civil Society / Development Partner Participant
98	Ms. Chika Offor	Vaccine Network (Development Connectors)		FCT Abuja	Civil Society / Development Partner Participant
99	Comrade Muhammad Yusuf Nadabo	Ward Development Committee, Barnawa Ward, Kaduna South Local Government Area	Ward Developme nt Committee Chairman, Barnawa Ward	Kaduna	Panellist
100	Rev. Joshua Haruna Yakubu	Ward Development Committee, Kachia Local Government Area		Kachia	Community / Facility Stakeholder Participant
101	Mr. Sanusi Hamza	Ward Development Committee, Zaria		Zaria	Community / Facility Stakeholder Participant
102	Ms. Chidinma Anyiam			FCT	Participant
103	Mr. Albert Karis			FCT Abuja	Participant

Appendix 3: Technical Presentations

See attached files:

Presentation 1: Citizens & Patients as Agents of Change By Dr Biobele Davidson, Strengthening Health System Lead, BudgIT Foundation.

Presentation 2: Powering Accountability: Ward Development Committees as Drivers of Change in Kaduna State By Prof. Clara Ejembi, Vice Chairperson, Health Systems Strengthening, HSRC/HSRC Lead, SCAPP Project, Kaduna.

Presentation 3: The Last Mile Test: Fixing Service Delivery Bottleneck by Dr Ndaeyo Iwot, Secretary HSRC.

Presentation 4: Scapp Project Experience on Financing & Accountability – Basic Health Care Provision Fund (BHCPF) and Beyond By Dr Lecky Mustapha, Chairperson HSRC Presented by Dr Suleiman Usman, HSRC.

Presentation 5: Scaling Citizen Engagement in Primary Healthcare By Roseline Nyong, Assistant Program Officer, Strengthening Health System Lead, BudgIT Foundation.





