

NASARAWA STATE OF NIGERIA

Integrated Rural Development - through a prioritised Health Agenda



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Government of Nasarawa State, Nigeria
Lafia
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1.0 BACKGROUND

“Several years ago, a certain Farmer in a remote part of Nasarawa State witnessed how a weak and tired woman who was said to be bleeding following child birth was being transported to the next available health facility from her village to seek medical help. The woman was sandwiched between two men on a motorbike. While the man in front struggled to manoeuvre the motorbike along the rough and hilly country side, the one behind her supported her from falling off the motorbike as they climbed in and out of ditches, and up and down huge bumps. Although the Farmer could do little to help this emergency situation, the outcome of this case had a permanent presence in his mind. He also wondered - how many of such events may be taking place on daily basis in rural Nasarawa State. The Farmer had the conviction that actions must be taken by those responsible to make sure that rural people like this woman have quick access to medical care when and where they need it. But when and how will it be done?”

The difficulties people have been going through in accessing health care in Nasarawa State can roughly be assessed if one imagines that this opening incident or something similar occurs everyday and in many places across the State. Accessibility to health care services has therefore been a major problem. A survey¹ conducted by the State in 2008 revealed that out of total number of 668 PHC clinics in the State, only 95 (14.2%) could provide basic emergency obstetric care; 28 of them (4.2%) had the capability of providing malaria services, while running tap water was only available in 73 PHC clinics (10.9%). In the meantime, the populations of the State and especially those in rural areas are continuously been subjected to many common diseases such as malaria, pneumonia, diarrhea, dysentery, tuberculosis etc, which can easily be prevented and/ or treated.

Access to health care services was a major contributor to the unacceptable poor health indicators.

Similarly, due to their biological vulnerability, women, children and the elderly in Nasarawa State like their counterparts elsewhere also require specific health services that are necessary for the promotion of their health and well being. Nonetheless, the 2008 Nigeria Demographic and Health Survey (NDHS)² report showed that in Nasarawa

¹ Survey carried out in May 2008 by the Nasarawa State MDGs Project Implementation Unit for the purpose of gap analysis in 2008 Conditional Grant Scheme (CGS) – Federal Government of Nigeria application

² Nigeria Demographic and Health Survey (NDHS) Preliminary Report.

State, only 16.1% of children below 2 years of age had the required vaccination for the prevention of childhood diseases. The same report also indicated that, although 72.6 % of pregnant women in Nasarawa State received ante natal care from a health professional, only 33.8 % were delivered by a health professional. These figures no doubt have strong implications for the observed high probability of children dying between birth and their fifth birthday (under five mortality) as well as the high probability of women dying during child birth (maternal mortality) in Nasarawa State. (See Annex)



**Equity was an issue:
There was a need to reduce
exclusion and social
disparities**

In addition, as most people in the State are farmers, they are at risk of certain occupation-related health problems such as snake bite and physical injuries that may require emergency medical attention or hernias resulting from the tedious manual labour that may need surgical operation. But the health services of Nasarawa State did not seem to be organised around all these needs and expectations of the people despite huge investments that have been committed to this sector. This situation has been the cause of unnecessary suffering and loss of life among poor rural communities in the State.

The poor health outcomes in Nasarawa State were not only the result of limited coverage of basic health services but also reflected inadequate quality of care. All aspects of the health care delivery system - from poorly informed consumers to under management of public services - were affected. Many of these problems were related to gross deficiencies in critical inputs such as drugs, supplies, equipment and health professionals as well as dilapidated health facilities. In addition, there was lack of supportive supervisory systems, procedures and skills for dealing with common health problems and quality assurance mechanisms for improving service delivery. Previous attempts to improve quality of care - with drugs, equipment and facility upgrading and standard treatment protocols - also failed largely due to not paying adequate

attention to the development of accompanying management and maintenance systems. Not unexpectedly, therefore, utilisation rates were extremely low. A high proportion of health facilities reported providing PHC services but those that provide daily services were quite few. Underutilisation results in high unit costs and is an inefficient use of scarce resources.

It was this context that prompted the current Executive Governor of Nasarawa State, **Alhaji (Dr) Aliyu Akwe Doma** - who was also 'the Farmer', referred to in our opening story - to do things differently on assumption of office in May 2007. It was a challenge that needed new values, principles and approaches. The Governor and his team figured out that to get the existing health facilities functioning and patients returning will require massive improvements in availability of health facilities as well as management of drugs, supplies, equipment, transport and human resources. An adequate water supply and sanitation in health facilities was also a critical need.

Doing Things Differently:

Organising the health care services around people's need and expectations



They also noted that overall physical access could still be a problem, but getting the existing health facilities to function and to link them up to higher levels of care through a referral system would substantially increase coverage of the population. A major shift in the management and organisation of State and Local Governments arrangements for health care delivery was also required to ensure more judicious use of available scarce resources as well as a substantial increase in budgetary allocations for health. All these imperatives were needed if the new administration in Nasarawa State was to be more responsive to the new challenges as it began to make serious progress towards achieving the Millennium Development Goals (MDGs).

This report is a summary, outlining the *strategy* and the *key components* of an 'emergent model' of primary health care (PHC) service delivery that has come out from finding solutions to intractable problems that have been confronting the health sector in Nasarawa State. The model basically uses a 'health agenda' to drive

'integrated rural development' that in turn leads to sustainable primary health care delivery system.

2.0 STRATEGY

Despite the presence of urban centres such as Lafia - the State capital, Keffi, Akwanga and areas adjoining the Federal Capital Territory (FCT), Nasarawa State is largely rural - and this is where majority of the population also live. With the general deplorable state of primary health care services in the State, rural people are particularly disadvantaged and thus have to be specifically targeted with the provision of basic health services.

The approach adopted therefore is:

To cover the entire rural population of the State with an essential package of health care services, within the limits of available resources, and de-emphasizing political affiliations.



**Universal Coverage with an Essential Package
of Health Care Services Linked to Critical
Sectors – sustainable water and electricity**

And the key **guiding principles** in implementing this strategy include:

- Ensuring that political and social exclusions and disparities are reduced to the barest minimum;
- Health services are organised around the needs and expectations of the people, given the socio-economic conditions and geography of the State;
- Health is integrated into other areas that make rural living more productive;
- Effective collaboration between the State, Federal and Local Governments in resource mobilisation and commitment to health; and
- Increasing stakeholder participation in planning and implementation.

3.0 KEY COMPONENTS

The following are the key interventions undertaken in an integrated manner:

- ✓ Increasing geographical access to all rural populations
- ✓ Delivery of a package of essential health care services
- ✓ Improving the quality of health care services
- ✓ Creating effective demand for health care services
- ✓ Community ownership and participation in management of health facilities
- ✓ Sustainable professional management support
- ✓ Providing direct linkage to other critical sectors

3.1 Increasing Geographical Access to all Rural Population

The physical distance to health facilities/services has been a major hindrance for most rural populations in accessing health services in Nasarawa State. Coupled with poor state of roads (either permanent or seasonal), lack of transport and communications - this situation particularly creates serious problems for patients requiring emergency care or those who need to make many repeat visits for treatment over a long period. Still some villages are only accessible through neighbouring States such as Benue, Kogi and the FCT. Although massive construction of roads on all flanks of the State is being undertaken to generally reduce the physical distance between many rural communities and access to socio-economic services.



**Before: Dilapidated
Health Facility**

Through a mapping of the existing health facilities in the State, a phased target of equitable distribution of health facilities was set. The initial target was to ensure that people have access to a health facility within a 20 kilometer (km) radius from where they live by 2008, followed by 10 km by 2009 and finally 5 km by 2010.

**And After: Completely
Refurbished and Upgraded**



So far, the 10 km mark has been reached with a total of 110 upgraded, refurbished or totally rebuilt health facilities fairly spread across the entire State. Many of these sites previously housed colonial dispensaries, some where community efforts left at foundation stages, while many others were disused Local Government health centres. The main focus was on strengthening already existing structures; nonetheless a few more were established in order to achieve total population coverage. In addition a total of 30 Comprehensive Health Centers that will serve as 'first referral centers' are being developed (some are already in operation). These are strategically located to give appropriate back up support to the PHC facilities across the whole State.

3.2 Delivery of a Package of Essential Health Care Services

The burden of disease that confronts the people of Nasarawa State is dominated by health problems that can be tackled with proven high impact interventions. They include malaria, tuberculosis, HIV/AIDS, childhood illnesses and issues related to

MDG4 - Routine Immunisation,
Appropriate Infant Feeding, Case
Management of Childhood Illnesses

Plus

MDG5 - Skilled Attendance at birth,
Community Awareness of Danger
Signs, Emergency Obstetric Care

Plus

MDG6 – Household Utilisation of ITNs,
Community DOTS, Blood safety,
Confidential Counseling and testing for
HIV/AIDs

Plus

Community Level Health Promotion
Activities

Plus

Management of Community
Accidents/Emergencies, Surgical
Treatment of Hernias and Referral

pregnancy and delivery, and care for the elderly. Others are accidents and emergencies due to the peculiar environment of the State as well as work-related problems such as injuries from farm implements or bites from snakes or animals and hernias. In the past health managers usually prompted by international donors had resorted to short-term service delivery “quick wins” interventions, which are clearly directed at reducing these major causes of morbidity and mortality in the State. Although this strategy is needed to bring about tangible change in health service delivery, paradoxically it has been observed to undermine the health system itself.

Through a need-based rational planning process an essential package of care that can be delivered through a strengthened PHC system for Nasarawa State was developed. The approach adopted focused on the delivery of preventive and curative services that target the health-related MDGs plus community level health promotion activities as well as management of common accidents and

emergencies in the community. This integrated package of essential health services is linked to and supported by an appropriate secondary level care that is also being strengthened through a different initiative.

3.3 Improving the Quality of Health Care Services

It has been noted that many communities in Nasarawa State may perceive quality of care from various viewpoints. But in general, quality of health services is seen to be poor when health facilities: have an inconsistent supply of drugs, vaccines and other supplies; are understaffed; have staff who display poor attitudes towards clients or whose competence they distrust; have irregular opening hours; have unofficial fees

for service; lack women-friendly services or lack female health workers. On the other hand, health workers may want to provide a quality service but are themselves demotivated by the lack of supplies and equipment.



**Availability of vital inputs:
Motivated Health workers with tools to
work with**

To address these critical quality issues, all the newly refurbished health facilities have been supplied with drugs, commodities and supplies to prevent and treat all the health problems as contained in the essential package of care. Each of the 58 facilities has a standard laboratory for the investigation of diseases such as malaria, tuberculosis, and HIV/AIDS. In addition, there is a borehole along side a 20,000 liter overhead water tank that supply water round the clock to the health facilities and the host community, as well as an uninterrupted electricity supply from solar panels that provide lighting, power for the medical equipment and also pump water from the borehole. There has also been massive training and re-training of all cadres of staff to improve their skills and competencies in the prevention and treatment of services required to deliver the essential care package. Furthermore, there has been attitudinal re-orientation of health workers to promote positive attitude and practices in their daily engagement with clients. Again, depending on local circumstances, many of the health facilities have introduced flexible opening hours, while several facilities have instituted gender-sensitive confidential processes for male and female patients.

3.4 Creating Effective Demand for Health Care Services

Even when physical access has been improved, drugs and equipment made available and staff trained and well behaved, anecdotal evidence suggest that there may still not be adequate utilisation of health services by many rural populations in Nasarawa State. This lack of effective demand for health care services may be due to socio-

cultural or religious factors but is usually largely the result of misinformation commonly surrounding many health related issues such as malaria, TB, routine immunisation, contraception and HIV/AIDS.

In order to increase demand and motivate communities to make use of available services, focused activities using culturally acceptable behavior change communication (BCC) approaches were put in place. In addition, there are many non-governmental organisations (NGO) now working in Nasarawa State and collaborating with government to galvanise communities to promote positive personal, household and community action for health.

3.5 Community Ownership and Participation in the Management of Health Facilities

Previously, community engagement in the identification, planning and implementation of health programmes in Nasarawa State has been minimal. Inadequate community participation has resulted to inappropriate siting of facilities, and gross under utilisation of services.



Increasing Stakeholder Participation:
Facilitated entry leads to community involvement and provides the platform for transparency and accountability

It was observed that all communities in the State naturally have some level of organisation that enables them to carry out activities that protect their common interest as well as allow them to work towards a common purpose. Nonetheless, past approaches to community participation have been very prescriptive without taking note of existing community structures and values.

This time around, after the initial contact with communities using credible NGOs to facilitate entry, all the beneficiary communities were allowed to set up their structures based on their understanding of the programme. Through the community management committees a platform for the planning, implementation, supervision and evaluation of the health facility activities has been created. The memberships of

these committees are very inclusive with women and youths adequately represented. This ensures that needs and expectations of all segments of the communities are well represented. Many communities exhibited good practices, which were shared and adopted by others.

Moreover, the reviewed Local Government Laws of the State now gives Traditional Rulers - who are highly respected by their people - more responsibilities in the active management of health facilities as well as sensitizing and mobilizing their communities for positive health actions.

Community Involvement in Action:

At Alogani-South in Nasarawa-Eggon LGA, the community management committee built and equipped an additional building to cater for male patients as the original one reconstructed did not make adequate provision for men. This same community also provided an all-inclusive management structure that has now been adopted by many other communities in the State.

From Katakpa in Toto LGA, a member of the management team rode his motorbike to Lafia, the State Capital, to give feedback on what was happening as regards certain persons who have failed to carry out assignments for which money has been paid out.

And in Gbunchu in Akwanga LGA, robbers who tried to remove the solar panel installed in their health facility were fought back by members of the community – and have since kept a security watch at the health centre.

3.6 Sustainable Professional Management Support

There is an increasing realization that improving service delivery in health care to a large extent depends on the ways resources and services are managed. It was observed that the lack of managerial capacity especially at the PHC level in Nasarawa State could become the 'binding constraint' to scaling up PHC services and achieving the Millennium Development Goals (MDGs). Moreover, it is the expectation that the PHC system in Nasarawa State is driven by the principles of good governance and decision making is based on rationality.

The development and maintenance of such management capacity within the State has been institutionalized with the establishment of an executive agency - the Nasarawa State primary Health Care Development Agency (NAPHCDA) - for that purpose in June 2009. The agency which is being funded by joint contributions from the State and Local Governments will provide the needed supportive management environment for PHC services in the State. Such an enabling environment will provide systems for financial management, management of information, human resources management,

procurement and distribution of drugs and supplies management etc, in support of the entire PHC service delivery system in Nasarawa State. In addition, the State government has also established a Public Works Maintenance Agency whose mandate include the preventive of maintenance of all public health facilities including the re-built PHC infrastructure.

3.7 Providing Direct Linkage to Other Critical Sectors

For a holistic approach to health, all sectors must be mobilized through good governance, strong political will and commitment to galvanize all stakeholders towards a common purpose - better health for all. In the past, inter-sectoral collaboration between health and other sectors such as education (school health and health education, girl-child education); Agriculture (food security, adequate and proper nutrition); Water (adequate and safe, clean water); and environment (pollution and vector control) just to mention a few, remained a rhetoric. The noticeable lack of water supply and electricity in many PHC facilities in the State attests to the non existent collaboration at the community level.



The Ginda B Challenge:

At 500m above sea level - all geophysical survey methods employed failed to show any sign of water – community water sources from ponds and streams where identified – one that was prolific was dredged, stone pitched and concrete ground water reservoir constructed – submersible pump was then used to pump water through 800m of pipe network uphill to a 20,000 liter steel overhead tank - water distributed to PHC Clinic and Community through pipe network stretching about 1500m.

In order for the State to attain the level of health status required, other social and economic sectors, other than health, have to take specific actions within their sphere of influence. Such actions are needed to synergize with key health specific actions,

which would in turn bring about health gains for the entire population. This understanding provided the deliberate basis for directly providing water and electricity in each of the health centres that would serve not only the needs of the facility but also that of the host community. This inter-sectoral action has now created the impetus to explore further how other related sectors can be linked with health in a continuous cycle that forms an integrated rural development pattern.

4.0 THE NASARAWA PHC MODEL

***“Integrated Rural Development
through a prioritised Health
Agenda”***

By ensuring that every one living in a rural community in Nasarawa State is guaranteed access to an essential package of care, delivered through a strengthened PHC system linked to other critical sectors - water and electricity for the communities served - has created a self-reinforcing model of integrated rural development.

5.0 GOING FROM HERE

Based on the positive feedback coming from the various communities already reached with this model of PHC system, and with the increasing demand from so many other communities to adopt this model, it may appear that Nasarawa State has finally hit the ‘right formula’. While this may be so, the State Government has also discovered a better way of putting together its various development agenda into a ‘workable whole’ on the frontline - the communities where people live, work and play.

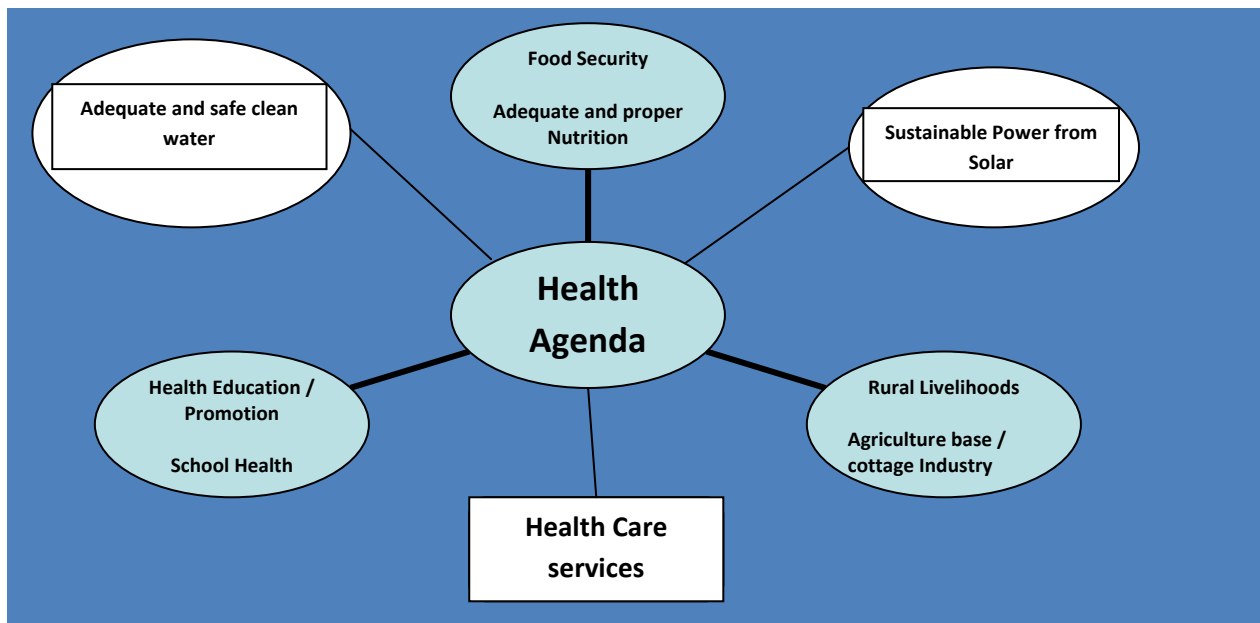
Consequently, from now on the overall goal of this programme of activities will explicitly be that of achieving rapid integrated rural development in Nasarawa State. And the purpose will therefore be to promote this model of PHC all across the entire State and integrate health into all sectors at the community level. Thus:

- The ‘Bada Koshi Agricultural Scheme linkage will ensure that hunger is eliminated, people are well nourished and rural livelihoods are sustained.

- The technology of generating electricity from solar panels will be promoted and supported to power all rural areas. Apart from providing lighting, this improved power supply will stimulate the creative energies of the people to begin to innovate - by developing new products and services - to generate employment especially for the youth.
- With water always available, women especially will have more time to do things that will improve themselves - leaning new skills or becoming better educated.

These are only illustrative of how integrating health into all other sectors in rural Nasarawa State will not only synergistically produce a 'better health outcome for all' but also a 'more productive, socially acceptable life for all". In effect the output from such a 'system of rural development' is more than the sum of the component parts. And this is the expectation of the future from the people and vision of a better Nasarawa State for all that the State Government under the present leadership of Governor Aliyu Akwe Doma is able and willing to meet.

Moving up to Scale: How the Health Agenda Drives Integrated Rural Development in Nasarawa State



ANNEX - NASARAWA STATE HEALTH INDICES

Total Population (2009 Projection):	3.1 million
Pre-school children:	133,603
Women of Reproductive Age:	496, 046
Estimated Population of Pregnant mothers:	114,333
<i>Under Five Mortality Rate:</i>	<i>150 per 1000</i>
<i>Maternal Mortality:</i>	<i>1 per 100 live births</i>
Life Expectancy:	51.5 years

Source: Government Views and Decisions on the Report of the Nasarawa State Health Care Assessment Committee. July, 2008

Enquiries to:

Nasarawa State Primary Health Care Development Agency

