[1]LINKING HEALTH AND DEVELOPMENT IN NIGERIA: THE ORIADE INITIATIVE

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Abstract

In spite of the integrated vision of the Alma-ata declaration, pathways between health and poverty have been poorly analyzed and health has largely remained a secondary dimension to development rather than its central focus as required by the declaration. Health development programs have also recorded minimal success in fostering a true sense of local participation and ownership and communities have been beneficiary, not partners or stakeholders. Several reform initiatives including the World Bank's Comprehensive Development Framework, the renewed strategy of Health for All of the World Health Organization and the United Nations Special Initiative for Africa have been proposed to address these deficiencies in previous programs.

Since 1995, the Center for Health Sciences Training, Research and Development (CHESTRAD) International has implemented an operations research project, the Oriade Initiative. The Initiative presents co-financing and co-management based on existing local practice as adaptable and feasible strategies for sustainable development with active participation of the local community and its partners. The Initiative is implemented in four inter-dependent steps: community organization and mobilization, empowering for sustainability, poverty and health development surveys and sectoral development activities. It is active in 6 communities in 1 urban and 5 rural communities in Nigeria.

Initial experience suggests that giving power and voice to local communities require time, up to three years. International commitment to provision of technical assistance to local communities to attain this level of engagement is required is ownership is to be truly local, and communities are to effectively participate in their own development. The renewed efforts for comprehensive and participatory development needs to be viewed within this context, giving greater recognition to the role of local communities in implementation, evaluation and financing of health initiatives within an overall strategy of poverty reduction and local development.

Development and Health

The conference at Alma-ata proposed Primary Health Care (PHC) as an 'integral part of the country's social and economic development' and called for the adoption of a more inclusive approach to health development which integrates other sectors and provides an enabling environment for social and economic growth (WHO, 1978). In spite of the integrated vision of the declaration, pathways between health and poverty have been poorly analyzed and health has largely remained a secondary dimension to development rather than its central focus. Consequently, health investments are not at the center of development assistance (WHO, 2000). Aside from placing health at the center of social and economic development, the Alma-Ata declaration was very clear in its intent to promote active community participation and self-reliance in health development efforts at all levels. The declaration advocated for the involvement of local communities and households in priority setting and in the implementation of health interventions. It further affirmed that 'the people have a right and duty to participate individually and collectively in the planning and implementation of health care' (WHO, 1978).

In 1994, the World Bank published **'Better Health in Africa: Experiences and Lessons Learned'**. This publication argues that with greater community participation via decentralization of health systems and innovative health care financing, significant health improvements in health and development are within the reach of many African households. Strategies supported by United Nations to foster African engagement and ownership of the development process is presented in its Systems Wide Special Initiative for Africa (UNSIA). UNSIA affirms that the most important condition for reform is ownership of the process by the countries and the civil society they serve. Inter-sectoral collaboration is promoted for the creation of an enabling environment for health including the provision of water and sanitation, roads and rural infrastructure, development of information technology for sustainable development and access to micro-credit/enterprise schemes for development. The World Health Organization (WHO) supports this new paradigm for health and development (WHO,

1998). WHO urges African governments and their partners to design national development plans that provide opportunities for innovative reforms for health and poverty reduction within post war or crisis reconstruction and also in the emergence of new democracies (Brundtland, 1998). In its renewed health for all policy, the organization stressed that in addition to developing sustainable health systems, all organized efforts to improve health require making health central to development by combating poverty and aligning sectoral programs to health (Lipson, 1996, Lucas et al, 1997). As development paradigms move from a focus on economic growth to more concern for poverty and local ownership, improvements in health outcomes have gained recognition in programs of national development and civil society participation identified as the largest single factor in development (Wolfensohn, 1999, World Bank, 2000). World Health Organization has constituted a Commission on Macroeconomics and Health (CMH) with the task of conducting the needed analysis of how health relates to macroeconomic and development issues. The World Bank (WB) Comprehensive Development Framework (CDF) seeks improved balance in policy-making and inter-sectoral cohesion for development. More importantly, the CDF argues that countries, communities and households should be in the lead with areas of support identified by partners within a country-defined agenda for local and national development (WB, 1999).

Health and poverty in Nigeria

Poverty represents a waste of human resource that could be invested to the benefit of the society in long-term productivity and growth (Novak, 1996). There is no universal definition of poverty and much of the debate on this issue has evolved from a 'western or economic perspective' The classic definitions are traditionally those of relative poverty (physical, economic and socio-psychological) or absolute poverty indicating a lack of resources. Relative poverty indicates that people are poor in relation to other people, while absolute poverty suggests living below a certain minimum standard quality of life (Chambers, 1995). The goal is to define local thresholds of quality of life below which one can be classified as poor (Oladipo, 1999). The Nigerian preliminary report on the World Bank global consultations with the poor suggests that communities in Nigeria have a rich, complex and comprehensive experience of poverty,

defining it using a range of material and non-material indicators. Increasingly, communities perceive poverty as an overwhelming denial of their right to a quality of life that is enabling and empowering with characteristics of social exclusion, vulnerability and insecurity (WB, 1999).

It is estimated by the United Nations that about 20% of Africa's population reside in Nigeria and that over 50% of African investment is in its most populous nation (Chinsman, 1998). In spite of substantial economic progress and social advancement in the past thirty years, there is still much human suffering and the country continues to face enormous challenges in setting a development agenda that meets the needs of its citizenry in a cost-effective and equitable way. About 40% of the Nigerian population lives in absolute poverty (defined as earning less than $1.00 a day) with about 80% of the poor residing in rural areas (UNDP, 1996). The Gross National Product (GNP) has declined from $ 1,000 in 1980 to $260 in 1995, placing Nigeria among the 20 poorest nations in the world (UNDP, 1998). The Physical Quality of Life Index (PQLI) recorded in 1980 was 38% in Nigeria, while Kenya reported an index of 53% and Ghana and Cote d'Ivoire 41% respectively (UNDP, 1996). The United Nations Development Program's (UNDP) Human Development Index (HDI) for 1996 placed Nigeria 137th of the 174 countries assessed lagging behind Cameroon, Ghana and Zambia, countries without her natural and human resource. The 1998 figure was more dismal and Nigeria ranked 142 among the 174 countries assessed (Oladipo, 1999).

Table One: Human Development Index in Nigeria (1960 – 1996)

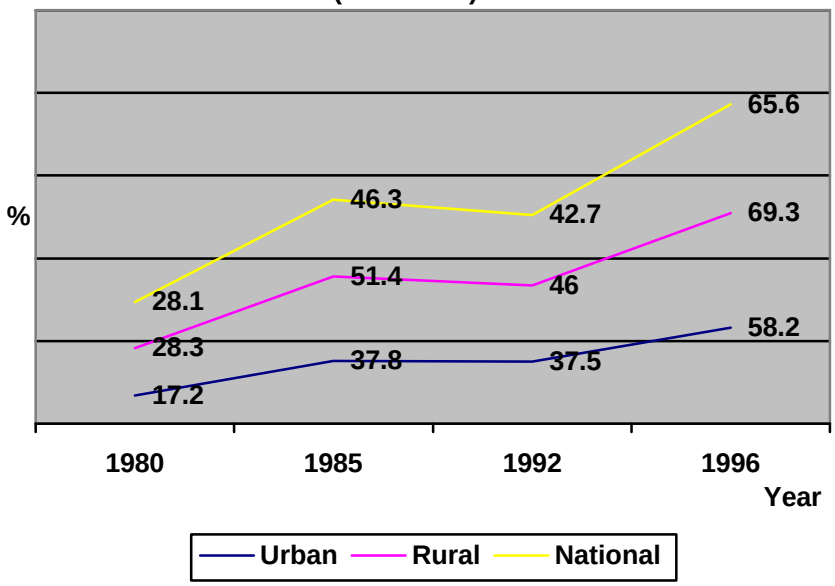
Year	1960	1970	1980	1990	1991	1992	1993	1994	1995	1996	1997	1998
HDI	0.18	0.23	0.30	0.32	0.24	0.35	0.25	0.35	0.40	0.40	0.41	0.39

Source: UNDP Human Development Report, Nigeria (1996), Oladipo, 1999

Recent figures from the Federal Ministry of Health indicate that infant mortality is 114 per 1000 live births and under-five mortality is 92 per 1000 live births for the male child and 174 per 1000 live births for the female child. Life expectancy is 52 years, adult literacy rate 59% for males and 39% for females; only 49% have access to safe drinking water and 56.3% access to organized health care services (UNDP, 1998).

In its 1999 publication of the poverty profile for Nigeria, the Federal Office of Statistics report that during a 17 year period (1980-1996), the proportion of core poor rose five-fold from 6.2% in 1980 to 29.3% in 1996, with the greatest percentage increase in the period between 1992 and 1996. Levels of urban poverty also worsened sharply from 17.6% in 1980 to 37.8% in 1985 with an all time high of 58.2% (FOS, 1999).

Figure One: Poverty Incidence in Nigeria by Sector (1980-1996)



The Human Poverty Index (HPI) for Nigeria in 1998 was reported at 46.1 and Nigeria has become one of the poorest countries in the world, a pitiable state of poverty in the midst of plenty (Chinsman, 1998).

This paper presents experience in the design, planning, and implementation of community managed poverty and sustainable health development project in Nigeria – the Oriade Initiative. It also presents approaches to sustained community engagement and financial sustainability of local efforts to alleviate poverty, promote self-reliance and engage partners in local development.

The Oriade Initiative

Since 1995, a non-governmental institution (NGO) in Nigeria, the Centre for Health Sciences Training, Research and Development (CHESTRAD) International has advocated for local development based on the principles supported by national development objectives and policies, the World Bank, WHO and strategies identified by UNISA (Kale et al, 1996, Dare 1998a; 1998b; Dare, Gibril, 1998). As a part of this process, a community based operations research project for poverty alleviation and sustainable development through health reform, the Oriade Initiative, is implemented. The Oriade Initiative presents co-financing and co-management based on existing local practice as adaptable and feasible strategies for sustainable development with active participation of the local community and its partners. Its broad goals are to implement comprehensive people-centered poverty alleviation programs with health as its focal and entry point, implemented by self-reliant local communities via innovations in co-financing and co-management. Drawing on the Alma Ata declaration for primary health care and activities of the Bamako Initiative, it seeks to build the capacity of local communities to assess their own health priorities, identify solutions to them, implement these solutions and monitor the impact on pre-defined health and development outcomes. The Oriade Initiative is currently implemented in four states in Nigeria with over 4,000 members in 6 communities engaged in self-reliant community development. The Oriade Initiative has the following objectives:

To:

1. Advocate for broad-based dialogue with stakeholders, including the civil society, in the identification, planning and evaluation of development activities at the local level
2. Build the capacity of local leaders (existing and new) for participatory development, collaborative health leadership, comprehensive development planning/financing, transparency and good governance
3. Promote sustainability of local health development efforts by community engagement in innovations in co-management and co-financing

4. Disseminate key lessons and experiences learned to stakeholders and partners in African health development

The initiative was designed for implementation in inter-dependent steps following requests for technical assistance from local communities to implement or design programs of poverty alleviation, health and/or development. Activities also assist implementing communities to collect and appropriately use locally gathered information for planning and action, establish a social savings and investment scheme, build partnership with public sector stakeholders at all levels and negotiate development assistance from donor agencies. The initiative is implemented in the following steps:

Step 1: Community Organization and mobilization

This step entails comprehensive community diagnosis to determine the eligibility of communities to participate in the initiative. Eligibility criteria include past history of self-help, existence of active civil society organizations including NGOs/CBOs and trade associations or cooperatives, commitment to collaboration with pubic sector authorities, consent of traditional heads of the community and communal harmony. It is also important for the community to have in place, or plan to establish a gender and youth inclusive local management committee. This may be the community's own development committee, the village based committee established by the local government or a newly established committee for the initiative with representation from all other committees that may be active in the community. The initial management committees comprises of 10 persons (5 men, 3 women, one male youth and one female youth) identified by the community. Membership also includes two representatives from the local government including its political head.

To foster participation of the wider community, advocacy and empowerment dialogues (town meetings) are held quarterly and as required by planning demands. These dialogues provide a forum for the local management committee to report back to the community and to discuss new directions and challenges for

possible solutions by the community. Dialogues are held in the town hall and all members of the community are encouraged to participate.

The community supports local operations of the management committee by establishing a weekly contributory scheme. The level of contributions and schedule of payment are established by the community consensus at the dialogue. From this contribution, the committee pays village based workers and supervisors as agreed at the dialogue. The capacity of the committee to negotiate and understand development assistance from various partners, including from the local government and their civic/leadership responsibilities is a crucial and continuous strategic and leadership skills building activity during the dialogues.

Step 2: Empowering for Sustainability

A unique attribute of the Oriade Initiative is the emphasis on community co-financing to establish the administrative and financial framework for support of community development. Community contributions form the nidus of a contributory financing scheme for the initiative, **Investment-Oriade**. This is a weekly contribution paid by members of local communities. It is designed to ensure sustainability of local development efforts and provides a platform for public sector financing and the participation of international aid/development agencies in the activities of the initiative. In addition, it provides for sustainability of technical assistance provided by the local NGO/CBO and the NGO coordinating base of the initiative. Although membership of the initiative is voluntary, contribution of members to the scheme is compulsory for members. To commence this community contribution, a minimum number of 5,000 persons in the local community should have registered as members by payment of an annual registration fee of =N= 100.00 ($1.00). Weekly contributions are currently fixed at minimum of =N= 10.00 per week. Communities, depending on their social and economic profile may elect to pay a higher amount. The pooled funds are used for financing of local operations and development priorities in various sectors. Disbursements are to sectoral funds as follows: Health

(12.5%), Education (10.0%), Agriculture (12.5%), Micro-credit (5.0%), Monitoring and Evaluation (5.0%), Investment (25.0%), General Funds (5.0%), Local Operations (10.0%), Technical Assistance (15.0%). Communities may however elect to vary proportions to sectoral funds depending on local priorities as established at the community dialogues. This distribution ensures that 85% of the contribution remains for the use of the community of which ABOUT 80% is allocated to sectoral developmental activities and 20% is invested. Accruals from this investment are disbursed yearly in the proportions similar to the above. The local committee manages the funds with technical assistance and capacity building provided by the coordinating base of the Oriade Initiative.

The health fund is managed as a community based health insurance scheme. The current benefit package for regular contributors provides for free treatment of four episodes of simple malaria, 50% subsidy on the annual health screen for anaemia, nutritional status, hypertension and diabetes. It also provides on a subsidy on other fee for service schemes that are offered to the community. Other benefits of regular contribution at the minimum level include access to micro-enterprise training based local produce and eligibility for micro-enterprise/development networking. Access to micro-credit requires contribution at least 50% higher than the stipulated minimum contribution. The management committee sets exemption policies and identifies beneficiaries.

With establishment of the Community Social Savings and Investment Scheme, the 'foundation blocks' for the initiative are in place. The results of these activities and programs are sustainable as every segment of the community and stakeholders have participated in the process, visibly contributing, managing and having a stake in their own local development.

Step 3: Baseline Survey of Poverty and Health Development

The Poverty and Health Development Profile (PHDP) is an annual cross-sectional survey of registered members to monitor indicators of health status and access to social assets including safe water supplies,

sanitation and health care services. The data collected also provides data for mapping the distribution of poverty and inequities in the community, and also for program evaluation and planning. Assessment of poverty is based on a combination of public health, social and economic indicators set by the participating communities. Other indicators in agriculture, ownership of productive assets are community-specific and not included in the Composite Poverty Assessment Score (CPAS)[2]. The PHDP is conducted annually and funded by community co-payment of =N= 200.00 ($2.00/head) with subsidy provided at =N= 800.00 ($8.00) per capita. Subsidy may be provided by the state/local government or by a development partner.

Step 4: Sectoral development Activities

With completion of activities in steps 1-3 above, the community is not only empowered to participate in, and negotiate its own development, but is also ready for resource mobilization in support of the implementation of its community managed poverty alleviation and development proposal. Sectoral activities include projects in health (malaria, child survival, safe motherhood), economic empowerment (micro-enterprise support and training, micro-credit access, backyard farming), agriculture (indigenous farming and preservation techniques, use of renewable natural resources, establishment of agricultural cooperatives) and education (vocational training, adult educations, primary and secondary education). Development assistance and state intervention is required for the establishment of sectoral activities. Sustenance of these activities is however encouraged from the community social savings and investment scheme.

[2] The CPAS is assessed based on responses to the following questions: Are you unemployed? Are you unskilled? You cannot read? You have no formal education? Are you living in charitable accommodation, squatting or homeless? Your monthly cash income is less than the national minimum wage? You do not have access to safe water supplies? You do not have access to safe refuse disposal? You do not have access to safe sewage disposal services? Your household size is greater than 6? You do not have access to health care services? You do not have access to legal services?

Respondents who record greater than 6 yes responses are graded as absolutely poor, 1-6 as relatively poor and respondents with all responses as no are assessed as not poor.

Conclusion

Implementation of the Oriade Initiative commenced in Nigeria in 1996 in 1 urban and 5 rural communities. Our experience so far affirms that community organization for engagement in local health and poverty reduction initiatives require time, depending on levels social capital and desire for economic benefit in the participating community. Where social capital is high, community engagement has taken shorter periods of about 18 months; and where economic desires of the local population overrides its social capital, more effort, up to three years, is required to achieve community engagement in communal poverty reduction activities. Malaria is identified as focal disease as 'it does not recognize, gender, age or social class' It is also generally associated with loss of income, school absenteeism and inability to participate in social activities, especially during peak transmission periods i.e. the rainy season. As revealed in the CPAS, local communities identify poverty in both economic and social terms, with a deep appreciation of the broad context in which their social and economic environment expose them to lower levels of quality of life.

There is growing global acceptance of the broad nature of poverty, extending beyond traditional dimensions of income/consumption, to include health, education, productive capacity, social exclusion, vulnerability and voiceless ness. Furthermore, the general decline in public sector expenditure on social services and drastic reduction in availability of donor funds to support social development, including health, has renewed interest in community participation with financing as essential components of the community's participation. This realization has resulted in a critical review of development assistance with the adoption of approaches that promote dialogue between development partners and African governments on the one hand, and between governments and their communities on the other, placing people at the center of the development process (WB, 2000). Programs of national development need to be viewed within this context giving recognition to the role of local communities in design, implementation, financing and evaluation. Health as a crucial asset for development also needs to be

given central consideration and strategies for implementing primary health care reviewed with a view to placing health at the center of socio-economic development and of investments in development assistance. Strategies for community financing of development assistance need to be identified, tested and evaluated. This is however not without its own dilemma as many poor communities are still unable to provide the required financing to support minimum benefit package for poverty alleviation and many African governments are still trapped by heavy debt burden that make it an onerous task to provide the required subsidy in support of these benefit packages. Initiatives to relieve these debt burdens should give prime recognition to the net resource inflows required to provide support for unmet social needs, redirecting the benefits of relief towards basic social services and human needs (Sachs, 1999). Oriade Initiative attempts to respond to some of the operational issues in local participation in development design and financing, and poses more, with the ultimate goal of designing an acceptable, feasible and cost-effective community-managed strategy for local health and development in Nigeria.

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