1st Northern Governors' Health Summit

Report of Proceedings

Theme:

Alarming Death Rates in the Northern States: *The Time for Change is Now!*

Arewa House, Kaduna.
12th November, 2007

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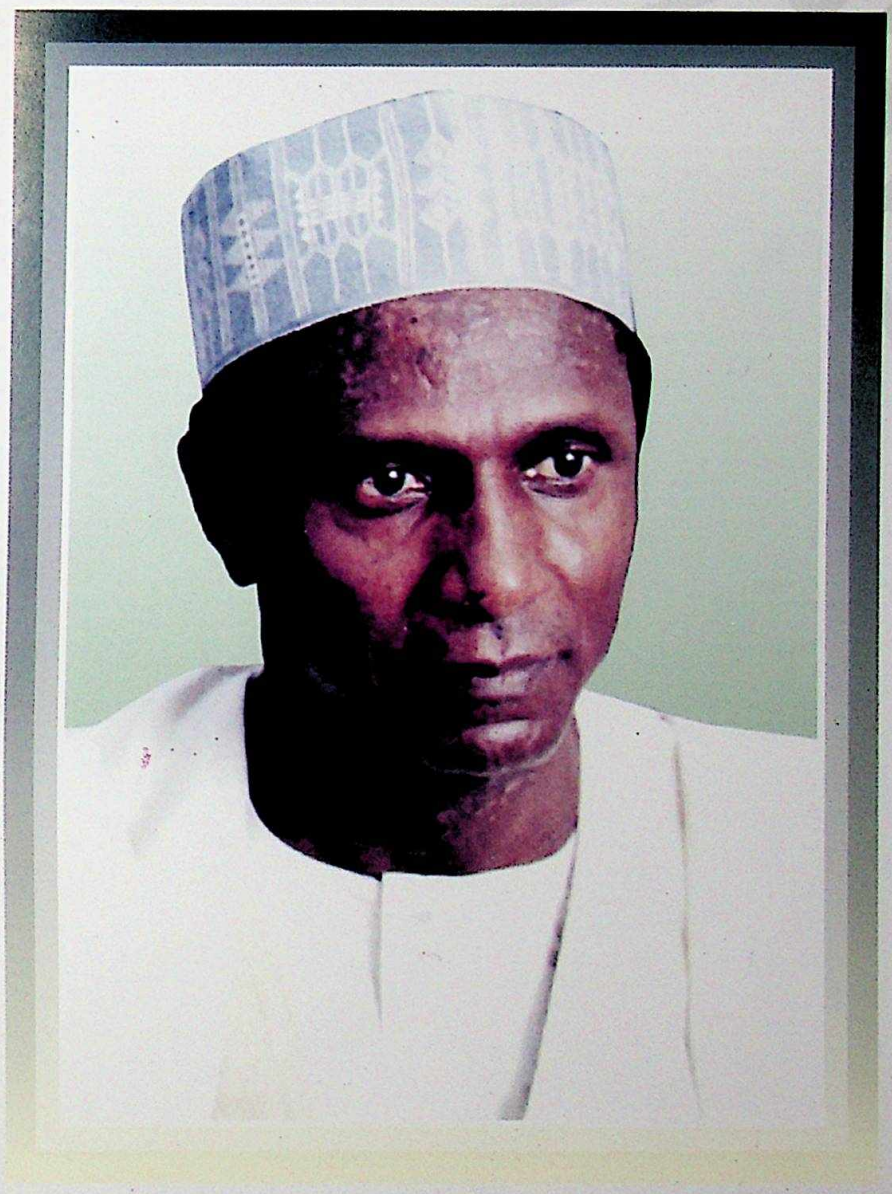
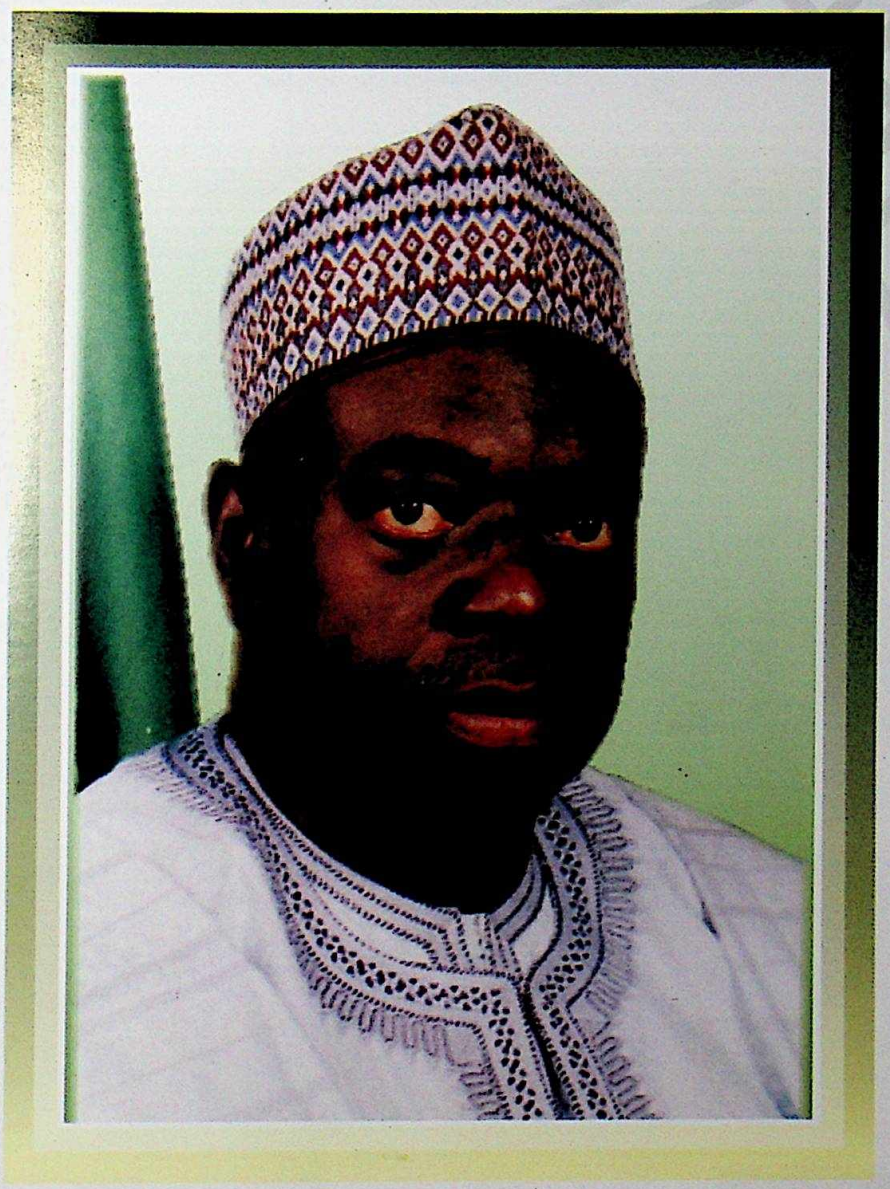


His Excellency
Alh. Umaru Musa Yar'adua *(GCFR)*
President, Commander-in-Chief of the Armed Forces
Federal Republic of Nigeria



The Chief Servant
***Dr. Muazu Babangida Aliyu,* OON**
(Talban Minna)
Executive Governor, Niger State &
Chairman Northern Governors' Forum

1st Northern States' Health Summit

His Excellency,
MURTALA NYAKO
Executive Governor, Adamawa State

MEMBERS
Northern Governors' Forum

His Excellency,
ISA YUGUDA
Executive Governor, Bauchi State

His Excellency,
GABRIEL SUSWAN
Executive Governor, Benue State

His Excellency,
ALI MODU SHERIF
Executive Governor, Borno State

The Chief Servant
DR. MUAZU BABANGIDA ALIYU, OON
(Talban Minna)
Executive Governor, Niger State &
Chairman Northern Governors' Forum

MEMBERS
Northern Governors' Forum

His Excellency,
MUHAMMED D[illegible]
Executive Governor, [illegible] State

His Excellency,
SULE LAMIDO
Executive Governor, Jigawa State

His Excellency,
ARC. MOH'D NAMADI SAMBO
Executive Governor, Kaduna State

His Excellency,
IBRAHIM SHEKARAU
Executive Governor, Kano State

ALIYU MODIBBO UMAR PhD.
Minister of the Federal Capital Territory, Abuja

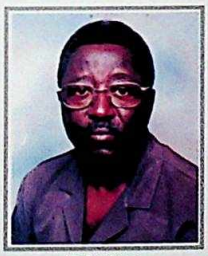
His Excellency,
BARR. IBRAHIM SHEHU SHEMA
Executive Governor, KatsinaState

His Excellency,
SAIDU USMAN DAKIN GARI
Executive Governor, Kebbi State

His Excellency,
IBRAHIM IDRIS
Executive Governor, Kogi State

His Excellency,
ABUBAKAR BUKOLA SARAKI
Executive Governor, Kwara State

His Excellency,
ALIYU AKWE DOMA
Executive Governor, Nassarawa State



His Excellency,
JOHN JANG
Executive Governor, Plateau State

His Excellency,
ALIYU MAGATAKARDA WAMMAKO
Executive Governor, Sokoto State

His Excellency,
DANBABA SUNTAI
Executive Governor, Taraba State

His Excellency,
MAMMAN ALI
Executive Governor, Yobe State

His Excellency,
MAHMUD ALIYU SHINKAFI
Executive Governor, Zamfara State

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Foreword

by the Chairman of the Northern Governors Forum

The first Northern States' Health Summit with theme: **Alarming Death Rates in the Northern States: The Time for Change is Now** was called as our response to the challenges facing the health sector in the Northern States of Nigeria. The Northern Governors' Forum (NGF), which I have the privilege to lead as Chairman, and UNICEF in partnership with other stakeholders considered it as most appropriate to call a Summit to provide an opportunity for frank, bold and realistic appraisal of all the major issues militating against the delivery of quality health care services to the people we serve.

I am particularly pleased that for the first time we have been able to realize the need to call ourselves together - political leaders, high level policy makers, development partners, non-governmental organizations, health practitioners and health scholars - to brainstorm, with the main objective of finding realistic solutions to the problems hampering effective health services delivery in the Northern States. Indeed, the overwhelming attendance and the quality of presentations at the Summit underscore the fact that such a forum was not only timely but worthwhile and long overdue, although one day proved not to be adequate.

We, at the Northern Governors' Forum are committed to supporting the resolution reached at the Summit, as well as other efforts aimed at reversing the alarming death rates in the Northern States'. Specifically, we have declared total war against Malaria and other diseases prevalent in the North. We are operationalising the provision of 'free' medical care for our children 0-5 years, free ante-natal and delivery care for women up-to 40 days post delivery and the aged 70 years and above, in most of the Northern State in Nigeria.

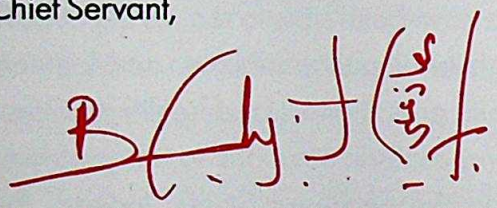
We are not unmindful of the enormous financial implications of our ambitious service delivery. However, we are confident that given the prudent management of our resources, focused and purposeful political leadership in our various States, as well as our innovative approach to finding alternative funding options we shall succeed in making everlasting positive impact on the lives of our people. We shall vigorously

explore the Public-Private-Partnership (PPP) options and realistically engage our international development partners in realizing our aspirations in the health sector.

We urge all well meaning individuals, corporate organisations and development partners to join us in this coalition to fight the scourges of diseases hampering the quality of lives of our people.

Finally, I commend this Report to all stakeholders who desire to contribute in improving the quality of health care delivery in Nigeria. It is your document; please read it and comprehend it. We have a collective responsibility to ensure effective implementation and monitoring of the resolutions reached at the Summit for the overall benefit of Nigerians

Chief Servant,



DR. MUAZU BABANGIDA ALIYU, OON
Talban Minna)
Executive Governor of Niger State and
Chairman Northern Governors' Forum (NGF)

Acknowledgments

by the Chairman Organizing Committee

On behalf of the members of the Organising Committee (OC) of the first Northern States' Health Summit, I wish to express my sincere gratitude to all those who directly or indirectly supported the organization of the historic Summit called by the Northern Governors' Forum, under the distinguished Chairmanship of Dr. Mu'azu Babangida Aliyu, OON, Executive Governor of Niger State.

Specifically, we appreciate the overwhelming support of the Chief Servant of Niger State, the Executive Governor who gave all the encouragement and paid great attention to the details of the planning processes, in spite of the time constraint, to ensure that the Summit achieves its desired objectives. Mention must also be made of the contributions of the host of the Summit, the Executive Governor of Kaduna State, Arch. Mohammed Namadi Sambo who was very accommodating.

The exciting partnership and collaboration with UNICEF in putting the Summit together deserves special recognition. The OC is eternally grateful to the Country Director of UNICEF and all principal officers of the Agency, who directly or indirectly contributed to the success of the Summit. Special mention must be made of the pioneering role of Mrs. Mahera Khatoun, formerly of UNICEF 'C' Field Office, Kaduna in the conceptualization of the Summit.

Equally the support of all the other Northern Governors and the Federal Capital Territory (FCT) Minister for facilitating the participation of their key officers at the Summit is acknowledged. Certainly, the attendance of the top officers of the stakeholder ministries from the 19 Northern States and the FCT enriched the quality of the deliberations at the Summit and signified that the much needed political attention is being paid to the issues of health care delivery in the North.

Similarly, we deeply appreciate the enormous support from the Federal Ministry of Health, led by the Honourable Minister of Health, Professor Adenike Grange, who took a personal interest in the Summit, along with the Honourable Minister of State for Health, Arch. Gabriel Aduku, as well as other Federal Health Agencies such as

National Agency for the Control of AIDS (NACA), National Health Insurance Scheme (NHIS), National Primary Health Care Development Agency (NPHCDA), etc.

In the same vain, the wealth of experience brought to bear in development work for the successful hosting of this summit by Dr. Mohammed Kuta Yahaya, Secretary to the State Government is highly appreciated. Mention should also be made of the meticulous perusal of this document before its final production by Alhaji Yahaya Shafii Dangana, Fcai, Ratibin Nupe.

Gratitude should also be expressed to the Sultan of Sokoto, Alhaji Muhammadu Sa'ad Abubakar III who led other prominent Traditional Leaders from the North to attend and participate at the Summit. The presence of our royal fathers at the Summit was not only encouraging but a demonstration of the linkages between the traditional Institutions in the North and public policy decision-making.

We wish to acknowledge with gratitude the support and participation of some of the following International Development partners and Non-Governmental Organisations (NGOs) based in Nigeria, which were invited to the Summit: Development Research Project Centre (DRPC); Mac Arthur Foundation; PATHS; WORLD BANK; CIDA; US EMBASSY; ACTION AID; SOCIETY FOR FAMILY HEALTH; CIDA; SOCIETY FOR FAMILY HEALTH; ACCESS; PPFN; ACQUIRE; GHAIN; JICA; DFID; UNFPA; HERFON; CDC; PACKARD; GOWON CENTRE; CLINTON FOUNDATION; COMPASS; and COALITION FOR CHANGE.

Finally, we acknowledge and thank Dr. C. L. Ejenbi, Dr. Buba, Dr. S. Ojomo and Dr. Hadiza Mohammed who compiled the report.

Dr. Isah Yahaya Vatsa
Commissioner of Health, Niger State &
Chairman,
Organizing Committee
December, 2007

Acronyms

AIDS	Acquired Immune deficiency Syndrome
BEOCC	Basic Essential Obstetrics Services
BP	Blood pressure
DRF	Drug Revolving Fund
ELSS	Expanded live Saving Skills
EOC	Emergency Obstetrics Care
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
HIV	Human Immunodeficiency Virus
LSS	Live Saving Skills
MDG	Millennium Development Goals
NACA	National Agency for the Control of AIDS
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
SHC	Secondary Health Care
SMOH	State Ministry of Health
THC	Tertiary Health Care
UNICEF	United Nations Children Fund

Summit Agenda

1ST NORTHERN STATES HEALTH SUMMIT AT AREWA HOUSE, KADUNA

TIME	ITEM DESCRIPTION	RESPONSIBLE PERSON
11.00-12.00Noon	**Arrival Day 11th November, 2007** Media Advisory Release on the Summit on November 11, 2007 in Kaduna	**Dr. Isah Yahaya Vatsa,** Honourable Commissioner of Health, Niger State and Chairman LOC for the First Northern Health Summit 2007
9.00-11-15AM 9.00-9.05AM	**ACTIVITY DAY 12TH NOVEMBER, 2007** **OPENING CEREMONY** Opening Prayer	Emir of Shonga in Kwara State, **Dr. Haliru Yahaya & Ven. Dr. A. Akinyemi** Programme Advisor Diocese of Jos Health and Development Service, Jos.
9.05-9. 9.25AM	Welcome and Introductory Summit Address:	'Objective of the Summit' **Dr. Isah Yahaya Vatsa,** Hon. Commissioner of Health, Niger State & Chairman LOC
9.25-9.35AM	Good will Messages: NACA, NPHCDA Development Research Project Center, Kano, Private Sector Foundation, UNFPA etc.	**Mr. Ayalew Abai,** UNICEF Representative in Nigeria, Abuja
9. 35-9.45AM	Address by the Sultan of Sokoto	His Eminence The Sultan of Sokoto **Alhaji Sa'ad Abubakar III**
9.45-10.05AMs	Drama Sketch	Drama Group ABU Zaria
10.05-10.20AM	Overview of Health Indicators in Northern Nigeria	**Dr Kole Shettima,** MacArthur Foundation, Nigeria.
10.20-10. 40AM	Status, Challenges and Opportunities in the Health System in Northern Nigeria.	**Dr. Clara L. Ejembi,** Department of Community Medicine, ABUTH Shika, Zaria.
10.40-10.45AM	Address by the Chief Host	His Excellency, **Arc. Moh'd Namadi Sambo** Executive Governor of Kaduna State.

10.45-10.55AM	Address by special Guest of Honour	The Special Guest of Honour **Prof. Adenike Grange,** Honourable Minister of Health
10. 55-11.15AM	Address and declaration of summit open by the Chairman of the Summit,	**Dr. Mu'azu Babangida Aliyu oon,** Chief Servant of Niger State and Chairman, Northern Governor's Forum
11.15-11.17AM	Introduction to Group Work	**Prof. I. A. O. Ujah, mni** Department of O & G and Dean Faculty of Medical Sciences University Teaching Hospital.
11.17-11.30AM	TEA BREAK	
	TECHNICAL SESSION I	
12.30-13.30PM	Group Work on thematic issues based on presentations:-	**Prof. I. A. O. Ujah, mni** Department of O & G and Dean Faculty of Medical Sciences University Teaching Hospital, Jos.
13.30-14.30PM	LUNCH BREAK/PRAYERS	
	TECHNICAL SESSION II	
14.30-15.30PM	Plenary :Presentations of Group Work	Hon. Commissioner of Health, Bauchi State, **Dr. Altine Tongo**
15.30-16.00PM	Resolutions/Way Forward	**Dr. Oladipo Shittu,** Department of O&G and Chairman MAC ABUTH Shika, Zaria
16.00-16.20PM	Chairman's Closing Remarks.	**Dr. Mu'azu Babangida Aliyu,** Chief Servant of Niger State and Chairman, Northern Governors' Forum
16.20-16.30PM	Vote of Thanks	**Prof. W. N. Ogala** Professor of Pediatrics A.B.U Zaria.
	MEDIA FEEDBACK	
17.00-18.00PM	Press Briefing/Interaction	**Dr. Mu'azu Babangida Aliyu,** Chief Servant of Niger State and Chairman, Northern Governors' Forum with his colleagues in attendance.
18.00-18.15PM	Departure Day 13th November, 2007	

Summit Resolutions

FIRST HEALTH SUMMIT FOR THE NORTHERN STATES OF NIGERIA

HELD ON NOVEMBER 12, 2007
AT AREWA HOUSE, KADUNA

RESOLUTIONS

One of the major issues confronting the whole world is the persistence of high maternal and childhood deaths despite all the international efforts made to prevent them through the *Safe Motherhood and child survival initiatives* that began more than twenty years ago. Over 600,000 women continue to die annually from pregnancy related causes in the world. Nigeria alone accounts for 10% of global maternal deaths, one Nigerian woman dying every ten minutes. Nigeria also has one of the world's highest death rates of children aged below five years, one out of every five children born in Nigeria does not live to see his or her fifth birthday.

The persistent inequalities in health status, especially of women and children, between the Northern and Southern States of the country remain a major source of concern. Whereas the Northern States of Nigeria are home to half of the Nigerian population, they account for a disproportionate two-thirds of these deaths. With a maternal mortality rate of 1,028 and 1,549 in the North West and North East zones of the Nigeria respectively, a woman from these zones is between six to ten times more likely to die from pregnancy related

causes than a woman from the South West zone of the same country. A child born in the southern part of Nigeria is twice more likely to see his or her fifth birthday than a child born in the northern part of the country. Majority of these deaths are from conditions that are obviously preventable. Incidentally, most countries and the Southern States of Nigerian, who now have fewer death rates have achieved this through the strengthening of their health systems and the institution of proven, simple, inexpensive and affordable death and disease reduction measures that are yet to be similarly embraced in the Northern States.

Distressed by this situation and acknowledging that the persistence of this disproportionately high mortality and morbidity will not be consistent with the dividends of democracy they wished for their people, the Executive Governors of the 19 Northern States of Nigeria decided to take steps that will stop further preventable deaths in their respective States.

In furtherance of this, the First Northern States Health Summit with the theme 'Alarming Death Rates in Northern Nigeria: The Time for Change is Now' was held on November 12, 2007, at Arewa House, Kaduna, to articulate an enduring response that would address, without delay, the low political commitment to health and social development, problems of inadequate health funding, health resources inadequacies, deficiencies of health services and health management and coordination defects among others.

Consequent upon these, the States Executives hereby resolved as detailed in the table below:

1ST NORTHERN GOVERNORS' HEALTH SUMMIT, 12TH NOVEMBER, 2007
SUMMARY OF RESOLUTIONS REACHED.

S/No.	Areas of Consideration/ Improvement	Resolutions Reached	Time Frame	Responsible Person(s)
1	**Improve on the financing of healthcare in their States through:**	Commitment to a minimum allocation of 15% of their total budgets to healthcare, in accordance with the Abuja Declaration of 2001.	24 month	Governor
		Ensuring timely and complete release of funds for healthcare.	12months	Governor
		Establishing effective mechanism for coordinating and tracking of all resources ploughed into healthcare.	12 months	Commissioner MoH LGA
		The adoption of Social Health and Community Health Insurance schemes for their States.	24 months	Governor LGA Chairman
		The Implementation of free health services for the vulnerable groups of the population including (especially women during pregnancy, childbirth & puerperal conditions), under five-year children, the elderly and the physically challenged persons.	12 months	Commissioner MoH LGA
		Partnering with development partners, bilateral agencies and private organizations to leverage additional resources for financing health services in their States.	Immediate	Commissioner MoH
		Stimulating greater commitment to investing in health care services delivery by the Local Governments.	12 months	Ministry/Dept for Local Government Local Government Service Commission (LGSC)
2	**Invest in human resources capacity building through:**	**The d**evelopment of an emergency human resource plan **for the** Northern States in Nigeria.		Commissioners MoH (all 19 States)

Time Frame: From commencement of action (s) to it full achievement
Responsible Person (s): The person with direct accountability. It is this person who will be held accountable for achievement of the desired result regardless of who s/he works with to achieve it

S/No.	Areas of Consideration/ Improvement	Resolutions Reached	Time Frame	Responsible Person(s)
		Evolving innovative strategies to increase the number of skilled and motivated female healthcare providers e.g. midwives and community midwives	12-18 months	Governors through Commissioners MoH & MoE
		Pursuing the deployment of NYSC nurses to PHCs, especially in the rural areas	12-18 months	Commissioner MoH & NYSC Directorate
		Removal of restrictions to the attraction of skilled health personnel from other parts of Nigeria seeking employment in the States with acute human resource shortages by giving them tenure appointments.	12-24 months	Governors & Civil Service Comm. (Ministry/ Department of Establishment)
		Engaging the services of retired midwives and other needed health workers to strengthen the states' capacity especially in Primary Health Care (PHC) services	12-24 months	Civil Service Commission & Local Government Service Commission
		Engaging the services of medical consultants to provide specialized services for States' Secondary Health Facilities including on part-time basis.	12-16 months	Civil Service Commission
		Redistribution of human resources to redress inequity	12-24 months	Commissioner MoH & Local Government Service Commission
		Harmonizing the remuneration of health workers for competitiveness.	18-24 months	Commissioner MoH
3	**Ensure the availability of other resources for quality health services delivery:**	Upgrading all dispensaries and health posts at Primary Health Care Centres and providing basic infrastructure in all health facilities.	18-24 months	LGA Chairmen
		Redressing inequity in the distribution of health facilities by building new ones in areas where they are not available.	12-36 months	Governors & LGA Chairmen

Time Frame: From commencement of action (s) to it full achievement
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S/No.	Areas of Consideration/ Improvement	Resolutions Reached	Time Frame	Responsible Person(s)
		Setting up/revamping drug revolving fund schemes to ensure regular availability of essential drugs in all the health facilities.	12-18 months	Commissioner MoH LGA Chairman
		Defining minimum standard equipment for each level of care and working assiduously to ensure the equipment are provided and maintained through establishing centralized equipment needs assessment, procurement & maintenance units. **(Review for adoption "minimum ward package")**	12-24 months	Commissioner MoH & LGA Chairmen
		Procuring consumables centrally, through standing orders, from reputable manufacturers	12-24 months	Commissioner MoH
		Acquiring resource-intensive equipment through 'turn-key' or 'equipment leasing' contracts.	24-36 months	Commissioner MoH
4	**Improve Health Services By:**	Developing a health plan in each State that would include the definition of range of services to be provided by the type of health facility and the resources needed.	12 months	Commissioner MoH
		Investing in strengthening Primary Health Care by mobilizing local governments to commit to PHC development and providing technical oversight and support for the LGA PHC services. Additionally, at least one health facility in each geo-political ward to be upgraded to provide comprehensive and integrated health services. This should also comprise at least the minimum service components of Primary Health Care for twenty-four hours and ensuring that these facilities are able to provide Basic Essential Obstetric Services.	12-24 months	Commissioner MoH LGA Chairmen Head of PHC Agency (when it becomes operational)

Time Frame: From commencement of action (s) to it full achievement
Responsible Person (s): The person with direct accountability. It is this person who will be held accountable for achievement of the desired result regardless of who s/he works with to achieve it

S/No.	Areas of Consideration/ Improvement	Resolutions Reached	Time Frame	Responsible Person(s)
		Strengthening the secondary health facilities by keying them to the National Board Transfusion Scheme and establishing functional Ambulance Services that will be coordinated at the State Ministry of Health.	12-24 months	Commissioner MoH
		Investing in social mobilization and behavioural change communication for the promotion of healthy lifestyles and appropriate health care seeking behaviours.	Immediate commencement & continuing	Commissioner MoH Commissioner Min of Information (MoI)
		Scaling up HIV/AIDs information and services to ensure universal access.	Immediate & continuing	Commissioners MoH, MoEduc & MoI
		Restoring the Sanitary Inspection Scheme to ensure environmental health.	18-24 months	Commissioner MoH, CSC & LGSC
		Encouraging private entrepreneurs to establish state-of-the-art hospitals in the region to receive referred patients and complement tertiary health facility services.	24-36 months	Governors
5	**Improve staff attitudes and performance through:**	Re-orientation, re-training and motivating staff.	12-24 months	Commissioner MoH
		Implementing SERVICOM ideals in the states.	12- 24 months	CSC & LGSC
6	**Review & improve mechanism for monitoring & evaluation at all levels of care by:**	Creating a budget line for monitoring, supervision and evaluation.	12 months	Commissioner MoH LGA Chairman
		Ensuring regular availability of monitoring tools & recording materials at all levels of the health care system.	12 months	Commissioner MoH LGA Chairman

Time Frame: From commencement of action (s) to it full achievement
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S/No.	Areas of Consideration/ Improvement	Resolutions Reached	Time Frame	Responsible Person(s)
		Promoting regular, integrated and supportive supervision.	12 months	Commissioner MoH LGA Chairman
7	**Strengthen health management and coordination through:**	Setting up a Primary Health Care Development Agency in each State for the coordination of PHC activities.	12-24 months	Governors
		Establishment of 'Community Health Committees', akin to 'Community Security Committees', with membership from all levels of the health system and the private sector which will engender patient referral, monitor and evaluate the local health system for performance. The committees will also include traditional and local leaders, with meaningful gender representation.	12-24 months	LGA Chair men
		Developing efficient and effective management systems for Primary Health Care based on the PHC principles of community involvement and participation.	12-24 months	Commissioner Health & Director PHC agency
		Effective coordination of the roles and responsibilities of the different actors in health care delivery.	12-18 months	Commissioner MoH
8	**Provide conducive environment by:**	Ensuring accountability, transparency, and probity in all spheres of governance in facilitation of effective and efficient health care delivery.	12 months	Governors Commissioner MoH LGA Chairman

Time Frame: From commencement of action (s) to it full achievement
Responsible Person (s): The person with direct accountability. It is this person who will be held accountable for achievement of the [illegible] s/he works with to achieve it

The Executive Governors of the Northern States of Nigeria affirmed their commitment to achieving a considerable reduction of these unnecessary deaths in their states, in conformity with MDG ideals, during their tenure in office and will respectively establish a Technical Committee on Health that will prepare a detailed workplan for the implementation of these resolutions. These committees will also be responsible for monitoring, supervising and evaluating the performances of their respective state government and report biannually to the Forum (Northern Governors' Forum).

Chief Servant,

DR. MUAZU BABANGIDA ALIYU, OON
Talban Minna)
Executive Governor of Niger State and
Chairman Northern Governors' Forum (NGF)

Background

The Commitment to organize this Summit was first secured, at a meeting of top government functionaries from States that fall under the UNICEF Zone C Field Office, less than two months to the event. On September 3, 2007, UNICEF convened an advocacy/sensitization meeting in Birnin Kebbi for Secretaries to State Governments and Commissioners of some stakeholder Ministries of States in the North West geopolitical zone. The purpose of the meeting was to mobilize political commitment for greater investment in health with a focus on Accelerated Child Survival and Development (ACSD). Alarmed by the poor health indices in the zone and encouraged by the demonstrable feasibility for change, using cost-effective intervention as shared by UNICEF (Annex 1) following extensive discussions, the meeting resolved to hold a Health Summit involving the highest political leadership, technocrats and bureaucrats in the 19 States in the North. The need for the Summit was re-emphasized at a subsequent advocacy and farewell visit to the Governor of Niger State, Chairman of the Northern Governors' Forum, by the Assistant UNICEF Representative from the UNICEF Zone C Field Office, Kaduna, on 17th October, 2007. At that meeting, a decision was reached that the Summit be called and the date fixed.

The Chairman, Northern Governors' Forum, the Convener of the Summit, constituted a 21-member Organizing Committee, drawn from the academia, health institutions, state governments and UNICEF Zones C and D Field Offices (Annex 2). The Organizing Committee was inaugurated on 31st October, 2007 by the Governor of Niger State at the Government Lodge, Minna. In his speech at the inauguration of the Organizing Committee (Annex 3), the Chairman of the Northern Governors Forum challenged the Organizing Committee to help give direction to the Summit that at the end, the Governors will appreciate the magnitude of the comparatively high mortality rate in the Northern States and know how to use their meagre resources to prioritise the problems, identify the most cost-effective achievable, innovative, high impact out-of-the-box short and medium term actions to take and how to implement the actions. He also emphasized the need for the Summit to determine the financing mechanisms to be adopted in place and the bottom line in terms of service delivery at the different levels of health care. Other terms of reference are the types of services government should provide and how they should be coordinated to ensure the elimination of

duplication and guarantee synergy. He recommended that one of the outcomes of the Summit should be a three year action plan with clear milestones and the formation of a committee to advise on and monitor implementation.

The Organizing Committee, chaired by the Commissioner of Health, Niger State, at its planning meetings, decided on the theme of the Summit: "**Alarming Death Rates in the Northern States: the Time for Change is Now**" as focus on the three health-related Millennium Development Goals, participants and partners to be invited to the Summit, the programme, background materials to be provided to participants and their roles and responsibilities. Given the weaknesses manifest in the health system that frustrate effective delivery and cost-effective interventions, the Organizing Committee decided that the thematic areas for syndicate sessions should focus on the following components of the health system:

- Health care financing;
- Health resources;
- Health care services organization and provision;
- Health management and coordination.

To facilitate the syndicate sessions discussions, analytical status report and discussion guides for each of the thematic areas were developed by members of the Organizing Committee. These were presented and critically analysed at an expanded meeting of the Organizing Committee before the Summit.

Summit Objectives

The objectives of the Summit were outline as follows:

- To sensitise participants on the magnitude and causes of the high death rates in the Northern States of Nigeria;
- To secure political commitment from the political leadership positive for change;
- To identify and prioritise areas of interventions;
- To develop a road map as a prelude to a 3-year strategic plan.

The Summit

Participation

The Summit, chaired by the Governor of Niger State, Dr. Muazu Aliyu (OON), attracted more than 500 participants drawn from various states' ministries (Health, Women Affairs, Economic Planning and Local Government), traditional institutions, academia, development agencies, federal ministries and agencies, civil society organizations and the media. The participants included the Governors of Niger, Kaduna, Sokoto and Zamfara States, the Deputy Governor of Kebbi State and representatives of the Governors of Kwara, Nasarawa and Bauchi States and the FCT Minister. Also in attendance were the Minister of Health, Prof. A. Grange, the Minister of State for Health, Eng. Gabriel Adikwu, the Heads of federal parastatals (Executive Directors of NACA, NPHCDA and NHIS), the Sultan of Sokoto, Alh. Sa'ad Abubakar III represented by the Etsu Nupe, Alh. Yahaya Abubakar, the Emir of Shonga, Dr Haliru Yahaya and the representatives of the Emirs of Zazzau and the Lamido of Adamawa. Similarly, some Speakers and Members of some States Houses of Assembly, Honourable Commissioners of Health, Permanent Secretaries and Local Government Chairmen were in attendance. The list of registered participants is shown in Annex 4

Opening Ceremony/First Plenary Session

In his welcome address, **Dr. Isah Vatsa, Chairman Organizing Committee** acknowledged and appreciated the large turn out to the Summit, the commitment of the Chairman of the Northern Governors' Forum and his colleagues to the convening of the this first ever Northern States' Health Summit. This, he considered a clear demonstration of commitment to change. He applauded the interest of development partners to the socioeconomic development of Northern Nigeria in particular and the country at large. He traced the reason for the first Northern Health Summit to the concern over the unacceptably high and persistent poor health indices and the alarming death rates especially of women and children in the region and the need to find solutions to the problems. (Annex 5)

In his goodwill message, **the UNICEF Country Representative**, Mr Ayalew Abai represented by Dr Robert Limbi, expressed his happiness over this initiative of the Northern Governors and hoped it will bring to the fore ways of transforming the lives and health of the people of Northern Nigeria positively. He reiterated the appalling health statistics with particular reference to women and children in the Northern States. He also expressed his happiness over the low prevalence of polio and measles recorded this year in Nigeria. He went further to say that this initiative will contribute to the attainment of the MDGs especially reducing child mortality (MDG4), improving maternal health (MDG 5), combating HIV and AIDS, malaria and other diseases (MDG6) and forging partnerships (MDG 8). He pledged the unflinching support of UNICEF to reversing the mortality trends in the Northern States (Annex 6).

The Director General of National Agency for the Control of AIDS (NACA) Prof. Babatunde Osotimehin, in his goodwill message, appreciated the initiative of the Northern Governors for holding the first Northern Governors' Health Summit. He identified and appreciated the efforts and contributions of the Governors of the Northern States in the fight against HIV and AIDS. He called on the Northern Governors' Forum to ensure improvement in access to HIV and AIDS information, counselling, testing and treatment services.

The Executive Director, National Primary Health Care Development Agency (NPHCDA) Chief (Mrs) Koleosho Adelekan, while congratulating the Northern State Governors for this historic Summit, reminded them of their role in national development and advocated for sensitive and committed leadership. She lamented the slow pace in the achievement of the Alma Ata declaration and the MDGs. She warned that quality health for Nigerians can never be achieved unless urgent and decisive actions are taken to redirect resources towards achieving the Millennium Development Goals. In order to achieve these goals, the attention, support and collaboration of all stakeholders are required in the following strategic areas:

1. Development of human resources for health services delivery;
2. Upgrading of existing health facilities/provision of new ones where necessary;
3. Training and retraining of health workers;
4. Developing efficient and effective management systems for primary health care based on the PHC principles of community involvement and participation;
5. Effective coordination of the roles and responsibilities of the different actors in health care delivery.

Finally, she called on the Governors to facilitate the engagement of the various Local Governments in health care delivery in their communities and make them accountable to their people. She then pledged the Agency's continued necessary support and prayed that the Summit will come up with innovative recommendations and follow-up activities. (Annex 7)

On behalf of the **Development Research Project Centre, Kano and other Civil Society Organizations** Alh. Shehu Makarfi, expressed their sincere gratitude to the Northern Governors for convening this historic Summit. This, they considered was a mark of commitment to improving the lives of the people in Northern Nigeria. He recommended the following concrete interventions as solutions to stemming the tide of high maternal and child mortality in the Northern States:

1. Evolving innovative strategies to increase the number of skilled personnel and enhance the motivation of female healthcare providers (Midwives);
2. Creating Primary Health Care Development Agencies in all the states;
3. Providing a budget line for maternal health in each State Ministry of Health.

He concluded by inviting all stakeholders to collaborate in addressing maternal health problems, emphasizing the importance of monitoring and supervision. (Annex 8)

The representative of **His Eminence, the Sultan of Sokoto,** (Alh. Saad Abubakar III), the Etsu Nupe, Alh. Yahaya Abubakar, noted in his remarks that a healthy nation is a wealthy nation and that mothers are the greatest assets of any country and should therefore be supported by all concerned. He then pledged the commitment and support of the traditional institutions towards the realisation of the noble goals of *reducing* the alarming death rates in Northern Nigeria.

A short **drama sketch** by students and staff of Ahmadu Bello University, Zaria, under the direction of Dr. Martins Ayegba, tilted '**What killed Hauwakuluwa?**' depicted socio-cultural factors influencing fertility decisions, ignorance, male dominance, ineffective traditional health care system in the face of delivery complications, rural poverty, transportation difficulties, poor road networks, lack of skills, poor attitude of health staff and unavailability of basic equipment at the health facility level as critical determinants of the death of Hauwakuluwa following bleeding complication after childbirth.

The Country Director of MacArthur Foundation, Dr Kole Shettima, in his presentation titled **"Why I am embarrassed to be a leader from Northern Nigeria",** noted the deplorable health indicators in the Northern States that, he opined, should embarrass any leader from this part of the country and call to question his or her stewardship. He informed the participants that while only 2% of the world's population is made up of Nigerians, the country accounts for 10% of the world's maternal deaths. The highest burden of these maternal deaths in Nigeria is from the northern part of the country. He noted that, for example, the maternal mortality ratio is only 165/100, 000 live births in the South West Zone of the country but as high as 1, 568/100, 000 live births in the North East Zone. He identified eclampsia and haemorrhage as the leading causes of maternal death. He proposed sector-wide approach, health systems development, re-introduction of sanitary inspectors and strengthening health education in schools as solutions. Specifically, he identified the following as low-cost but effective technology that the north can adopt for maternal mortality reduction:

- Launching of free medical services for pregnant women and children under five in the State;
- Developing formulae and securing the commitment of the Local Governments to ensure that health related financial obligations are shared in a ratio of 70:30 between the State and the LGAs at an estimated cost of N7.5billion in 2007, N8.5billion in 2008 and N9.0billion in 2009;
- Plan to equip the state's primary and secondary health facilities and address personnel shortages in the 26 government-owned secondary health facilities;
- Plan to upgrade one health facility in each of the 255 wards in the state;
- Enacting appropriate legislation in support of the plans.

The Chairman of the Northern Governors' Forum, the Governor of Niger State, Dr. Muazu Babangida Aliyu, began by declaring 2008 as the year for war against malaria, a commitment to ensuring free healthcare for children under five, pregnant women and the elderly above 70years of age by the Northern Governors. He expressed delight in the fact that there are many traditional leaders in the North who are well educated and are experienced retired public servants who can partner with Government in the provision of quality health care to the people.

The Chairman then noted that the objective of the Summit is to ensure that the people they (the Governors) serve are able to benefit from the best medical and health care services available in this era. He said the vision of the Governors is to form a coalition and work in collaboration and unity of purpose to fight and reverse the unfortunate poor indices of health in the Northern States.

He said: **"By this Summit, we, the Northern Governors are making a commitment by signing the health contract that we shall work assiduously and in concert on to reduce the alarming death rates in our States by effectively reorganising and managing our health services".** He voiced his confidence in the gathering to prepare a road map for

addressing the numerous health problems besieging the populace, such as, polio, malaria, VVF, tuberculosis and measles.

He advised his colleagues to imbibe the culture of transparency, accountability and the application of due process in order to restore public confidence in their governance. In line with the National Health Policy, which makes Primary Health Care (PHC) the cornerstone of health care delivery as well as the first point of call for the teeming grassroot population, he called on political leaders, traditional rulers and development partners to support the Government in the provision of quality primary health care services at the LGA level.

He reminded the participants that good governance at Local Government Level cannot be achieved without electing credible, well educated and competent leaders at that level. He then paid tribute to the leadership style of President Umaru Musa Yar'adua, GCFR, who has made a significant difference as an honest, transparent and committed servant-leader who strongly believes in the rule of law and due process.

Finally, he re-affirmed that the Summit is a conscious effort by the Northern Governors to address underdevelopment of their people and that, soon, similar Summits will be organized to address issues affecting Education, Agriculture and the Economy with a view to improving the quality of lives of the people. The Chairman then declared the first Northern Governors' Health Summit open. (Annex 12)

"Act Now: That Our People in Northern Nigeria will Live and not Die" was the title of Dr. C. Ejembi's presentation. She stressed the fact that health is a basic human need as well as a basic human right. Health is also at the core of security and development. It is an entry point for breaking the vicious circle of ill health, poverty and underdevelopment and creating the circle of health, prosperity and sustainable development. She noted that **health is politics and stewardship of health is the essence of good governance**.

While focusing on maternal and child health and HIV and AIDS, she painted a graphic picture of the alarming disparity in the health indicators between the

Northern Zones of the country(especially the North-West and North-East Zones) and the Southern Zones. For example, with a maternal mortality ratio of 1,564/100,000 live births in the North East Zone, 1028/100,000 in the North-West Zone and 167/100, 000 live births in South-West Zone where each time one woman is buried because of death associated with pregnancy or child birth, the North-West zone buries six women and the North-East buries eight women for the same cause and in some of our rural/LGAs, studies have found that it could be as high as 15 burials. Similarly, she observed that for each child aged less than 5 year that dies in the Southern Zones, the North-West and North-East looses two each. Also observed was the fact that the highest prevalence of HIV in the country is in the North Central Zone.

She lamented the high death rates particularly of children in Northern Nigeria. It was observed that an average healthy child in the north is more likely to be exposed to disease causing agents than his/her southern counterpart because of poverty, poor water supply, sanitation, poor hygiene, ignorance and overcrowding. Such a child is less likely to receive preventive intervention and more likely to have lower resistance to disease as a result of malnutrition. When the child develops a mild illness, he/she is less likely to receive appropriate home treatment and the care giver is less likely to know when and where to seek additional help should the illness become severe. Because of lower access to primary and referral level health facilities due to distance and poverty, when such a child eventually, reach a health facility, he/she is less likely to be managed appropriately because of resource gaps or staff attitude. The end result is of course, death!

She noted that ignorance, misconceptions, poverty and health-systems related factors all work in tandem to contribute to the high death rates observed in the region. The causes of both high maternal and child morbidity and deaths where grouped into underlying social and economic factors; poor health behaviours (including health care seeking behaviours) that both affect risk of illness and negative health outcomes.

Focusing on the health system, she analysed the health resource issues that militate against effective and qualitative health care provision in the Northern States. On the aspect of health care financing, she mentioned problems such as over dependence

on federation account and development partners, low funding of the health sector at all levels, poor governance and commitment to health especially at the LGA level , lack of accountability and the absence of health care financing policy and health plan. While these are general problems, additional problems in the Northern States include comparatively less funding for health in spite of their greater health problems, greater dependence on government funds, lack of diversification of funding options and higher rates of poverty. Because of comparatively higher poverty levels, clients in the North are less able to purchase health services. In the area of health facilities and infrastructure, she noted the comparatively lower numbers of PHC centres and the larger proportion of dispensaries and health posts that provide only lower level health care in the region. She also noted the comparatively fewer general hospitals, with between 80 to 90% being government owned in the Northern Zones, which compares to less than a third of the Southern Zones. Human resource gaps, she noted, are also major issues in the Northern Zones. It was noted that more than half of the PHC facilities, that provide Anti-Natal Care (ANC) and delivery services, do not have even a single Midwife - the critical personnel for these services. Other categories of health care providers are also inadequate. Drugs are hardly available in health facilities, equipment are not available and what is available is obsolete. The services provided are of poor quality and essential maternal and child health services are not provided in a large proportion of the PHC facilities.

She wondered our people are asked to go to these health facilities when there is nothing to offer them. These health systems-related factors, she noted, work in tandem with ignorance and poverty to limit utilization of services. She provided statistics to show the wide disparity in the utilization of antenatal, delivery and immunization services between the Northern Zones and the Southern Zones.

Given the current rate of progress, it is unlikely that the MDGs goals will be achieved. She enumerated the challenges as: securing meaningful political prioritization of health and social development at LGA and State levels, total re-planning of the health system, exploring other funding options and ensuring equity in accessing services as well as promoting positive health behaviours. The following were identified as

opportunities that could be leveraged to gain mileage: the new political dispensation (with a new crop of leaders to steer the ship of governance for the next three and half years), emergence of visionary and more accountable leadership, increased inflow of funding and availability of NEEDS and SEEDS that would provide opportunities for promoting ownership and serve as tools for resource mobilisation.

She concluded by noting that reversing the high death rates in the Northern States is a task that can be done, should be done and must be done. Collectively and transparently committed with each of us making his or her contributions, we shall succeed!!! (Annex 13)

SYNDICATE SESSIONS

Following the opening ceremony/first plenary session, participants were divided into 4 groups to discuss the issues raised and proffer workable recommendations, using the background situation report and discussion/questions as guide. The issues and recommendations from each group were presented at plenary for discussion and inputs from other participants.

(We need the reports of the facilitators/rapporteurs of the different groups to find out issues discussed and consensus reached. As well as the final report of the groups on the issues and recommendations that were submitted)

GROUP 1:
Health Care Financing

INTRODUCTION

Health care financing is a key element in ensuring sustainable provision of health care services. It has to do with various sources of revenue generation for health, how the revenues are pooled together and efficiently allocated and utilized. The sources and trend in the pattern of financing has changed over time in Nigeria. Government sources, mostly from taxation, ...used to be the main source of financing of health care. Other recent sources include out-of pocket household expenditure, health insurance, employer contributions, and development partners. Over time and with decline in government funding of health and social development, as a result of the IMF directed Structural Adjustment Program, the country adopted, from the mid '80s, as a strategy to resolve balance of payment deficits, various cost-recovery mechanisms which were introduced to raise additional revenue for the health care system. In the past few years, the National Health Insurance Scheme (NHIS) has become operational. In-flow of funds from development partners has more than

doubled in the past two years. The concept of Private Public Partnership (PPP) is gaining prominence.

There are general problems with health care financing in the country at all levels of government funding of health services. But they are all dependent on federation accounts as internally generated revenue is low. There are inter and intra-sectoral problems with funding of health care. While there are problems with health care financing that are general, some are peculiar or more prominent in the Northern States of the country. This group examined the general and peculiar health financing problems with a focus on the Northern States and attempted proffering some solutions on the way forward.

SITUATION	DETERMINANTS	SOLUTIONS
The federal budgetary allocation to health is 3.6%, less than the 5% recommended by WHO and much less than the 15% adopted by the African Heads of States at the Abuja 2001 declaration.	Poor commitment to health leading to low prioritization resulting in poor funding of the sector.	• Advocacy and sensitization of policy makers and other stakeholders to understand and appreciate the magnitude and dimension of the problem. •
• Per capita expenditure on health is $9 as against $34 recommended by WHO Macro-economics on Health.	• Knowledge of this issue among policy makers and policy implementors may be poor. • Poor commitment of policy makers at state and LGA levels to health care delivery. Poor appreciation of the role of health care in national development.	• Affirmative action/ declaration for renewed commitment to financing health care as a prelude to reversing poor health status indicators in the north. • Mandatory allocation of 15% of budget to the health sector by states and local governments in line with Abuja Declaration and National Health Care Financing Policy. • Deliberate and concerted effort to explore other sources of health care financing options.

SITUATION	DETERMINANTS	SOLUTIONS
• Most states and LGAs spent less than 3% of their budgets on health as against 15% recommended nationally and internationally.	Inability of the states to explore other sources of financing health care options such as: Social Health Insurance, Community Financing, MDG funds, Earmarked Taxes, Donor Financing, Public-Private Partnership (PPP) etc.	Laudable as the programmes may be, the method of implementation may create problems of transparency and accountability. Therefore, programmes need to be pursued through a pre-payment mechanism (via Community Based User Groups).
• About 70% of health expenditure comes from private out of pocket expenditure.	• High vulnerability of the group coupled with poor financial risk protection.	• Appropriate determination of cost-effective interventions, and institutionalization of standards such as Minimum Health Care Package. • Strengthening financial procedures and institutions of combating corruption.
• Introduction of free maternity services by some northern states governors • Inefficient utilization of resources and culture of corruption.	• Poor determination of cost-effective and cost-efficient health interventions. • General problems of lack of transparency and accountably at all level. • Absence of clear cut methods of exemption and deferral to take care of the vulnerable segment of population.	• Development of financing policies to ensure equity and access, especially for the vulnerable groups in the population. Arrangements for the protection of the vulnerable groups could include differential charges, exemptions from payment of charges, and social health insurance schemes. Development and financing of pro-poor health care programme to carter for the vulnerable segment of population.
• Wastage of resources in the name of health aids especially at LGA level.	• Budget approved to the ministries of health and departments of PHC are seldom release.	• Adequate financing of hospitals at secondary and primary health facilities through provision of monthly imprest which should be duly retired.

SITUATION	DETERMINANTS	SOLUTIONS
		• All monies approved to the ministry health should be released except where inability to release could be justified.
• Poor funding of secondary and primary health facilities.	• Serious bureaucratic bottlenecks in the release of approved funds for the conduct of activity.	• Health budgets shall be regarded as emergency fund as such should not be subjected to serious bureaucratic bottlenecks before it is released.
	• Poor capacity of officers to develop realistic and costed plans of action to execute health care programmes.	• Capacity building of health care providers on the development and realistic costing of plans that would guide the budgeting process.
		• Financing health care activities based on proper planning and prioritization.
• Budgeting without any recourse to short, medium or long term plans.	• Proliferation of many international organizations without proper mechanism of coordinating their activities.	• Equitable distribution of donors' support across the regions of Nigeria.
		• Development of appropriate mechanism for the coordination of donor funds at all levels.
		• Adequate involvement of northerners in the activities and programmes of international donors.
• Lack of prioritization in financing most cost-effective health care interventions.		• Good public health expenditure tracking and proper donor funds coordination.

SITUATION	DETERMINANTS	SOLUTIONS
• Donor funds are highly uncoordinated and fragmented with a lot of duplications.	• Dearth of knowledge on social health insurance as an option to health care financing.	• Adequate sensitization of policy makers and health care professionals on context, content and process of social health insurance programme. • Gradual and careful introduction of health insurance in the states and LGAs, starting with aggressive awareness creation. • Adequate participation of northern professionals in the operations of NHIS.
Health insurance as means of health financing options has commenced at federal level. National health financing policy has just been developed. • There is dearth of information on health care financing.	• Little or absence of participation of Fund Managers of NHIS from people of northern extraction. • Information on health care financing policy among professionals of northern origin is zero.	• Creating awareness on the context and content of the National Health Care Financing Policy among health professional of northern extraction. • Developing critical mass of northerners with knowledge on health care financing.
• Absence of effective expenditure tracking mechanism.	• Absence of health care financing management information system.	• Integration of health care financing information within NHIS.

GROUP 2: Health Resources

(1) STATUS

(a) Personnel

The dearth of human resources at primary level of health care in the Northern part of Nigeria has been a perennial issue in the last decade. The inadequacy of this resource (as revealed by ACSD/STS 2006 Report) has been the lack of critical cadres of frontline health providers namely, the Midwives and Community Health Extension Workers (CHEW) that are necessary for the delivery of care for the common and yet most killer ill-health conditions that afflict the majority of people in the community in the rural areas.

What with a situation where a health facility that is supposed to cater for the needs of over 10,000 people has only one or at most two lower cadre health personnel i.e Junior Community Health Extension Worker (JCHEW) with no drugs and equipment the availability of which may not even be appreciated, handled and administered by such cadre of staff. There is a gross inadequacy of staff, especially Midwives and Doctors in the Northern Zones. More than 70% of the 32, 000 doctors are located in the Southern part of the country. The enormity of this deficiency has not only negated the efforts of governments in making health services available, accessible, affordable and acceptable but severely compromised quality. This situation has led the beneficiaries to loose confidence and hope in both the health worker and the government. It is rear to find in any of the LGAs of the Northern States where there would be a complete compliment of staff (Team) that provides comprehensive and integrated health services at any grade of health facility. This is for reasons bordering on non-recruitment (as there are many in the labour market), mal-distribution (concentration in urban setting and scarcity in rural areas) or imbalance (gender ratio) and specialty (lopsided availability of cadre among providers e.g. more JCHEWs than CHEWs or more medical record officers than pharm/ lab tech. etc).

(b) Drugs

The perpetual Out-of-Stock (O/S) syndrome of drugs at all the levels of health care services (i.e. Primary, Secondary and Tertiary) has been a long standing challenge (threat) to health system in the country. It is more devastating at the primary level on which majority of the populace rely. It is a common (sad) feature in virtually all of the health facilities of the LGAs in the States of the North. It is not unusual for a health facility to lack drugs for as long as 15 months in almost all the LGAs which is why private or personal drugs supply system became institutionalized in the LGA health care system.

(c) Equipment and other supplies

Like drugs, the situation of equipment (especially medical and surgical) is even worse in almost all the HFs. Utensils for sterilization and conservation of essential supplies and disposal of wastes were almost forgotten by majority of lower cadre of health staff in the HFs due to absolute non-availability. Neither was there any attempt to ease the problem through substitution of same with local contents (plastic or wooden materials). Again, like drugs, essential equipment were sourced through personal efforts, the utilization of which constitutes increase in the premium charged by the health workers on the trickling clients. These have been the major causes of poor patronage and low coverage recorded in many health facilities.

(d) Structures

Health facilities of various grades suffer various forms of waste, dilapidation or even destruction across the region. Not only were they mal-distributed in the initial siting, they were also constructed so improperly that they hardly represent institutions that were supposed to provide integrated and comprehensive services, privacy, security and quality envisaged in provider efficiency. Many Health Facilities were of one or two rooms structures with nothing suggesting health services provision.

(2) DETERMINANTS

Despite huge fiscal overlay channeled yearly to health services across levels of governments, the anticipated dividends have continued to be elusive. This was because the necessary elements for generating and distributing services health resources were poorly placed in the system. These resources include:

- Health personnel;
- Drugs;
- Equipment and supplies;
- Structures.

(i) **Health Personnel** Of all the resources highlighted above, health personnel represented the highest deficiency in health resource cycle. This could, though not be associated with numerical indicator, be associated with utilization mode. There is clear adamancy in recruitment and distribution with no clear cut policy approach to maintenance through continuous education drive.

Coupled with this misdemeanor, the issues of qualification for basic training of various cadres of health workers constituted a significant bottleneck in the adequate supply of frontline health workers. So also is the policy on retirement that leads to loss of useful and active personnel for health care delivery.

(ii) **Drugs** Departure of both policy makers and technocrats form adherence to standardized norms had complicated the out-of-stock syndrome in the health system of the country. At every level of care namely, primary, secondary and tertiary levels, standard Essential Drugs List (EDL) has been prepared and adopted but the utilization of the tool always eludes procurement process. This has not only perpetuated non-availability but compounded faking and adulteration of products to cover up deficiency. This situation further helped in the institutionalization of private practice by the personnel.

(iii) **Equipment and supplies** The deficiency of these resources is attributed to poor processes of supply just like that of drugs. Standard list of equipment for types of facilities was completely ignored while procuring. Beside non-

availability, due to ill-distribution process, the few that were supplied were targets of pilfering by the workers. Often, some of the equipment, where supplied, were obsolete or damaged due to unnecessary storage.

SOLUTION

The importance of overhauling the service delivery system at grassroots (primary) level needs not to be over emphasized. The recipients of PHC services constitute the bulk of the people of this country (80%). The health problems also of the country are endemic among these people in the rural areas. The bulk of fiscal resources expended for health care are also extended on those localities yet with little or no significant result.

In dealing with the issues of various components of health resources, further assessment may need to be made to appreciate the extent of damage made due to their deficiencies. However, there is need to consider some short term interventions in order to plan properly for the long term measures.

Health Personnel

- Development and application of continuous education packages for the existing health staff with particular need for Life Saving Skill (LSS) and Emergency Obstetric Care (EOC) for the frontline health workers;
- Recruitment and deployment of frontline health workers;
- Redistribution of personnel appropriately;
- Intensification of training of Community Midwives in the region;
- Engagement of experienced personnel that have retired.

Drugs

- Review of drugs procurement policy in favour of ward system rather than the LGAs as units;

- Involvement of Ward Development Committee (WDC) members in the procurement, storage, utilization and re-procurement processes of each ward;
- Review of DRF system with members of WDC;
- Review of EDL with a view to developing drug list for ward health system;
- Review of Drug Records.

Equipment and Supplies

- As above

Structure

- Identification, designation and upgrading a Health Facility (HF) in the ward as ward referral centre;
- Streamlining Health Facilities (HFs) in the LGAs for provision of quality health care services on various shifts like 8 hour, 12 hour, and 24 hour service periods;
- Establishment of strong referral system between HFs through orientation and designation of facilities for referrals.

GROUP 3:
Organization and Delivery of Health Services

Primary Health Care is the fulcrum of Nigeria's National Health Policy. The country operates a pluralistic health care delivery system with both the allopathic and traditional health systems functional and the public and private sectors providing services. The constitution of Nigeria places health on the concurrent list with the health system decentralized under a federal structure. The federal system assigns different health system responsibilities to the three levels of government each of which is largely autonomous in terms of management and financing. Governments at each level are involved in all the major health system functions: Stewardship, financing and health services provision. However, the functions of each level of care are clearly defined in the national health policy and the National Health Bill awaiting passage in the National Assembly.

The **federal level** is responsible for policy guidance, technical support and oversight to the overall health system, developing national health plans, the national health management information system, issuing and ensuring adherence to norms and standards, provision of tertiary and specialist health care and management and coordination of international health matters.

State governments are responsible for developing state health plans, planning and managing the state health system managing secondary (and in a few cases tertiary) hospitals, regulation, facilitation and provision of technical assistance and support to the LGAs in the provision of comprehensive PHC, monitoring the state of health of their states, and mobilization of resources for the implementation of their state health plans.

Local governments are responsibly for Primary Health Care services under which services are organized by wards (there are 7 to 10 wards per LGA). The specific functions of the Local Governments are to determine how best to provide the essential elements of Primary Health Care, identify the support action required for each

component of the programme, mobilize resources to support the health programme, provide relevant health information to the people, design and operate mechanisms for involving the communities in the critical decisions about the health services, ensure that the essential infrastructures for the Primary Health Care programmes are in place, and collect relevant health data about the health resources.

The group interrogated the organization and delivery of health services in the Northern States of Nigeria, identifying key issues militating against effective performance, the magnitude of the problems and underlying causes and attempted to proffer some solutions on how to redress the identified problems.

	CURRENT SITUATION	SOME EVIDENCES	DETERMINANTS	SUGGESTED SOLUTIONS
1.	**Poorly functioning health structures and weak referral system**	• Northern states have 65% of Nigeria's Primary level health facilities(PLHF) but most are Dispensaries & Health posts; • North-East & North-West zones have less than one primary health centre (PHC) per 10,000 population; • Of northern PLHFs, only 31-55%, 18-50% and 28-41% are respectively provide Antenatal, Delivery and Postnatal services; • 59-68% of northern PLHFs offering antenatal & delivery services have no single midwife staff; • 0 - 8.8% of northern PHCs have 4 full-time midwives; • 24-hour services are available in 8-93%, 45-100% and 100% of Primary, Secondary and Tertiary health facilities respectively.	• Management-centered rather than patient-centered health structure, with 3-tiered services managed by three levels of government; • Non-existence of medium of communication between PHC, SHC, THC and Private Clinic managers in their communities; • No capacity built for patients referral; • Wide differences in level of political commitment from various governments to health sector; • Inadequate provision, administration and evaluation of funds allocated to health facilities; • Poor blood transfusion services; • Lack of functional ambulance services; • Absence of standard state-of-the-art hospital that can backstop all referrals from SHCs from the northern states.	• The PHCs in northern states be strengthened by every state government; • All maternity centers, dispensaries and health posts in the north be upgraded to PHCs; • Every northern state should increase the number of their PHCs to at least minimum coverage of 1:10,000 population; • Each state should aim at having at least 4 midwives per PHC for 24-hour coverage; • Every community should have a 'Health Committee' that will comprise Community leaders, managers of its PHC, SHC, THC and Private Clinics and Association officials (cf Security Committees) to monitor & evaluate health outcomes; • Each state should key into the National Blood Transfusion Scheme; • Ambulance Services Unit should be established in each State Ministry of Health to service the needs of all SHCs in the state; • Encouragement of private investors to establish state-of-the-art referral hospitals;
2.	**Poor logistical management of medical equipment and consumables**	• Blood Pressure machine available in only 66% PHCs, 78% SHCs and 92% Private Clinics; • MVA equipment available only in 8.5% PHCs, 29% SHCs and 53% Private Clinics;	• Non-existence of established system for equipment/consumables needs compilation, procurement and maintenance; • Most procurements made on ad-hoc basis;	• Each state should establish centralized equipment and medical consumables needs assessment and maintenance units; • Centralized procurement system should be strengthened to provide uninterrupted supplies to relevant health facilities;

* **References:**

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2. *FMOH: National Study on Essential Obstetric Care Facilities in Nigeria. 2003*
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4. *NARHS Nigeria: 2005*

GROUP 4:
Heath Management and Coordination

Health Management is a design that is tailored to deliver the Right Care, at the right time, in the right setting with the right team of personnel e.g the Doctors, Nurses, Pharmacist, Laboratory Staff and other Care Coordinators.

Health Management and coordination is perhaps one of the most vital ways in achieving Health care delivery. For the success of everything planning, management and subsequently monitoring and evaluation of it, are necessary. It also applies to health.

Management involves careful planning, execution, monitoring and then evaluation of whatever you planned to see if its going according to the schedule and design. That will give you opportunity to reflect on progress made so far and other changes that may arise.

Management and coordination refers to the processes/inputs that ensure programmes are planned and delivered to population groups to achieve planned impact. The planned impact being improved well being that allows a person to achieve his/her potential

What are these processes/inputs?

- Supervision
- Monitoring
- Evaluation

Communication- cross cutting and linking all other thematic areas.

Processes/inputs

Supervision: Integrated supportive supervision that utilize checklists and are conducted regularly should be established. State quarterly and annual National,

review Meetings should be organized to review the implementation process, share lessons learned and decide on way forward.

Monitoring is a continuous process of tracking progress of implementation of project or intervention program during the implementation phase to ensure that it is proceeding according to plan. It mainly focuses on inputs, processes and outputs.

Evaluation is assessment done at a point in time to see whether the objectives have been achieved and the interventions have produced the desired impact. Evaluation also addresses the relevance of the program in bringing change, the effectiveness and efficiency of program implementation and the sustainability of the program.

Evaluation is critical in assisting in policy formulation, resource allocation, advocacy and dialogue among stakeholders in health service delivery.

Requirements

Tools: work plans (Plans of Action), registers, checklists, forms

Indicators: relevant to the programmes (ANC, immunization, IMCI etc). Iindicators show progress in the implementation of activities planned for the achievement of the set objectives, as well as indicators to track progress towards coverage of interventions, quality, and impact.

Communication: advocacy, sensitization, awareness- relevant to various levels e.g. community dialogue (community level), use of media (newspaper, radio, television) at other levels to inform, bring about behaviour change and engender ownership of programmes.

Current situation

- Tools available at various levels-checklists, SOP etc;
- Indicators for measuring progress (or lack thereof) available;
- Knowledge and skills also not lacking;

- Logistics for getting supervision, monitoring and evaluation are weak and so are commitment- vehicles, funds;
- HMIS –available, but very weak (data collection, collation, analysis and use). Data management across the board is very poor to the extent that very often data used is stale dating back to 3-4 years.

What can we do?

Health Management and Coordination are critical elements in achieving optimum service delivery.

Coordination Issues

- There is fragmentation – all tiers of government are doing their own thing with no harmonization;
- No support for coordination- capacity and means lacking;
- Poor communication – within the various levels of care delivery and between the tiers;
- No harmonization between development partners/donors and between donors and government partners.

Monitoring & Evaluation issues

- Weak M & E system – inadequate logistics (vehicles, HMIS forms/tools, IT equipment). There are too many forms and these are cumbersome to complete;
- Lack of skilled M & E officers and programme officers;
- No M & E plan or where it exists it is not being utilized ;
- Poor record keeping – (including falsification of records for various reasons);
- Lack of feedback;
- Lack of standardized checklist – (treat generic issues) .

Management Issues

- Lack of management training in the medical, nursing & other health training institutions;
- Very Few managers, who lack skills.

Underlying factors

- Inadequate/poor political will and commitment;
- Poor attitude to work;
- Corruption;
- Lack of transparency and accountability.

Way forward

- Strong political commitment backed up with provision of adequate resources in a timely manner (funds, motivation);
- Capacity building to ensure acquisition of management, coordination, supervisory and monitoring skills;
- Development of practical and implementable work-plans ;
- Harmonization and simplification of monitoring tools to ensure uniformity and utilization;
- Entrench integrated supportive supervision;
- Provide the logistics for conduct of effective and regular supervision, monitoring and evaluation;
- Entrench ownership of the health programmes for sustainable development. This will also ensure that development partners and donors do not drive our health system.

SOLUTIONS

- Provision of water, light and toilets to all facilities;
- Siting of facilities be based on community felt needs and involvement;
- Need to develop facility distribution map.

SECOND PLENARY SESSION

Need to get rapporteur's report of session

The session was chaired by The Emir of Shonga, Alh. Haliru Yahaya with retired Justice Nasir Bello serving as Co-chair. The reports from the syndicate sessions were presented and discussed. The major points of discussion were:

- **Human resource requirements:**

  - There was a lot of discussion on whether there should be advocacy for the lowering of entry qualifications for midwifery. Some participants were of the opinion that anyone who has five credits at O levels will be less inclined to want to go for nursing or midwifery; rather they would prefer to go to university. Given the critical human resource shortages in the North and the dearth of qualified persons completing secondary school, especially females, it was felt that lowering the entry qualifications should be considered as one of the short term measures of attracting more females to go into the profession. Others felt that this would be seen as an attestation of disparities in abilities between the North and the South that should not be promoted. Still others were of the opinion that the North could come up with a new cadre of health workers that could be trained in the shortest possible time to fill the human resource gaps, especially midwives. The re-introduction of community midwifery was seen as a possible solution to the critical shortages of midwives.

    There were observations that many Northern States go outside the country to source for health personnel as a means of addressing shortages of trained health workers in their service. On the other hand, many Southern States have excess health workers that find it difficult to work in the Northern States because of unfavourable conditions of service including provision of contract appointments only. The general opinion is importing health workers is more expensive and they may not necessarily be as competent as the Nigerian health personnel, therefore favourable conditions of employment should be

provided so as to attract health workers from other States to the Northern States with critical shortages.

- Some participants voiced the opinion that the country needs to reconsider the wisdom of sending trained personnel of Technical Aid Group (TAG) to outside countries when some of the States in Nigeria have considerable greater needs than the countries these personnel are sent to. The suggestion was that the Northern Governors should advocate to the federal government to consider the States in dire need of health personnel as potential beneficiaries of TAG.

- **Primary Health Care:**

  - The roles and responsibilities of different stakeholders in PHC in Nigeria attracted a lot of discussion. Participants wondered whether NPHCDA's role is construction of PHC facilities as that is what seems to be commanding its attention instead of provision of technical support and systems development. It was also observed that the role of provision of technical support and monitoring of PHC that States should be providing LGAs have dwindled and in many States they are no longer being done. The need to review arrangements, roles and responsibilities as it relates to PHC was identified as a priority

  - Some participants felt that in addition to the lack of political commitment to PHC at the LGA level, the managerial competence to provide leadership and direction in health matters at the LGA level, especially in the Northern States is lacking. It was observed that the public health laws of Northern Nigeria stipulate that each health district must have a Medical Officer of Health that shall have responsibility for health matters for that district. While the majority of the LGAs in the South have doctors as their Medical Officers of Health/PHC Coordinators, many of them with Masters in Public Health degrees, this is not the case in the Northern States. Except for Federal Capital Territory (FCT), the LGAs in the Northern States have made little effort to fulfill this provision.

  - There were divergent opinions on the relevance or otherwise of having States' Primary Health Care Development Agencies. Opponents felt the problem with PHC cannot be solved by creating new structures as there is already a

department of PHC in the SMoH. Others were of the opinion that Katsina State has demonstrated the effects having such an agency could have in terms of PHC development and should therefore be emulated.

- **Health Plan:** many of the participants felt that given the degree of problems with the heath care system in the Northern States, there is a need to make deliberate efforts to plan the system *de-novo*. The Northern States need to each develop a comprehensive blue print of how they intend to re-position their health care system for better performance, develop health plans that defines minimum care package at each level of care and the resources required for provision of the services, as well as develop human resource and health care financing polices.

Closing

The closing ceremony was chaired by the Chairman of the Northern Governors' Forum, with the Governor of Sokoto State serving as the Co-chair. The Resolutions were presented, discussed, amended and adopted. In his closing remarks, the Chairman challenged the participants not to consider this Summit as another "business-as-usual" but to commit to using the resolutions as a platform for moving the health agenda of the Northern States forward. He opined that the problems of the Northern States, though daunting, are not insurmountable. With dedication, commitment and unity of purpose sustainable solutions shall be found. Solutions that are innovative and evolved locally by the Northern States. He pledged the commitment of his office to ensuring that the Northern Governors are held to account for the declarations they have made to improve the health status of their people.

In his vote of thanks, Prof. Ogala thanked the Northern States Governors for their demonstration of commitment to improving the lives of their people. Indeed, he noted that the convening of this first Northern Governors' Health Summit was a clear indication of a willingness to act. He prayed for the success of the interventions. He also thanked the Ministers of health for prioritising the Summit and being personally in attendance, the traditional rulers for the royal support, the development partners and all who contributed to making the Summit a success.

Next Steps

At the conclusion of the Summit, the following follow-up activities were collectively agreed upon:

1. Compilation and printing of the proceedings of the Summit;
2. Development of a three-year strategic health plan for the Northern States that will provide a roadmap for the implementation of the resolutions with clearly defined milestones;
3. Constitution of a Committee that will be advisory to the Northern Governors on health and will also be responsible for monitoring the implementation of the strategic plan;
4. Convening of annual meetings for the 19 Northern States Governors to present their progress report in implementation of the strategic plan.

MEDIA REPORT

Media Advisory Release On The Summit 11th November 2007

The session which was Chaired by Dr Isah Y. Vatsa, Honourable Commissioner for Health Niger State, had Professor William N. Ogala, Dr Clara Ejembi, Dr. Olawapo Shittu and Dr. Saidu Buba as members of the team that addressed the media.

The media were informed on the health indices that required urgent attention as summarized below:

As you are aware, one of the major issues confronting the whole world is the persistence of high maternal deaths despite all the international efforts made to prevent them through the *Safe Motherhood initiative* that began in 1987. Over 600,000 women continue to die each year from pregnancy related causes. Over 90% of these deaths occur in developing countries – Nigeria alone accounts for 10% of them.

- Every minute, one woman dies from a pregnancy related cause somewhere in the world;
- Every ten minutes, one Nigerian woman dies from a pregnancy related cause;
- Two of every three (2/3) maternal deaths occurring in Nigeria is from the Northern States;
- For every 100 children delivered in Nigeria, 20 will die before their 5th birthday;
- Two of every three (2/3) of these Nigerian children that die come from the Northern States;
- Meanwhile, only half of the Nigerian population live in the Northern States.

Surprisingly, almost all these deaths are preventable, and indeed most other countries and our Nigerian Southern States counterparts, have clearly demonstrated this through simple, inexpensive and affordable death reduction measures.

Furthermore, the team briefed the media on key activities of the Health Summit which included welcome address and Summit objectives, Goodwill messages from stakeholders with an address by the Sultan of Sokoto. The media was informed that the significance of the staged drama sketch was to highlight common causes of maternal mortality in our environment. Presentations on overview of health indicators, status, challenges and opportunities in health system in Northern Nigeria aimed at providing information on realities of health problems in the North were pledged.

He notified that the Chief Host, the Executive Governor of Kaduna State Arc Namadi Sambo would address the summit., likewise the Honourable Minister of Health Professor Adenike Grange, on critical issues affecting quality health care services in Nigeria.

The summit would be declared open by the Chairman, the Chief Servant, Dr Muazu Babangida Aliyu OON, (Talban Minna) Executive Governor of Niger State.

The technical session which was based on thematic areas would address critical issues that would reverse the current mortality rates in the North.

In conclusion, the summit was expected to come up with resolutions that would reduce the mortality rates in the North which the States will be expected to implement under a peer review mechanism.

Press men and women asked some questions which include the following:

Question: So many summits/conferences have been held in the past but conclusions from such programme are rarely implemented. How are we sure this not going to be one of them?

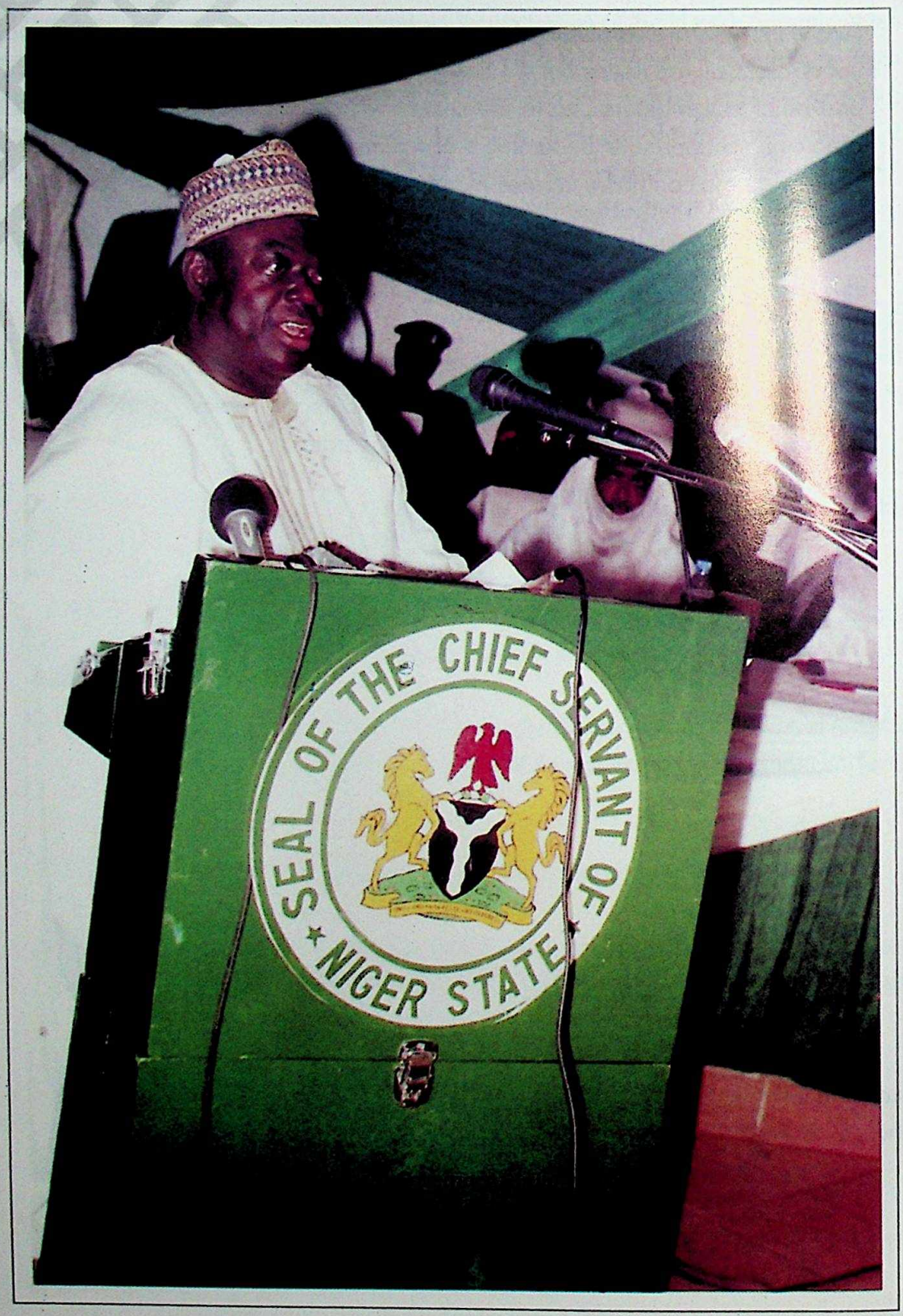
Answer: This is the first time the North is organizing a Health Summit and that it is initiated by the Northern Governors themselves therefore it is likely to receive the desired political support in order to ensure sustainability.

Question: Considering the multiple problems facing the North in terms of health care delivery, do you think one day is ok for the summit?

Answer: We are conscious of the problems and we know one day summit may not address all the issues but we can take advantage of work done by the LOC and other stakeholders before the summit which can be used to prioritize the problems. Furthermore the summit is also aimed at stimulating the commitment of stakeholders to contribute in reversing the unacceptable high mortality rates in the North.

Question: How can we confirm the States implement the resolutions?

Answer: There will be mid term review of the resolutions in a form of peer review mechanism where states will be asked to compare notes on the impact of implementation of the resolutions in the various States.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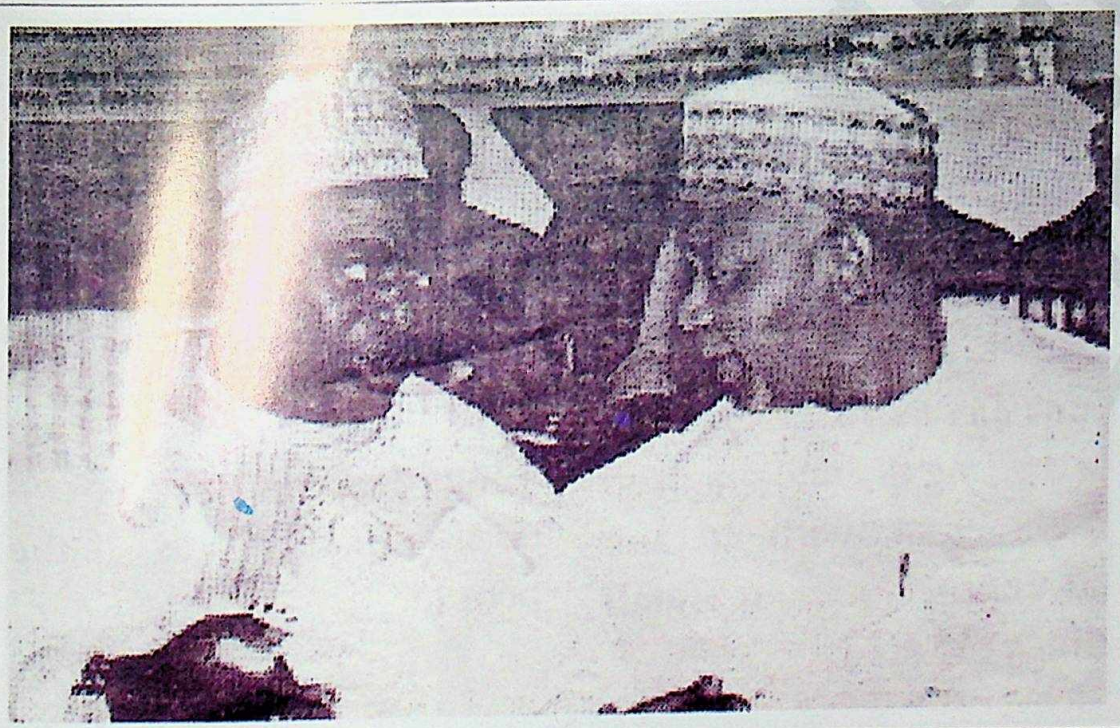
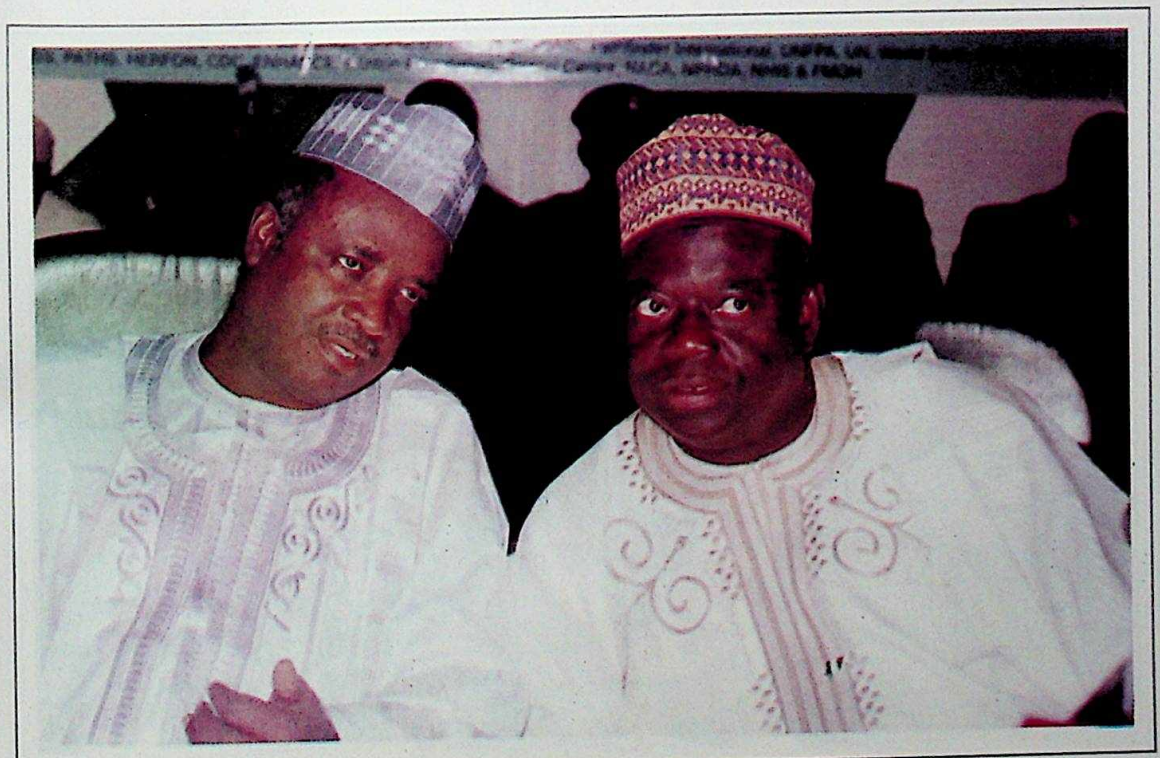
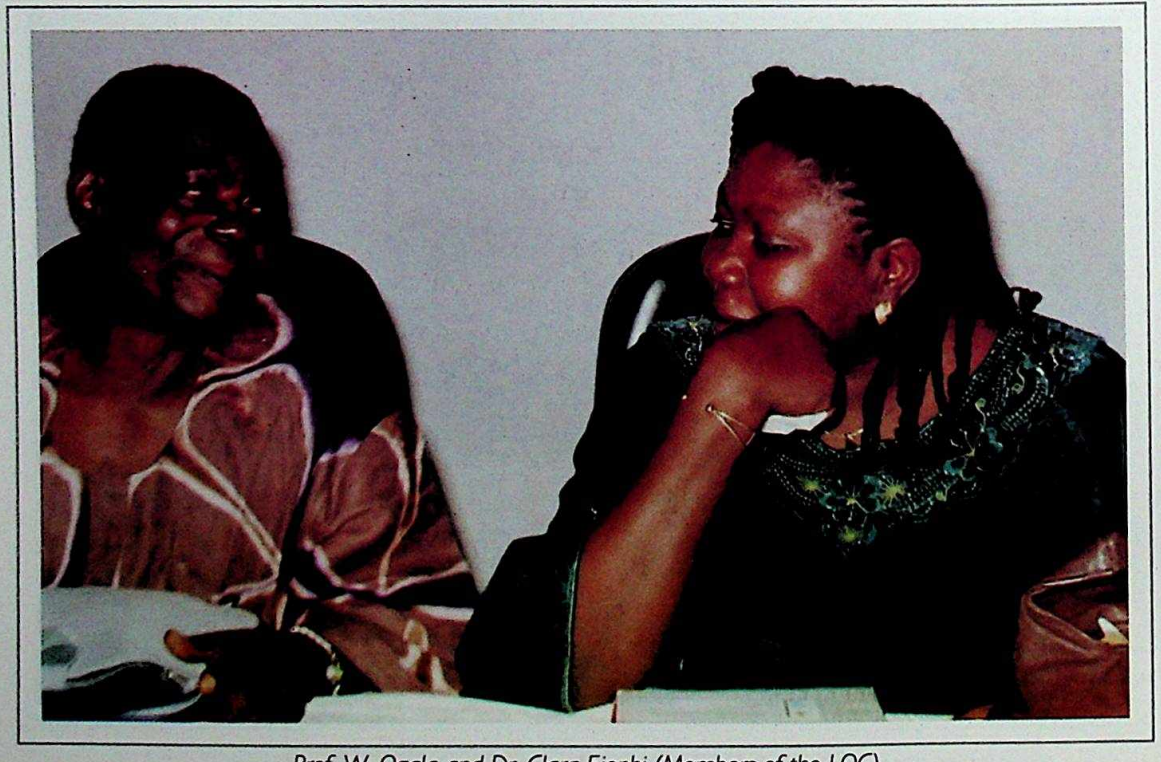


Chairman Northern Governors' Forum and Governor of Niger State Dr. Mu'azu Babangida Aliyu (Talban Minna) & Governor of Kaduna State, Arc. Namadi Sambo at the First Northern States Health Summit



Chairman, Northern Governors' Forum and Governor of Niger State Dr. Mu'azu Babangida Aliyu (right) with Sokoto State Governor, Alhaji Aliyu Magatakarda Wamakko at the First Northern States Summit

The banner carrying the 'THEME' of the Summit



Prof. W. Ogala and Dr. Clara Ejenbi (Members of the LOC)

States' Health Summit

Which recently took place @ Arewa House, Kaduna, on Monday November 12, 2007

Prof. Babatunde Oshotimehin of NACA (M) in a discussion with Niger SSG & a delegate to the summit

Dr. Mu'azu Babanigida Aliyu OON, Chief Servant of Niger State & Chairman Northern Governors Forum being welcome by Arc. Moh'd Namadi Sambo Executive Governor, Kaduna State.

Dr. Isah Yahaya Vatsa (M), Niger State Commissioner of Health & Chairman of the Summit Organizing Committee discussing with some officials at the venue.

Group Photograph at the Summit

Working Towards Better Healthcare In The North

By Kemi Yusufu
ASSISTANT CORRESPONDENT, Abuja

"Health is Wealth" is one of the most commonly used English sayings in Nigeria. It was therefore a welcome development when the first Northern Health Summit was held at the Arewa House Kaduna.

This all important meeting was spearheaded by the governors of the 19 northern states and UNICEF. The summit which was held November 12 has been described by observers as a step in the right direction.

Though it was not the first time, northerners would gather together to confront health issues facing the region, this meeting is definitely a break from the past.

This is because it had the highest level of decision makers in attendance. With the theme, 'Alarming Death Rates in The Northern States: The Time for Change is Now' it will be safe to say that the leadership of the north is ready to deal with the issues that have made efficient health care delivery a mirage in their various domains.

The northern governors led by the Muazu Babangida Aliyu, chairman of the Northern governors forum, experts in the medical field said was fortunate with the timing of the summit.

They said it had come at a time when the federal government is taking steps to bridge the communication gaps between itself, states and local governments.

For long, health policies from the centre have not generated meaningful impact to the grassroots.

The Minister of Health, Professor Adenike Grange, at recent interaction with pressmen stated that the federal government is set to harmonise policies at all levels of

*Aliyu

in the implementation of our programmes has been rather inadequate and always emerging as an afterthought. However, in the implementation of this investment plan, communication has been prioritised, so that we all are informed and able to take actions in our different capacities."

The minister said the poor health indices characterising the 19 states of the north is caused by shortage of trained medical personnel.

Grange, who was guest speaker at the event, identified the dearth of health workers in the northern states as the major reason for the high rates of infant and maternal

*Grange

disadvantaged.

She said: "I will like to draw your attention to the relative shortage of doctors, nurses and midwives in the northern states, even though there is an abundance of community health workers.

"As an example, despite the numbers of doctors graduating from medical school, there is a dearth of medical doctors in much of the northern region."

The minister also sighted disparity in the availability of antenatal care in between the north and the south.

"As the 2003 national demographic health survey report

care ranged from one per cent to 25 per cent.

"Statistics also show that pregnant women in the northern states were more likely to deliver at home and attended to by unskilled hands than pregnant women in the southern states.

"There are identified social and cultural factors that have contributed to this situation. It is my hope too that we can together identify some culturally acceptable solutions perhaps, the setting up of homes with easy distance of health

policies that would attract skilled medical personnel to their states.

"Statistics clearly show the absence of qualified medical personnel at the LGA level. Almost immediately I hope this situation will be redressed and LGAs will be supported by the state ministry of health to employ and retain doctors through the provision of such incentives as performance based remuneration and accommodation," she noted.

Grange equally urged the governors and traditional rulers

states recorded lower immunisation coverage for all vaccines compared to the southern states," she stated.

UNICEF, who partnered the northern governors' forum to organise the health summit called for governors to demonstrate their commitment to health through their actions.

Speaking through Robert Limlim, it described as timely the intervention of northern governors in the health sector.

Limlim said, "We all know that most common killer diseases of children and women can be prevented by cost effective, easy to manage and time proven interventions like immunisation.

"What remains are the political will, political choices and financial commitment by government and partners."

Dr. Aliyu Babangida, chairman of the forum and governor of Niger State, reiterated the resolve of northern governors to improve on health care delivery in the region.

"Our vision here today is to form a coalition to fight ancient scourges and reverse the unfortunate negative health indices of our states and the country at large.

"Our target is to join the world leading attempt to reduce child and maternal mortality, conquer malaria, polio, VVF, tuberculosis, measles and eventually defeat HIV/AIDS.

"Unfortunately, these targets are not likely to be met by 2015, not even by 2025 unless there is a genuine commitment on the part of political leadership to improve funding and the management of the health sector," he said.

For the organisers of the first northern summit on health, their next line of action needs to be quickly taken and must be in tandem with needs of the people.

From the Daily Independence

Providing Health For Our People Is A Joint Task -Gov. Babangida

It is the realization of the fact that a meaningful health care delivery can be made available to the people of their region through a joint effort of all stakeholders that 19 governors in the Northern Nigeria, under the aegis of Northern Governors' Forum staged what it called Northern Governors' Forum Health Summit in Kaduna recently.

*In this interview, chairman of the Forum, and Governor of Niger state, **Dr. Babangida Aliyu** says they are poised to give citizens in their respective state quality health care delivery after the summit.*

Sir, on Vesico Virginal Fistula, VVF, reports say it's a result of early girl child marriage, is it true that in the North; religion (Islam) encourages it?

Yes in Islamic injunction, a girl can be said to be ready to marry when she sees her period but then there is also a consideration for the physical as well as mental maturity for marriage and we are assuming that before a child gets married now she should get to an average age of 17 or 18 unlike in the olden days that people used culture and cover it by the injunctions of religion. What we are trying to do is to enlighten people in every state in the federation including the child rights law. If you calculate it, there is no how a child will be married until he/she reaches the age of 17. I know that in many villages it is still like every other culture, superstitions and every other culture still happen, now that is one of the essence of coming together to share our experience you will discover that some of us may find it easy to implement certain laws than other states.

That is why we think also in this country that before you introduce any fundamental law you need to go to the people and really discuss with them, not only introduce laws that will only deceive people, and I'm very frank of people saying we are introducing this concept of laws because the constitution says so but you must also discuss with the people because of the other unintended effects of particular things. It is not right for anybody to marry out his daughter just because he thinks she is ready for marriage when in actual fact she is not. So we hope that all the states will come together now and really discuss this matter and let each state pass the Child Right Act or draft law, the nation has passed its own but each state is supposed to domesticate it, so that we can implement. VVF is a dangerous disease for anybody who knows and most of the husbands actually abandon victims of VVF, I don't know whether you have visited hospitals where there are VVF patients? In the place you cannot stand the smell of that place, it is the responsibilities of the leaders to ensure that the lives and liberty and rights of everybody is protected. Now we have to come and see how we will protect these lives and liberties without antagonizing other people that may read things wrongly, so we are coming together to see how to fine tune our effort, you have seen the problems that normally come to us when we are not talking to one another, when one state wakes up and say this is what it will do different from other states. Since we share certain things in common as a region, that is why we are coming to tackle each problem one by one. You heard me announced that after the Health Submit, we will talk about education, we will talk about agriculture and we will talk about general economy and believe me other social factors that inhibit development and progress would have to be focused and discussed openly because for everything that you see either in religion or in law, there are other ways to mitigate whatever aspect. Many people simply seize the opportunity to make announcement as if it is the right thing. It most cases it is simply because they are not challenged, when you challenge them with the right knowledge they will change position.

This is the first Northern Health summit, in 2001, former vice president Atiku Abubakar organized education summit but since that time nothing has happened, as a matter of fact the, nation's education sector has been degenerating, how are we sure that this one is not a talk show?

I have said to you this is organized by the drivers themselves, you talked about the vice president who was organizing from the top but this is a bottom top approach, this is done by the governors, all the commissioners of health of the states and their officers are all here, they are the ones to implement these things. You heard each one of us announcing already what we have done in our states, now we expect that they should come out with recommendations that we must implement and if we do; in the next six months or one year, we will all come back to look at what the states have done. I gave an example, in Kaduna state the governor has given this free and given that free, and fighting malaria by 2008, even if Kaduna state fights malaria and in six months it achieves something, if Niger state, FCT, Plateau, Katsina, Kano and other neighbouring states are not doing anything, within six months they will be in a war situation. The same thing with polio, if you do not eradicate it in totality, you are as good as wasting your time, so that is why we are saying we will come, we will implement because we are now in the drivers seat and things have changed a little, may be what happened between 1999 to 2007 could be seen as experimentation, if any one of us goes around experimenting again, then he is wasting time because somebody has already done something eight years ago for you to see where the mistakes were made and where to move ahead. We are expecting to implement after this summit, for example when the Kaduna state governor was telling me that about two weeks ago, he has already instituted free medical services for pregnant women and children under the age of five, I told him I have started two months ago, if we have not spoken, we will do and people from other states will be coming to us but we ask other states to start because it is double all we need to do is to make sure we do not steal public funds because the money is there to do these things, that is where you come in, if in six months time you see us meeting, ask us, have we implemented? That is why we keep telling people this is your money, anything that we say we will do, and we announce it, please track it down and see whether we have done it. May be what has happened before was because nobody paid attention to what was happening but now everybody in my state knows how much money that comes to me every month, and they know how it is expended every month. If there is any balance they will know what we are going to do, the state assembly is there and the people, I'm running what I call Jamma'a forum. I will go from city to city, village to village and talk with the people, where I have explanation I do, where I don't have I apologize and ask for more time. May be if we push our leaders to that position we will be able to go somewhere. There is nothing sacrosanct about a leader, in most cases we are not the most intelligent people in the community, we are probably the luckiest picked out of them in my case, 3.9 million people, now if I don't look at it as a gift from God and merely treat it as such, may be I would have been wasting the people's time and God will judge me. We have resolved in our last meeting, that we would not want after we have spent eight years as so called excellencies, governors to end up crying in court. Leaders must carry themselves with decorum so that after, even if nothing, the society should be able to take care of them because of what they have done not because of what they have stolen.

Governor Babangida Aliyu

Don't you think it is good to put a mechanism that would monitor the implementation of some of the resolutions from state to state in order to see that the policy has gone down to the grassroot?

I don't want to pre empt a summit that has not been concluded. I want to expect that from every recommendation, there will also be schedule on how the recommendation will be implemented and then how to evaluate the success or otherwise of that particular recommendation, that will come when we come to close or to take the recommendation, I am sure each one will tell us how long will it take to recommend, if possible even the positions and then the possible inhibitions that we may come across and then how to evaluate success and like I said otherwise of that. All that will be included in the recommendation. If it becomes necessary that the 19 governors forum and the FCT, that we feel that there should be an observer to be able to do that, why not? not, each state would bring its own report, I expect that in case of health apart from the ministry of health there should be an inspectorate that should be able to tell you where you are at the moment, where you should be at a given time and what to expect at a particular time. Each state should have that and then we will be meeting to discuss the report of each state, and to see where some of us are lagging behind as a result of paying more attention to other things. Some of us have identified education, health and agriculture as the main priority at least for the next two years, may-be somebody who might not think otherwise but in the Northern states I think those are the things, to pay attention to at the beginning, may be infrastructure next, as the further one. If there is a need to have an independent assessor why not? but for now who have an internal mechanism of looking at how these things are done and some of us are frank enough to ask the right questions, will see what they will recommend for us.

This is supposed to be the Northern Governors Forum and out of the 19 governors we have only four governors?

The summit is not the Northern governors meeting. There is a difference, at the summit, we are looking for experts, all the 19 Commissioners of Health are here and there are directors, for each state we gave a place officially for about seven people, apart from the other paraphernalia of federal institutions and what have you. So we were not expecting all the 19 Northern governors to be here, but we expect that after the recommendations, the reports and everything will be officially sent to the 19 governors for implementation.

How will the Northern Governors tackle the issue of poverty and lack of food in the society?

The way we have started now, is the way we intend to go about it by prioritizing. Yes people are poor, yes people may not feed but again is a shame and is sad comment on us that as we are talking of poverty to the extent of people not able to feed, it is unfortunate but then, this a starting point, there is always starting point, the realization that something is wrong, I think is half at the solution. You heard me announced that after this one we will look at education, and even ask a rhetorical question and also gave an answer.

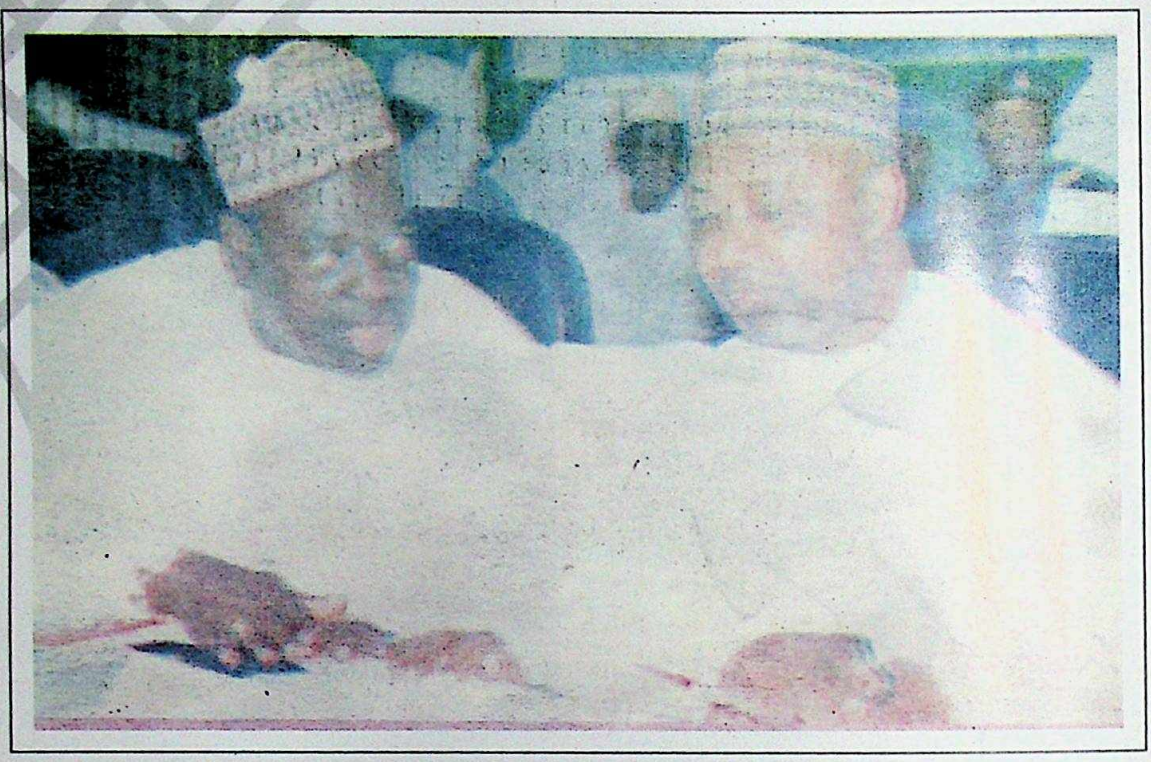
What is the competence of the North, everybody will tell you agriculture. If so is the case by now 2007 we should have been able to export not only Nigeria but able to export. I been able to give of Taiwan, of 19 with two hundred hectares of land, feed themselves are sure some of Taiwan rice in state, with 80 are able to courage it, and seedlings and things to do and will buy the When I went I did not see when you farmer, he is not only but to be make everything work, what small hectares farmers. So in other words I have already seen it, if I don't do anything for the next four years, I'm sure God will ask me, and we will stand from there, that is where you come in, begin to write, don't write only when you want me to come and give you money. Have a focus on the society, what do you expect and then write. Kwara state is doing fine with the Zimbabwean farmers, Niger and Benue have no business with poverty if they harness farming comes very well.

What is the stand of the Northern Governors' forum over the textile industry?

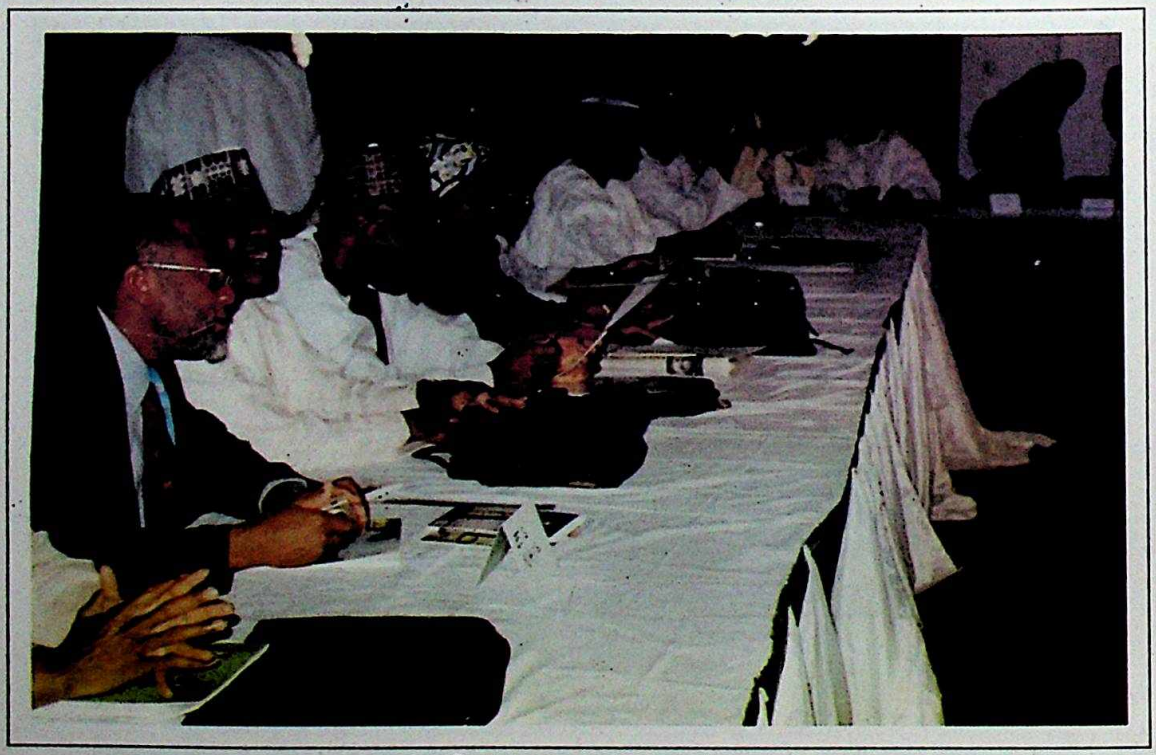
We have asked for a full report because many of us are new to the problem and the federal government's attention has been drawn not only to KTL but to the textile industry and a lot of assistance was supposed to have come from the federal government. The meeting that we had, we are waiting for the last report to be able to confront and also seek for assistance from the right places. I have talked with the Managing Director of NEXIM Bank on how to assist KTL. Sometimes a lot of debts have accumulated in such companies, you will need to break somewhere, like they have done in the federal system in privatizing, they would take the responsibility of all the indebtedness and liabilities for you to be able to do something because the liabilities have accumulated so much and for you to be able to do anything for KTL, you need to know what to do with those liabilities, that is where you are now. If we have met, we were supposed to have met until the governors retreat came and now we pushed the meeting to January we should have taken reports and take decision on what to do with the liabilities and move KTL forward. It is rather unfortunate it is a cumulative problem. More often than not, the kind of decision that would solve the problem, many people would shy away from that, because they don't want to be blamed.

Cross Section of Participants at the summit

Governor. Aliyu Wammako of Sokoto State, Chief Servant of Niger State and Chairman of the Forum with the host Governor Mohammed Sambo exchanging views during the summit.



Governor Mohammed Namadi Sambo of Kaduna State (right) with his Niger State counterpart, Alhaji Mu'azu Babangida Aliyu at the Summit



Participants at the summit

Across section of participants

Chairman, Northern Governors Forum, Dr. Mu'azu Babangida Aliyu [L] of Niger State; Governor Namadi Sambo [R] of Kaduna State and Director - General, National Agency for the Control of HIV/AIDS, Prof. Babatunde Osotimehin discussing at the Health Summit

Drama on maternal mortality at the summit

Drama on maternal mortality at the summit

How to move the North forward

By MUAZU BABANGIDA

Millions of our people are today poor and suffering because of the acts of commission or omission of some of our past leaders. There can be no greater cause for us as leaders than to ensure that the people we serve – every man, woman and child – should be able to benefit from the best medicine and healthcare that is available in this era. Our vision today is to form a coalition to fight the ancient scourges and reverse the unfortunate negative health indices of our states and the country at large. It is very sad to note that in this part of the country, for example, about half a million of our children will die in child birth every year and many children do not reach their fifth birthday.

Health indices of the North portray a people highly underdeveloped and I believe that this is most unfortunate especially when we recall with pride that the North had been at the helms of affairs of our great country for far longer than other parts of the country. This begs the question: I have often asked what drew the line for the decades of political leadership? Where and when did things go wrong? We recall with nostalgia the era of [illegible] compatible political leadership in the likes of late Sir Ahmadu Bello, late Sir Tafawa Balewa, former President of Nigeria and Mallam Aminu Kano champion of the cause of the talakawa.

I am very happy when my colleague the Kaduna State Governor mentioned the amount he will be spending on health care delivery. People need to know, not just money. They need to track whether you are spending one million or two million. They need to follow up to see whether you are doing what you said you would do.

Each one of us should make a commitment by signing a health compact that we shall work assiduously in concert to reduce the alarming death rates in our states by effectively organizing and managing our health services to meet the real needs of our people; and so join the world-beating attempt to reduce child and maternal mortality, conquer malaria, polio, VVF, tuberculosis, measles, pneumonia, and eventually defeat HIV and AIDS. Unfortunately, these targets are not likely to be met by 2015, not even by 2025, unless there is genuine commitment on the part of the political leadership to improve the funding and management of the health sector.

Similarly, may I use this opportunity to reassure our development partners of our collective resolve to insist on transparency, accountability and the application of due process in our dealings in our various states. We are not unaware of declining donor confidence in most parts of the country, due largely to poor counterpart commitment and diversion of funds in some States. We are confident and determined, at the Northern Governors' Forum to ensure that whatever assistance provided by our development partners gets to the target populations, always and promptly. We are prepared to fight and embrace ethical corruption and indiscipline in our policy.

This cannot be done unless there is good leadership at all levels of Government and Governance. To my mind, the Local Government level is the place where the most serious activities that impact on the lives of the people take place. Hence, there is every need for us all to be sufficiently interested in what takes place at that level, especially in ensuring that we get the right caliber of people at the helms of affairs in our Local Government councils always. We all agree that the Local Government remains the foundation of development of the society as far as our present political and constitutional dispensations are concerned. We must face the reality that the other parts of the country are moving ahead while we lag behind because we have been complacent about what goes on at our Local Government level, including allowing the leadership of that most important tier of government to be hijacked by few selfish and corrupt individuals, in most cases by charlatans who see politicking as a profession and as an avenue to steal public funds.

We must not tolerate leaders who are selfish and concerned about their personal interests and the welfare of their families and cronies only. We must seek out for selfless people, who will be servant-leaders, no matter where they may be or how educated they feel about taking up the challenge. That is the surest way we can collectively fight disease, poverty, illiteracy, ignorance and general underdevelopment in the North and the country at large.

The biggest challenge before us today is to sensitize our people on the need to accept and elect only leaders with proven records of honesty, competence and personal integrity into leadership positions generally, and especially at the local government levels, if we must achieve our aspiration of transforming the lives of our people through the implementation and execution of good policies and projects, including supporting primary health care activities in order to assist us in reducing the alarming death rates in our states. After all, the real essence of government, to my mind, is about performance and service delivery, and the people have the right to be served with dignity by men and women of conscience and real fear of God at the grassroots level.

With the benefit of hindsight, the important role of the Local Government was succinctly described in the foreword by Late (the) Brigadier Shehu Musa Yar'adua to the 1976 Local Government Reforms, which states that "... the federal (military) Government was essentially motivated by the necessity to stabilize and rationalize Government at the local level. ...Local Government should do precisely what the word government implies i.e., governing at the grass roots or local level." The main thrust of that Reform was to "stimulate development at the grass roots" without necessarily "reducing or abolishing the traditional functions of our Emirs, Obas and Chiefs, whose 'organic unity' was consciously preserved.

All hands must be on deck to link our and elect credible and competent people into the local government administrations in all Northern States, if we must attempt to meet up and close the gap between the North and other parts of the country. The idea of electing retired but not tired Nigerians or accomplished senior citizens, people with integrity and high sense of responsibility into that level of administration is to be encouraged in our various States. For instance, in Niger State, it is on record that Prof. Shehu Yelo offered to serve and was elected as the Chairman of Yelo Local Government in 1986, long after he had been once a commissioner in Niger State in 1976 and a Professor of Veterinary medicine in ABU Zaria for many years. Similarly, late Alhaji Bagudu Sheriffs also offered to serve and was appointed as the Chairman of the same Yelo Local Government several years after he had retired as Chairman, Federal Civil Service Commission, a position he held for over a decade. I must state that achievements recorded in that Council during their respective tenures have not been matched to date. We really need to encourage people of such standing to come out and provide leadership at this most important level of Government.

The Northern Governors' Forum is deeply concerned with the general underdevelopment of the people we serve. We are determined to make a positive difference in the lives of our people and will soon address issues in Education, Agriculture and the Economy in the Northern States. As a region we must begin to identify and recognize our CORE COMPETENCIES and enhance them. We must also identify and recognize our weaknesses and rectify them in order to compete favourably with other communities and nations.

Dr. Muazu Babangida Aliyu, OON (Talban Minna), the executive governor of Niger State and Chairman of Northern Governors' Forum (NGF), delivered this address at the first Northern States Health Summit held at Arewa House, Kaduna

NEWSPAPER CAPTION

Northern govs plan big for health

... To cut mortality rate

From MUSTAPHA SAVE, Kaduna

Ojo Maduekwe
Foreign minister

THE 19th Northern Governors' Forum (NGF) meeting said the forum has reaffirmed its commitment to ing the health compact and to work assiduously in ert to reduce the alarming death rates in the region ffectively organizing and managing health services to meet the real needs of their people

Speaking yesterday at the first Northern States Health mit at Arewa House, Kaduna, chairman of the forum Niger state governor, Dr. Mu'azu Babangida Aliyu (Talban Minna) said their target is to join the world ting attempt to reduce child and maternal mortality, ...measles, malaria, polio, Vesico Vaginal Fistula (VVF), tuberculosis, ...monia and eventually defeat HIV/and AIDS

The chairman said unfortunately, these targets are not likely to be met by 2015, not even 2025, unless there is genuine commitment on the part of the political management on the health sector.

According to him, the stewardship role of the government in driving forward to achieve the Millennium Development Goals (MDGs) is crucial in this regard, adding that over the years, they have observed that the budgetary allocation to the health sector and donor financing of health programmes and projects

Contd. on P2

sions, Maduekwe blamed the problem on bureaucracy.

"When we came in 1999, the process adopted at that time was that payment was made by the ministry of finance direct

Contd. on P2

Shekarau seeks separation of convicted waiting-trial inmates

NEWSPAPER CAPTION

Thursday November 1

OUR VIEW

Health Of The North

A health summit sponsored by the Northern Governors' Forum and UNICEF was held in Kaduna this Monday. The first of its kind in a region blighted by poverty, ignorance and diseases, the summit was attended by Northern state governors, commissioners of health, as well as officials of state and federal ministries of health. Non-governmental organisations in the Northern states were no less visible.

If there is anything the one-day summit achieved, it is that it helped to draw the world's attention to an emergency situation in Northern Nigeria. It was a wake-up call to health-care providers not only in Northern Nigeria but in all of sub-Saharan Africa. Many participants at the summit gave evidence that a health crisis exists in Nigeria. Among them was the minister of state for health, Gabriel Aduku, who reeled off statistics: 100 million Nigerians are active malaria patients who spend more than N800 billion for its treatment each year. Upwards of one million Nigerian children die before their fifth birthday every year. The number of women dying from pregnancy-related diseases is alarming.

The ugly health statistics also indicate that an uneven percentage occurs in the North. This suggests that Northern leaders should double their efforts at lifting their people out of poverty, ignorance and diseases like VVF, malaria and HIV/AIDS. Health institutions should be rehabilitated and the poor should have access to them. Once life is lost, everything else is lost.

COMPUTERS COMPUTERS COMPUTERS

NEWSPAPER CAPTION

Etsu Nupe, Alhaji Yahaya Abubakar representing, The Sultan of Sokoto - Alhaji Sa'ad Abubakar III

Royal Father at the 1st Northern Governors' Health Summit

Prof. Akpala of the NPHCDA and Dr. M. Dogo, Executive Secretary of NHIS

Prof. Babatunde Oshotimehen (NACA Chairman) & Mrs. Koleosho Adelekan Executive Director NPHCDA)

ANNEX 1

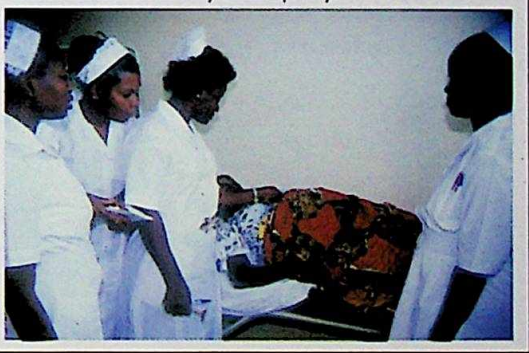
Presentation by Mr. Bala Shekari at the Meeting of the Secretaries to Government and Key Stakeholders at the Birnin Kebbi Meeting

ACCELERATING CHILD SURVIVAL AND DEVELOPMENT (ACSD) IN WEST AFRICA, THE NIGERIAN EXPERIENCE
and its Implications for the North West & Central Nigeria.

Mr. Bala Shekari
Health Specialist UNICEF C-Field Office–Kaduna
at SSG/Hon Commissionners meeting
Held in Kebbi State on 3rd Sept.07.

BACKGROUND

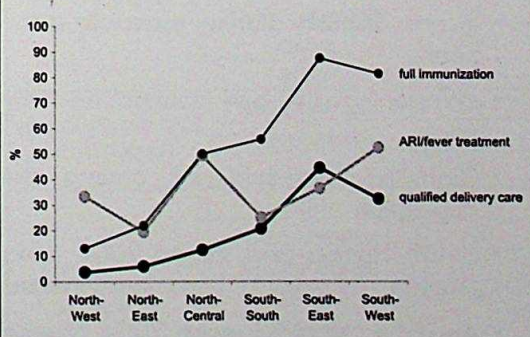
* In year 2000 an estimated 3 million women were pregnant and had 2.4 million live births.
* While giving birth to these 2.4 million babies, 170,000 women died from complications of pregnancy and childbirth.
* This means that every single day, 2 Airbus loads of pregnant Nigerian women crash.
* These crashes however do not make it to the news bulletin because they occur quietly.



BACKGROUND

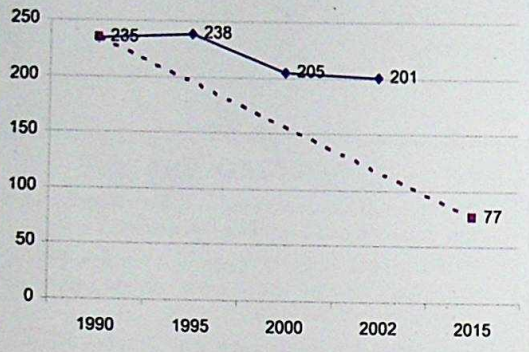
- For every woman that dies during childbirth in developed countries, 100 women die in Nigeria.
- In developed countries, every delivery is assisted by a skilled attendant, defined as a qualified midwife or doctor.
- In Nigeria, however, only 13% are assisted by skilled attendants.
- The situation is made worse by problems from other sectors.

REGIONAL DIFFERENCES IN HEALTH SERVICE UTILIZATION, NIGERIA, 2003



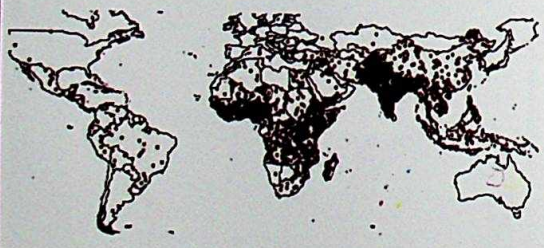
Source is 2003 NDHS.

MDG No.4:
Reduce by 2/3 the under five mortality



MDG No.5:
Increase the proportion of birth attended by skilled personnel

World-wide distribution of deaths
NB :Each dot= 5, 000 deaths



- ACSD adopted as regional strategy
- in April 2002 to address the end decade (2000) situation, to operationalize the MDG.

Back ground on the Nigerian Economy-improving

- Inflation on the decline – 15% in 2004, 11.6% in 2005 and 8.5% in 2006.
- External reserves grew by about 446% from US$7.68 billion in 2004 to US$42 billion at the end of 2006
- GDP growth averaged 6.5% between 2004 and 2006
- Non-oil sector growth rate averaged 8.5% per annum between 2004 and 2006.
- 7th largest world producer of oil, huge reserves of natural gas
- Phenomenal growth in the inflow of foreign direct investment
- Debt relief and final clearance of external debt

Economy Improving However

- Income disparity glaring, especially in the north
- Worsening child and maternal mortality rates
- High Poverty incidence among the population
- UNDP/Human Devt. report 2004 ranks Nigeria 151 out of 171 countries surveyed
- According to MDG report 2004 Nigeria may not achieve MDGs by 2015

WHY ACSD?

- Infant Mortality Rate (IMR) 109/1000 live births
- Under-five Mortality Rate (U5MR) 217/1000 live births
- Coverage for tested & proven interventions known to reduce childhood mortalities very low e.g.
- Children sleeping under Insecticide Treated Nets (ITNS) < 2%
- Immunization coverage < 30%
- ORS use for management of diarrhea <25%

The Marginal Budgeting for Bottlenecks tool

- This tool, developed by teams from the World Bank WHO & UNICEF, was designed precisely to helps plan, cost, and budget incremental allocations to the health sector to guarantee meaningful impact towards achieving the Millennium Development Goals for Health.

MBB – a three questions tool

- What are major health system bottlenecks hampering delivery of health services?
- How much money (additional) is needed for expected results?
- How much can be achieved in health outcomes by removing the bottlenecks?

IMPLEMENTATION

MORE THAN 100 districts in 11 West African Countries

17 million persons, including 3 million Under Fives

Countries were:

- BENIN, GHANA, MALI, GUINEA/BISSAU,
- SENEGAL, NIGER, GAMBIA, CAMEROON,
- GUINEA, CHAD, BURKINA FASSO

Innovative Strategies Developed

Child Health Days SENEGAL

- In remote villages, at least once every 6 months, EPI+ ITNs/ door to door re-impregnation, ANC, deworming, distribution of ORS packs, Chloroquine and antibiotic blister packs to CHW

Child Week: GHANA

- EPI catch up, ANC, ITNs, deworming, strengthening links between CHW and Health centre, improving access to HC, birth registration

Catching up EPI and door to door re-impregnation of Bednets: BURKINA

Birth registration+ BGC+ Vitamin A post Partum & ITNs: GAMBIA

Birth registration+ + Vit. A post Partum & ITNs + Hygiene + Nutrition: G.BISSAU

Operational research: SENEGAL, BENIN,

- ARI Community management , replicated in Gambia, Burkina Faso, G Bissau, opening in Guinea, Sierra Leone.

More than 18000 lives saved within 3 years

ABOVE 15% U5MR REDUCTION GOAL	SENEGAL	25%
	MALI	21%
	SENEGAL EXPANSION	18%
	GHANA	17%
	BENIN	16%
BETWEEN 10 AND 15% U5MR REDUCTION	GUINEA BISSAU	14%
	GUINEA CONAKRY	12%
	BURKINA	10%
BELOW 10% U5MR REDUCTION	CHAD	10%
	BENIN EXPANSION	11%
	MALI EXPANSION	9%
	GAMBIA	9%
	NIGER	9%
	CAMEROON	5%
	GHANA EXPANSION	3%

Additional Results

....that could /will save many more lives

- Strengthened position to advocate for child survival
- Adoption of ACSD approach as National level policy
- Leveraging large scale funding for child survival
- Adoption of ACSD by AU

AU Vision

July 2005

CALLS UPON Member States to scale up the process of attaining the goals, in particular the fourth goal on Reducing by two-thirds the mortality of under-fives, which can be achieved y low cost, and high impact interventions;

COMMENDS UNICEF and WHO for its Accelerated Child Survival and Development (ACSD) Programme and REQUESTS UNICEF and other partners to extend the programme to the whole continent and Member States to mainstream the programme into their national health policies, the Poverty Reduction Strategies and Health Sector Reforms;

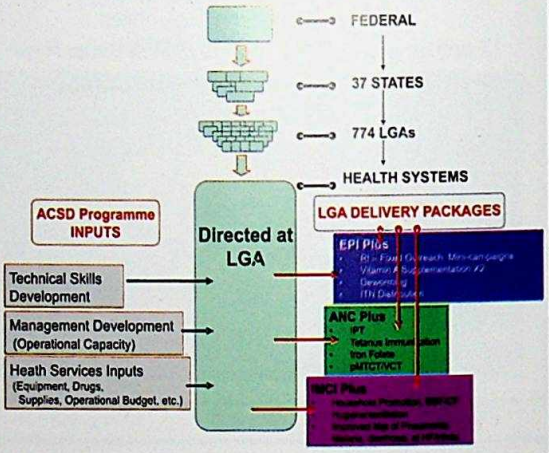
URGES Member States to collaborate with AU, UNICEF, WHO and other partners, to elaborate a road-map on MDG4 for reduction of child mortality and morbidity

ASCD in Nigeria: Introduction in 2006

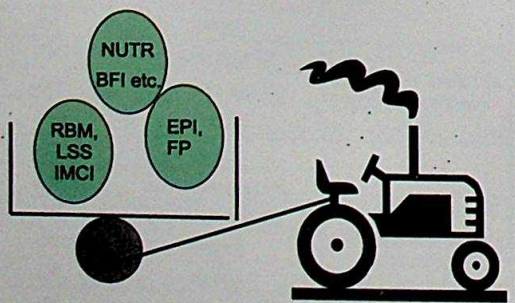
- Context:

- Presidential initiative on MDGs: through integrated approach how to at best reach MDGs 4 , 5 , 6
- Malaria Booster Program WB: better programming of Malaria interventions within health essential package
- EPI routine: integrated approach addressing Polio eradication and also additional key essential interventions: Insecticide Treated Nets, Oral Dehydration Sachet, Breast feeding
- Safe motherhood: introduction of Newborn health
- Linking community involvement within health system strengthening.
- Demonstrating at State level feasibility of reaching MDGS, So far all States and 111 LGAs have been sensitized and have produced PoAs for ACSD as at 2007.

ACSD Concept - NIGERIA



Vision:



Major achievements/Opportunities so far:-

- First time we had stakeholders and implementers under one roof to identified health bottlenecks, identified under lining causes and proffer solutions.
- POAs were developed.
- Advocacy to LGAs resulted in some Like Kurfi LGA of Katsina State allocating between N10,000 to N15,000 monthly to each Health facility for the day to day running of services.
- Abandon health facilities projects by the State Gov't for over 16-20 years in Oke-aba, Isin,Sinawu and Taberu communities of Kwara State, were completed and put to use.
- 3 communities of Aiyetoro-Oja in Kwara State, Awon and Agunu of Kaduna State with this period provided health facilities that have now received at least 3 deliveries.
- UNICEF and WHO were call upon by the Kaduna State Governor to participate in a committee to develop modalities for the take off of free medical services for pregnant women and children Under-five.Far reaching recommendations on Health Reforms were recommended and being considered for implementation.

Major achievements/Opportunities so far contd:-

7. UNICEF has again been invited to participate in the commettee for implementation.
8. Electrification of health facilities e.g. 4 in Kurfi and 6 in Ingawa LGAs of Katsina State.

- Renovation of toilet facilities in Koko Besse in Kebbi State, Kurfi and Bakori LGAs of Katsina State.
- Completion of abandoned projects by the community in Pamo, Isin LGA of Kwara State and by Koko Besse LGA at Rafin Alhaji community of Kebbi State.
- Renovation of Ikeje PHC in Olamaboro LGA by the community.
- Construction of sanitary wells in 7 health facilities by Kurfi LGA of Katsina State through partnership with the various communities.

Human Resource

12. Sponsoring of 4 secondary school leavers for Midwifery training in 2 LGAs of Kebbi State (Koko Besse and Shanga)
13. Deployment of Midwives and some other technical staff to some needy communities e.g Iga Ugbamaka and Agaliga Efabo communities of Olamaboro LGA of Kogi State, Wurmo community of Kurfi LGA
14. Engagement of services of non technical staff by communities to complement government e.g Pandogari and Alkarya communities of Kurfi LGA in Katsina State.

Major achievements/Opportunities so far contd:-

15. **Equipment**

- Repair of broken down equipment to enhance the maintenance of cold chain system at Oke Aba in Isin LGA of Kwara State

16. **Drugs**

- Ward Development Committee (WDC) purchased drugs to re-activate the DRF scheme at Besse in Koko Besse LGA of Kebbi State.

17. **Services provided (range and scope)**

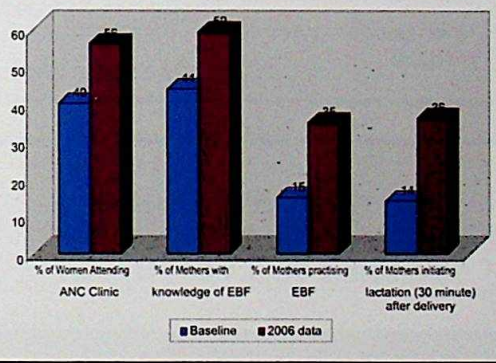
- Routine immunization improved from monthly to weekly in some health facilities in Kogi and Kebbi States.
- Commencement of outreach services in some facilities in Olamaboro LGA of Kogi State and Kurfi LGA of Katsina State.

Major achievements/Opportunities so far contd:-

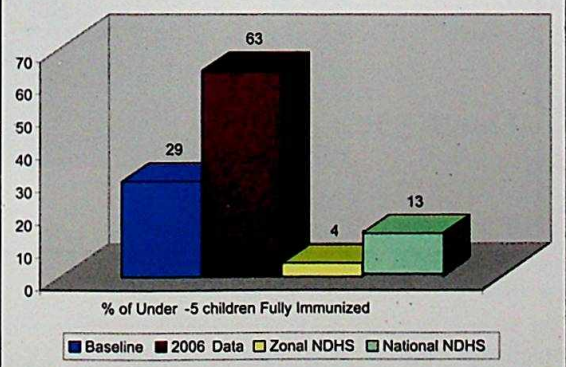
Supervision

- Some LGAs have developed schedule for supervision e.g. Kauru LGA of Kaduna State.
- Capacity of LGA officials to conduct supportive supervision of health facilities and health workers improved in most LGAs.

ANC Attendance, Knowledge and Practice of Exclusive Breast-feeding and Timely Initiation of Lactation



Immunization Status: 2006 Update in Relaion to Baseline, Zonal and National NDHS (2003)



Constraints/Challenges:

- Low level of political commitment at LGA level
- Donor dependence on programmes implementation at all levels
- Dearth of basic resources for health care service provision (DRF collapsed and LGAs not providing drugs; no equipment and inadequate staff especially Midwives/Nurses at LGAs facilities)
- Inequity in distribution of available health resources
- Gross deficiency of health worker skills
- Non availability of basic data for planning
- Grounded community-outreach services
- Non/poor quality supervision

RECOMMENDATIONS:

- Hold stakeholders meeting to agree on roles and responsibilities to intensify and sustain technical support supervision.
- High level advocacy to LGSC and individual LGAs to employ more staff especially nurse midwives
- Conduct advocacy/sensitization workshops for LGA policy makers as was done when PHC first introduced in the country
- Encourage LGAs to redistribute staff and other resources to redress inequity
- LGAs to revamp DRF and provide a dedicated bank account for drugs
- Organize orientation training on Modified LSS for CHEWs on the short run to take on ANC
- Also IMCI training for health workers for improved management skills for sick children.
- Hold periodic review and document good practices.

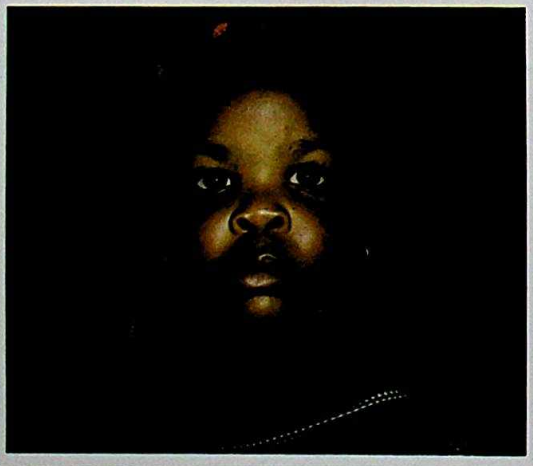
The message I like to impressed to all is :-

At any given opportunity we come in contact or issues of ACSD are brought under our preview henceforth;

Our positive action[illegible] Save more lives

And Move us towards achieving MDGs 4,5,&6

SO THAT WE WILL HAVE CHILDREN THAT WILL GROW TO THEIR FULL POTENTIALS



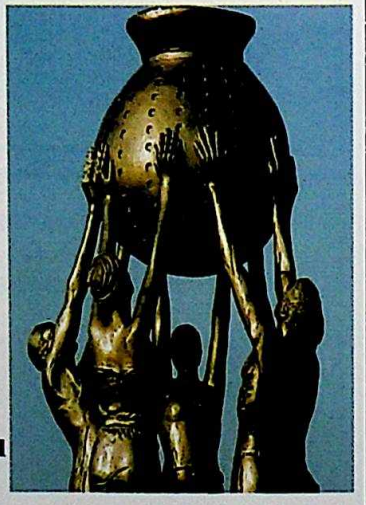
Together

Everyone

Achieves

More

Thank you



ANNEX 2
List of Members of the Organizing Committee

S/NO	NAME	ADDRESS	REMARKS
1.	Dr. Isah Y. Vatsa	Hon. Commissioner, Niger State	Chairman
2.	Dr. Clara Ejembi	ABUTH, Zaria	Member
3.	Dr. Mohammed Qabasiyu	Exec. Chairman, Katsina State PHCDA	"
4.	Prof. William . N. Ogala	ABUTH, Zaria	"
5.	Dr. Nasiru Sambo	ABUTH, Zaria	"
6.	Dr. Oladapo Shittu	ABUTH, Zaria	"
7.	Dr. Saidu Buba	Specialist Hospital, Maiduguri	"
8.	Prof. I. O. Ujah	University of Jos Teaching Hospital, Jos	"
9	Dr. Isaac Warnow	Federal Medical Centre, Gombe	"
10.	Dr. Hadiza G. Galadanci	Kano Teaching Hospital, Kano	"
11.	Dr. Mohammed Usman	MOH, Minna Niger State	"
12.	Alh. Nuhu Shehu	Retired Staff, NPHCDA	"
13.	Dr. A. M. Lasisi	Federal Medical Centre, Bida	"
14.	Dr. Hadiza Mohammed	Women Affairs, Niger State	"
15.	Dr. I. B. Sule	Water Resources., Niger State	"
16.	Mrs. Elizabeth Shaba	Perm. Sec., Min. of Health, Niger State	"
17.	Mr. Bala Shekari	UNICEF Field Office Kaduna	"
18.	Dr. Susan Ojomo	UNICEF Field Office Kaduna	"
19.	Dr. Luika Bahago	Office of the Governor, Niger State	"
20.	Dr. Abdulkadir Arah	Office of the Governor, Niger State	"
21	Dr. Abdullabi Mohammed	Ministry of Health, Niger State	

ANNEX 3
Speech by the Chief Servant

ADDRESS BY THE CHIEF SERVANT, DR. MUAZU BABANGIDA ALIYU, OON (TALBAN MINNA), THE EXECUTIVE GOVERNOR OF NIGER STATE, AT THE INAUGURATION OF THE LOCAL ORGANISING COMMITTEE (LOC) OF THE FIRST NORTHERN STATES' HEALTH SUMMIT: 31ST OCTOBER, 2007

PROTOCOL:

2. It gives me immense pleasure to welcome you to Minna and to this occasion of the inauguration of the Local Organising Committee (LOC) of our First Northern States' Health Summit being planned to hold at the Arewa House, Kaduna on Monday, November 12th 2007.

3. Distinguished professionals, before I proceed, permit me to give you an insight into the whole idea of the proposed Northern States' Health Summit. As you are aware, providence has bestowed on us the priviledge of providing leadership to our people in our various States at a most challenging time of our national history, a time when our people have lost hope and confidence in the political leadership at various levels for reasons too obvious to be repeated here unfortunately. And for me, I have the additional challenge to provide leadership to the 19 Northern States under the platform of the Northern Governors' Forum at this particular time.

4. Therefore, we thought that we must seize this rare opportunity, of being at the centre stage, to make a positive difference in the lives of the people we are

priviledged to serve, in order to make the world a better place than we met it, which has been our guiding principle in life.

5. But why a Northern States' Health Summit, the question may be asked. I believe that as professionals you will agree with me that all the national development indices, especially the health indicators portray a gloomy picture of the North, whether you are looking at infant mortality, maternal mortality or life expectancy, etc. It is thus our responsibility to do everything possible to reverse these negative trends in the interest of our generation and posterity.

6. This is the major reason why we anxiously embraced the idea of a Northern States' Health Summit which was proposed at the meeting of the 'C' Field Office of UNICEF held in Birnin-Kebbi on 3rd September, 2007 with Secretaries to the State Government (SSGs) and Commissioners of Stake-holder Ministries, to create an avenue for frank and in-depth situation analysis by health technocrats, bureaucrats and practitioners in the North with a view to finding realistic, sustainable solutions to the problems identified.

7. Distinguished professionals, you have been nominated to serve on this important Committee in recognition of your professional competence, vast experience and contributions to the delivery of effective healthcare services to Nigerians resident in the North. Specifically, we want your Committee to be responsible for organizing the historic event of the First Northern States' Health Summit, including carrying out the following assignments:

a) Proposing a Theme and the Objectives of the Summit

b) Identifying competent resource-persons, key-note speakers and discussants at the event.

c) Proposing the officials at the event, viz. Special Guest of Honour, Guest of Honour, Chairman of Occasion, Chief Host, etc.

d) Producing an Action Plan with Strategic Implementation framework at the end of the Summit to serve as reference guide for the 19 Northern States' Governments.

e) Any proposals/suggestions considered by the Committee to be capable of enhancing the overall success of the Summit.

8. Given the limited time available to the LOC and the enormity of the assignment, it is clear that you all have an opportunity to register your names in the Northern Hall of Fames at the end of your assignment, which I know you are equal to.

9. It is my hope that at the end of this onerous assignment, we would have been able to collectively set the ball rolling for revitalizing and reinvigorating the health sector in the North with a view to improving the quality of life of our people.

10. A proposal will also be tabled at the Northern Governors' Forum on the need to have a Standing Northern States' Health Advisory Committee to enable us to share ideas, experiences, and bench-mark as a peer review mechanism in the discharge of our responsibilities in the Health Sector. I hope that some of you will find your ways into that important Committee if it is considered by my colleagues.

11. On this note, distinguished professionals, ladies and gentlemen, it is my honour and priviledge to inaugurate the Local Organising Committee (LOC) of the First Northern States' Health Summit to the glory of Almighty Allah and for the upliftment of the health status of the Nigerians living in the North.

12. May Allah assist you in carrying out your assignment. Thank you and God bless.

ANNEX 4
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ANNEX 5
Address by the Chairman of the LOC

WELCOME ADDRESS BY DR. ISAH YAHAYA VATSA, CHAIRMAN, LOCAL ORGANIZING COMMITTEE ON THE OCCASION OF THE FIRST NORTHERN STATES' HEALTH SUMMIT AT THE AREWA HOUSE, KADUNA: MONDAY, 12TH NOVEMBER, 2007.

PROTOCOL:

2. It is my singular honour and privledge to welcome you all to this epoch making event of the first Northern Health Summit being organized by the Northern Governors' Forum and UNICEF with the support of leading development partners, donor agencies and other relevant stakeholders. It is indeed a great pleasure to be associated with a programme like this, which has a potential to make lasting impact on the lives of millions of Nigerians living in the Northern States and the FCT, and to be with so many people, professionals from different parts of this country to advance the cause of healthcare delivery.

3. May I especially welcome the Chairman of the Northern Governors' Forum, the articulate and visionary Executive Governor of Niger State, Chief Servant, Dr. Muazu Babangida Aliyu, OON (Talban Minna), who's greatest passion is contributing to the development of society and its people. Sir, that you accepted to facilitate this historic event, with the cooperation of your colleagues, which is taking

place on the anniversary of your 52nd birthday reaffirm your commitment to the socio-economic development of Northern Nigeria and the country at large. We believe that God has a special role for you to play on earth and we are happy to be associated with you. We pray that Almighty Allah continues to guide, protect and bless your life.

4. I want to also respectfully welcome the members of the Northern Governors' Forum here present. Your Excellencies, we appreciate your roles in making this event a reality despite the short time we had to put things together.

5. Similarly, we warmly welcome the Country representative UNICEF and members of the UNICEF team, Development Research Project Center who are partners in this important project as well as other development partners and donor agencies for sharing our vision of making a society a better place for our people.

6. I want to particularly welcome the Honourable of Minister of Health and the Chief Executives of leading parastatals and agencies of Federal Ministry of Health for sparing their time to be with us today.

7. Distinguished ladies and gentlemen, we believe that the presence of all of you here is a demonstration of the concerns that you have about the state of health care delivery in our society and your determination to contribute your quota in changing the situation for the better. We are aware that our State Governments, particularly the present class of leaders are doing a lot in the health sector in their various States.

8. It suffices to say here that religious manipulations in Northern Nigeria had not only destroyed political equilibrium but also health as well as education services delivery. One wonders why immunization against preventable childhood illnesses is causing a lot of controversies still in the North. Meanwhile adultery, drug abuse and armed robbery with their attendant consequences are ravaging Muslim Ummah with no such reaction from the public. Thus, such responses are due to utter misunderstanding or misconception of Islam on a lot of educational and health issues. Thus a time has come not to allow such posture to continue to destroy us.

9. Consequently, the poor health indices and the alarming death rates in the Northern States call for collective aggressive action by all stakeholders in tackling the situation. We are fortunate to have at the helms of affairs in our Northern States, leaders with the zeal and determination to bequeath worthy legacies for our people.

10. Therefore, we all have a good opportunity now to do things differently, not only to meet up but to surpass the other parts of the country and to move towards achieving the Millennium Development Goals 4, 5 & 6. (i.e. reduce child mortality, improve maternal health and combat HIV/AIDS, malaria & other diseases). For the avoidance of doubt, this Summit is called principally to address the following issues, among others:

- Identify the magnitude of the problems, sensitize and advocate ake olders, especially highest political class, to address them.
- To identify the determinants of the problems and secure poli ll and commitment that will translate into increased resources for health re elivery services in Northern Nigeria.
- To identify priority areas which require urgent interventions.
- To develop a road map for accelerating preventive measures for maternal and childhood morbidity and mortality.
- To propose a mechanism for follow-up and feedback.

11. On behalf of the Local Organising Committee (LOC) and my colleagues, the Commissioners of Health of the Northern States, I wish to assure you all that adequate monitoring and feedback mechanisms would be put in place to periodically inform the Northern Governors' Forum of progress in each State as far as the resolutions from this Summit will be concerned. We shall equally encourage periodic local review of progress made on the agreed solutions to the problems at the State levels.

12. Your Excellencies, Your Highnesses, ladies and gentlemen, it is important to note that what we are gathered here for is paramount to the general well being of our people especially the less priviledged amongst us. The lives of millions of our people will be affected by the actions and inactions of the key planners present in our midst today as well as the resolutions that will emerge from this Summit. We therefore enjoin everyone to take the Summit serious and to participate actively in all that will be taking place today. Perhaps, this may be the only opportunity for some of us to contribute to

a project of this historical value and significance. We cannot afford to waste this chance of being part of the history of enthroning a legacy of qualitative healthcare delivery in the North.

13. At this juncture, Your Excellencies, Your Highnesses, ladies and gentlemen, I once again welcome you all to this historic maiden Northern Governors' Health Forum. May we have very fruitful deliberations.

Thank you and God bless you all.

ANNEX 6

Remarks by the Country Representative of UNICEF

GOODWILL MESSAGE
BY
MR. AYALEW ABAI, UNICEF REPRESENTATIVE, NIGERIA
DELIVERED AT THE NORTHERN STATES' HEALTH SUMMIT
HELD AT AREWA HOUSE, KADUNA,
MONDAY 12TH NOVEMBER, 2007

The Chairman, Northern Governors' Forum and Chief Servant of Niger State,

Dr. Muazu Babangida Aiyu (OON),

Your Excellencies, the Executive Governors here present,

The Honourable Minister of Health, Prof. Adenike Grange,

The Special Adviser to the President on Millennium Development Goals,

The NPHCDA Director and Director-General of the National Agency for the Control of HIV/AIDS,

Development Agencies in Nigeria here present,

Distinguished Participants from the States,

Medical Partners,

Ladies and Gentlemen,

Today's occasion is yet another opportunity to bring our minds together and reach a consensus on how to address one of the most pressing and urgent priorities in the country, improving the health care delivery system. I'm pleased that this is being done by such a cream of distinguished personalities, leaders and officials responsible for the health care sector from the 19 Northern States of Nigeria. I feel greatly honoured to be with you. Please accept my sincere appreciation.

Let me seize this opportunity to congratulate all of you for this timely initiative which comes at the commencement of the current administration. This shows your resolve to get things right at the very beginning, starting from where it hurts most and that is the health of the people. I have no iota of doubt in my mind that, with your commitment and determination, we shall transform the lives of our people and affect them positively for a long time to come. Let us, therefor prepare and set our minds to achieve the objectives of today.

I congratulate the Chairman of the Northern Governors' Forum and all his colleagues, the Executive Governors, on the foresight in providing leadership to organize the Northern States' Health Summit which has long been overdue. The theme of the summit, **"Alarming Deaths Rates in Northern States: The Time for Change is Now"** is very apt and timely.

Being a development agency with a mandate for children, UNICEF is deeply concerned about the unflattering health statistics on children and women in Nigeria, especially, in the North. Every year; at least one million children born in Nigeria die before their fifth birthday, with most of these deaths occurring in the Northern States. The number of women who die due to pregnancy and related causes is also alarmingly high with a disproportionate percentage of the maternal deaths occurring in the North.

Distinguished Ladies and Gentlemen, you will agree with me that this situation is totally unacceptable. We cannot allow our children and women to continue to die in these large numbers, especially when we have the knowledge, the means and the resources to halt the situation. Since we have agreed that Nigeria will be among the top 20 economies by 2020, then in the same vein, we must resolve that Nigeria will be among the top-most countries reporting the lowest infant and maternal mortality.

We all know that most common killer diseases ,of children and women can be prevented by cost-effective, easy-to-manage and time-proven interventions like immunization, use of insecticide-treated nets, use of Oral Rehydration Solution (ORS), Vitamin 'A' supplementation, effective home management of acute respiratory infections, ante-natal care and assisted delivery. These are all interventions that do

not require sophisticated and expensive operations, yet in their absence, diseases claim million of valuable lives every year.

Excellencies, Distinguished Ladies and Gentlemen, these interventions have worked wonders in other countries with similar or worse conditions like those of Nigeria, both in and outside Africa. Even here in Nigeria we have seen major achievements, for example, the National Immunization strives in 2005, most States in Nigeria have significantly reduced deaths from measles. This year, Nigeria has recorded the lowest cases of polio ever and today, we are glad to be facing the eminent elimination of polio from the land of Nigeria. I congratulate the leadership of Nigeria, in particular, the leaders of the Northern States, who guided their people right.

I am therefore, in absolute agreement with the theme of this meeting which can be interpreted as **"the time to halt this needless loss of lives of our children and women, is now".**

Fortunately, the logistics and knowledge to deliver these interventions are available. What remain are the political will, political choices and financial commitment on the part of the governments and partners, to ensure that the knowledge and basic services are delivered to every community to save children and women from unnecessary death and suffering.

Distinguished Ladies and Gentlemen, by putting these interventions in place, you would be contributing to the attainment of Millennium Development Goals 4, 5, and 6. There are 8 years to 2015 which is the end date for achievement of the MDGs, and you have the unique privilege to be directing the affairs of your States during this period. By coming together as leaders, executives, stakeholders and development partners from your respective States at this point in time, you recognize that on your shoulders is laced, a historical and noble responsibility6 to ensure that all children and women in Nigeria and especially in the Northern States, realize their rights to health and live their lives to all fullness. Posterity will remember you as the leaders who took the bold decision to save the millions of lives of children and women, who otherwise, would have continued to die every day from ravages of diseases and poverty.

I know that this is not an easy task that can be achieved by the government alone. We need a viable partnership with bilateral and multi-lateral organizations, NGOs, Civil Society Organizations, Communities, families and the children themselves. This is where I want to assure you of the continued support of UNICEF, WHO, UNFPA and other UN agencies responding in the health sector as well as other International Partners in accordance with our respective mandates and priorities.

The Chairman of Northern Governors' Forum and the Chief Servant of Niger State, Executive Governors of Northern States, Honourable Minister of Heath, Your Excellencies, Distinguished Ladies and Gentlemen, I thank you very much and eagerly look forward to a successful Summit and most importantly, that the resolutions of today will be implemented speedily, so that all children and women will enjoy their rights to health and live together in equality and dignity.

Nagode.

ANNEX 7
Goodwill Message from DRPC

ADDRESS BY SHEHU USMAN MUHAMMAD, A VOLUNTEER ADVOCATE UNDER THE DEVELOPMENT RESEARCH AND PROJECTS CENTRE (DRPC) KANO TO THE SPECIAL SUMMIT OF THE 12 NORTHERN GOVERNORS' MEETING ON ALARMING DEATH RATE IN NORTHER STATES, HELD ON MONDAY 12TH NOVEMBER, 2007 AT AREWA HOUSE KADUNA

PROTOCOL

I have been asked to address you here today as a volunteer advocate for maternal health working with the Development Research and Projects Centre (DRPC) Kano and other civil organizations for improved maternal health outcomes in Northern Nigeria.

Permit me to start by saying that on behalf of the DRPC and all the other civil society groups present here today, we wish to express our sincere gratitude to the Northern Governors for agreeing to convene this historic Summit on the critical situation of health in Northern Nigeria. We will also like to take this opportunity to thank his Excellency, the Governor and Chief Servant of Niger State who is the host of this particular sitting, for his commitment to improving lives of the people of the North. At this point UNICEF must also be acknowledged for supporting this Forum and having the confidence in the leaders and people of the North to address their own problems.

The problems of health in Northern Nigeria are problems that we all know of very well. We experience these problems everyday in our communities, in our homes, in Newspapers, Hospitals and in the face of our people as they suffer daily. We are here today to talk about how the crisis in health affect our women, our mothers, wives, sister, daughters and other female relations.

Without healthy women, we cannot have healthy children and without healthy children we cannot have healthy families and we certainly cannot have healthy voters and no healthy Nation. Women are endowed with the role of bringing forth life for human reproduction. No woman should therefore die while bringing life. That is why women's maternal health is often taken as an indicator of the health of the society. So, a focus on women's health is a focus on the entire health status and a focus on maternal health is a focus on our collective conscience as a people.

Your Excellencies Sir, Governors in Northern Nigeria have recognized the need to address the problems of maternal health and in the past few years they have introduced free maternal health services, have built new women and children hospitals, reformed health systems, have established PHC Board, equipped women hospitals, imported foreign doctors, and have given indigenous doctors scholarships to go abroad to specialize in various medical fields. These are important initiatives for which you must be congratulated.

However, despite these efforts, I am sorry to report that the problems of maternal health of women in Northern Nigeria have not gone away and our women are still dying in large numbers. Recent studies conducted by reputable agencies such as the Society of Obstetrics and Gynecology, UNICEF, PATHS and other agencies have shown that maternal mortality rates still remain highest in Northern Nigeria than any where else in Nigeria.

Your Excellencies, Ladies and Gentlemen, in short, giving birth in Northern Nigeria is like a death sentence for many of our women.

While the figures vary from source to source and from region to region, we are told that for every 1,000,000 live births about 3,000 women die during child birth. This does not include the thousands of women who survive child birth but are left with IVF or RVF and several other pernicious and lifelong disabling conditions.

Ladies and Gentlemen, as a Northerner I am saddened, sick and embarrassed to admit that we are lagging behind the rest of the country in this important area of social development. We have done a lot but we must still do more and we must do it together.

I would therefore like to recommend the following:

First, we need to give immediate attention to increase the number of skilled and highly motivated female health providers (Midwives) who can take deliveries at the community level, from the community and trained for the community. We have peculiar problems in this part of the country for which we must find peculiar solutions.

Secondly, we recommend that as a matter of urgency, a budget line should be created in the Budget sof States Ministries of Health on Maternal Health. Where it exists, more funds be put for adequate maternal health services which can yield quick wins by making existing facilities more functional and improve maternal health for our women.

Thirdly, there is an important need to monitor all that we are doing in maternal health – to see what is working and how it can be expanded. We cannot work without the facts. We also need to be more conscious of cost and adopt cost-effective interventions such as enlightenment programmes.

Finally, I would like to encourage Government Planning and implementing agencies to extend a hand of friendship and collaboration to Civil Society Groups working at all levels especially those working at the community level. Many of these groups understand their maternal health problems and they are ready for partnership.

In conclusion, Your Excellency, Ladies and Gentlemen, these are a few thoughts to which we do not have all the answers. We simply share your concern and worry over the problems of maternal health and would like to work together in partnership to tackle these crises in Northern Nigeria.

Thank you very much for listening and we pray for God's guidance as we work in this important area which serves humanity.

Once again, congratulations for taking the step of acknowledging that we have problem.

Let us all work together to find a solution.

ANNEX 8
Goodwill Message by Executive Director, NPHCDA

GOODWILL MESSAGE DELIVERED BY MRS. T. I. KOLEOSO – ADELEKAN, EXECUTIVE DIRECTOR/CEO, NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY ON THE OCCASION OF THE SUMMIT ON HEALTH ORGANZIED JOINTLY BY NORTHERN GOVERNORS' FORUM AND UNICEF HELD IN AREWA HOUSE, KADUNA ON 12TH NOVEMBER, 2007

PROTOCOLS

Let me start in the name of Almighty God and to begin by first congratulating the Northern States Governors' Forum, its leadership and the entire members of Local Organizing Committee, as well as the Secretariat for putting together this historical summit on the health of people of Northern Nigeria.

This summit is coming at the most important time in the history of our great country Nigeria. Nigerian leaders have realized that the fate of the people of our dear country, the quality of health and life and its path to development and greatness in Africa can only be shaped by a sensitive and committed leadership, which our dear Governors from the North are demonstrating this morning, to bring hope and smiles to the faces of women and families who hitherto are vulnerable to illnesses and yearly death. 25 years after Alma Ata Declaration of health for all and about 8 years away from the global target of MDG, it is obvious that quality health will continue to elude Nigeria unless urgent and dramatic actions are taken to redirector resources towards realizing and achieving MDGs.

Permit me therefore to not only commend the efforts of the organizers but to also, remind Your Excellencies that Northern Nigeria has a population of more women and children dying of preventable and avoidable causes. The gap between health indices of the North and elsewhere in Nigeria is wide. It is delightful therefore to see a renewed effort by Your Excellencies in promoting, supporting and leading others elsewhere in Nigeria in organizing and initiating a partnership that will ensure quality of life and development in all its ramifications among your subjects.

The magnitude and level of resources required for these initiatives however requires attention, support, participation and collaboration of all stakeholders. Some of the most important groups are the religious and traditional rulers, the teachers and the academicians whose energies should be directed towards supporting progress and improvement of health of the people. These groups have crucial roles to promote positive understanding and ensuring that all objectives of this noble forum are attained within the shortest period of time. Whether this succeeds or not also depends on the technical commitment of health care providers of all cadres and political support of the leaders and community members whose people are consumers of health services.

During this meeting, Your Excellencies, distinguished participants, we should take time to study, analyze and deliberate on the following strategic areas and issues.

- Creating necessary interphase between all levels of health care that will facilitate appropriate referral processes;
- Review the existing human resources for health to ensure adequate coverage of all service areas;
- Upgrading existing facilities and designing the provision of new ones;
- Train and recruit skilled manpower to assist labour, and other health personnel for PHC management;
- Develop management system for PHC, based on community participation as specified in the principle of primary health care;

- Continue to coordinate the roles and responsibilities of partners and stakeholders in the PHC and sharing effective PHC delivery with them;

Beyond this summit however, may I humbly appeal that Your Excellencies facilitate the engagement of various Local Governments and communities and make them accountable to the people by playing all their expected roles. The Agency would continue to give you the necessary support. It is my hope that this summit will come out with innovative and workable recommendations as well as follow up activities.

Your Excellencies, distinguished participants, I wish you all the best. May Almighty God crown this effort with success.

Thank you for your attention, thank you for listening.

ANNEX 9

Why I am Ashamed to be a Leader from the North: presentation by Dr. Kole Shettima

Why I am Embarrassed To be a Leader from the North
By

Kole Ahmed Shettima PhD
Mac Arthur Foundation

Disproportionate Maternal Health Burden in the North

- Nigeria 2% of global population but carries 10% of maternal death
- Second highest number of maternal death
- Highest number of VVF
- 52,000 women die every year
- Or one woman dying every 10 minutes

Disproportionate Maternal Health Burden in the North Cont'd

- Or 2 EAS plane crashes every day
- 166 per 100,000 live births in the Southwest
- 1,549 per 100,000 live births in the Northeast

TWO LEADING CAUSES OF MATERNAL MORTALITY IN 3 STATES

Eclampsia

- Borno, Kano and Plateau: 45.5%, 46.3% and 11% respectively

Sepsis

- Borno, Kano and Plateau: 4.2%, 23.5% and 21.6% respectively

Solutions-Framework

- Service-wide and sector wide approach
- Health system approach
- Private Public Partnership

Low Cost Solutions - Health Promotion

- Need to reorient the health seeking behavior of our people
- Role for Sanitary Inspectors (?)
- Health Education in our school system

Low Cost Effective Solutions -Human Resources

- Human Resources: encourage the Minister on her plan to start a midwifery corp and special youth service corp.
- Develop an Emergency health professional training for the North
- Redress underutilization of existing human resources

Low Cost Solutions - Technologies

- Encourage the use of clamptex for management of elampsia
- Use of the Anti-shock garment for hemorrhage
- Emergency Obstetric Care Package

Solutions-Low Cost/Effective

- Institutionalize Free Maternity and Under Five health Care Services in Every State and Local Government
- 15% allocation for health
- Revitalizing Primary Health Care and institutionalize independent Primary Health Board

Solutions-Low Cost/Effective

- Institutionalize Free Maternity and Under Five health Care Services in Every State and Local Government
- 15% allocation for health
- Revitalizing Primary Health Care and institutionalize independent Primary Health Board

Conclusion - Takeaway

Short Term

- Free Maternal and Child health Services
- Emergency Midwifery Training
- Revitalization of Primary Health Care

Medium Term

- Girl Child Education
- Poverty Eradication

Appreciation

- Thank You

ANNEX 10
Speech by the Minister of State for Health

LET'S FREE NIGERIANS OF MALARIA NOW. AN ADVOCASY MESSAGE BY ARC. GABRIEL YAKUBU ADUKU, OON. HONOURABLE MINISTER OF STATE, HEALTH, AT THE FIRST HEALTH SUMMIT ORGANIZED BY THE NORTHERN GOVERNORS' FORUM AT AREWA HOUSE KADUNA ON MONDAY, NOVEMBER 12, 2007

1. INTRODUCTION

Despite being both preventable and curable, malaria remains one of the most serious health problems in Africa. The burden of malaria on individuals, families, communities and governments is heavy, unbearable, crushing and spell devastating disaster. The curable benefits, both in terms of human and economic development in malaria, that were eliminated/eradicated are enormous.

1.1. Statistical data indicates that an estimated 74 percent of the population of Africa lives in areas that are highly epidemic for the disease and 19 percent in endemic prone areas. Only 7 percent of the continent's population lives in low risk or malaria free zones. Malaria in Africa accounts for approximately 270 million episodes or clinical cases each year of which 70 percent are children under five years. 24 percent of all deaths in children under five is due to malaria. Malaria accounts for 30 – 40 percent of out-patient hospital visits, 10 – 15 percent of admission, while 80 percent of the cases are managed at the community level.

1.2. As a country, Nigeria today, suffers the most severe human and economic losses from malaria. Although malaria has been reportedly adequately contained in some tropical countries and completely wiped out in others, studies indicate that malaria remains the No. 1 killer disease in Nigeria.

- Malaria is responsible for high morbidity and mortality in Nigeria

accounting for 11 percent of maternal mortality, 30 percent of childhood mortality and 25 percent of infant mortality in Nigeria

- 80 percent of the country's population of 140 million is exposed to the disease annually.
- 110 million Nigerians are known to be active malaria patients with the cost of treatment estimated at N800 billion ($6.25 billion).
- As a government, Nigeria looses N132 billion ($3 billion) annually to malaria with the cost arising from man-hour losses due to absenteeism from offices, farms, markets, schools and factories as well as expenditure on subsidized drugs in government hospitals and grants for research and enlightenment campaigns.

2.0. MOVING FROM MALARIA CONTROL TO MALARIA ELIMINATION

2.1. Studies have shown that malaria is not only controllable but it can also be eliminated. Most countries among them, Saudi Arabia, America etc, that have either achieved or are achieving malaria elimination started by implementing control measures aimed at seriously decreasing their malaria burden and subsequently moving to a situation where malaria would no longer be a public health problem.

2.2. The scourge of Malaria in Nigeria can be eliminated if:

(a) There is a careful analysis of malaria control experiences in conjunction with detailed analysis of the environmental, epidemiological and socio-economic factors related to malaria

(b) There is the appropriate political will supported by fund allocation.

(c) There is sufficient knowledge of the local malaria species; local vector species and their ecology, biting and resting habits and patterns of malaria transmission etc.

3.0. WAY FORWARD

- One of the ways we can bid a deserving bye to the malaria scourge in Nigeria is for Nigerians to maintain and keep environmentally friendly life styles by ridding our environments of mosquito-breeding habitats.

- There is also the urgent need for all Nigerians to be involved in a massive grand alliance against malaria by identifying mosquito breeding and hatching sites and effectively destroying them.

- A particular day of the month can be set aside as "National Mosquito Eradication Day" such as the National Sanitation Days observed by Nigerians in the past.

- Another strategy is to encourage local researchers to come up with different remedies and programmes in the battle against malaria attack. One of such measures is the breeding of organisms that eat up mosquitoes as is being done in Kenya where mosquitoes are said to be developing resistance to some pesticides.

- Nigeria can adopt a National Mosquito Annihilation Programme by fumigating the entire country with proven insecticides as has been done in some countries like Saudi Arabia.

ANNEX 11
Speech by the Minister of Health

INEQUALITIES AND HEALTH IN NIGERIA

PAPER PRESENTED AT A MEETING WITH GOVERNORS OF THE NORTHERN STATES BY PROF. ADENIKE GRANG HONOURABLE MINISTER OF HEALTH, FEDERAL REPUBLIC OF NIGERIA

Your Excellencies,

I am indeed delighted at the opportunity to address you today and bring to the fore issues of great concern to me as Honourable Minister of Health and which issues I am convinced are equally of great concern to you as the Governors of your respective States.

His Excellency, President Umaru Musa Yar'adua, has enunciated a 7-point agenda to make Nigeria one of the top 20 economies by the year 2020 and development of Human Capital stands out clearly as one agenda that is crucial to the achievement of our goal. Health and education are the twin engines that can facilitate the rapid development of human capital.

Your Excellencies, permit me to quickly highlight the role of health in development and what available evidence shows with regards to that role. It is now well established that man is at the centre of all developmental efforts and any developmental agenda that ignores man and his wellbeing, particularly health, will fail.

Ill health contributes to increasing levels of poverty by reducing productivity and income and by diversion of family wealth into the care and treatment of sick mothers. Available evidences show that in Africa up to 45% of household income is being

spent on health care even when the quality of such care is not ascertained particularly now in Nigeria. For example, an Indonesian study showed that men with anaemia were 20% less productive than men without anaemia.

A joint Pan-American Health Organization/Inter-American Development Bank study showed that high life expectancy had an economic impact 0-5 years later. The results further suggested that for any additional year of life expectancy, there would be an additional 1% increase in GDP 15 years later.

Economic historians have suggested that as much as 30% of the per capital growth rate in Britain between 1780 and 1979 was a result of improvement in health and nutritional status (WHO, 1999).

More recent evidence from South East Asia has shown that declines in childhood mortality prompting a decline in fertility and contributing to demographic changes resulted in a large working age population and a reduced dependency ratio after a time lag. These demographic changes have been held accountable for 30 – 50% of the economic "miracle" in the region between 1965 and 1990 (Asian Development Bank, 1997).

Malaria has slowed economic growth in African countries by 1.3% per year. Over 35 years, the GDP for African countries is now 32% lower than it would have been in the absence of Malaria. Africa has thus lost about $100 Billion to Malaria in that period. Malaria-free countries average three times higher GDP per person than malarious countries even after controlling for other factors which impact on economic wellbeing (Jeffery Sachs, Harvard University).

The globally adopted paradigms of development have also shifted from mere economic indices into looking at the conditions of human existence and we now talk about the Human Development Index, which Mr. President's 7-point agenda has aptly captured as the development of Human Capital. This shift together with the evidence I have provided is a wake up call for us to invest more in Health for communal and National prosperity. Governments' focused investment in health will contribute significantly to poverty alleviation by improving productivity and reducing family and individual expenditure on health.

Your Excellencies, even as we invest in health, we must consciously target our investment to achieve the greatest good of the greatest majority. This is a responsibility to our people so that we can bring our communities and country to the position of our desire in the comity of Nations.

Using an epidemiological model that relies on the totality of evidence currently available, we see that Health Status is essentially determined by four sets of factors: human biology and genetic inheritance, environmental factors, system of health care organization and lifestyle factors.

The globally accepted mandate of the health sector compels it to be interested in the four sets of determinants since the ultimate goal of the sector is to achieve improved health status. Inequalities may thus exist in exposure to environmental risk factors, access to education on lifestyle factors and access to needed health services in addition to intrinsic biological factors.

I dare say that we now have evidence that can help us prevent even some of the genetic diseases. Thus, persons carrying the AS genotype can be educated not to marry any person also carrying the genotype so as to prevent the possibility of having children who will have the Sickle Cell Disease (SS Genotype).

Inequality in Health: Definition and Evidence:

Inequality can be defined as lack of equal treatment (unequal opportunity or treatment based on social, ethnic, racial, geographic or economic disparity).

Inequality may be socio-economic and cultural. It may also be gender, race or ethnic group-based. There are many other subdivisions among a population that may be used as the basis for inequality. Inequality in the realm of health may be indicated by unequal access to health care, use of health services, treatment by medical providers, distribution of health services according to needs, and expenditure for different groups.

Inequalities in health exist in all the regions and the poor are disadvantaged in terms of self-rated health status, morbidity, mortality, communicable and non-

communicable diseases, health behaviours and access to health care. There is evidence that in Nigeria, the trend in inequality in health and in health care access rose over the course of decline in economic indices in Nigeria.

The health of a nation, social groups and individuals reflect structural conditions within the environment, including the degree of income inequality, unemployment, workplace hazard and residential deprivation". At the same time, personal variables like attitudes, awareness, motivations and lifestyles are greatly influenced by the environment.

Social class determines the pattern of mortality and morbidity, a fact that has been established by many bodies of research done in different countries. Social class or socio-economic status is related to all illness and health in general. "It is almost universally the case that people in lower social classes have more morbidity, disability and shorter lives" and Nigeria is no exception.

Thus inequality exists between and within zones. Individuals in the lowest income brackets have the poorest health, manifested by the highest infant mortality rates, the shortest life expectancies and the greatest morbidity. People belonging to lower socio-economic classes are also subjected to intense psychological stress and suffer maximum job-insecurity. Unemployment has a significant effect even among the non-poor strata, with the unemployed being "five times more likely to come above the threshold of psychological distress than those who are at work or retired".

Within States, the burden of under-coverage of professional health care delivery is concentrated in rural areas particularly among the rural poor. Poor-rich inequalities in terms of disposable income within urban areas are on the increase and may be contributing to increasing violence with health impact and thus of public health interest.

Inequalities in the use of professional healthcare delivery are extremely large and much greater than inequalities in use of services like immunization and medical treatment of childhood illnesses. Very few of the poorest Nigerians get professional healthcare irrespective of where they live.

A combination of the supply and demand factors and the nature of the service probably explain the inequalities seen. The mixture of factors is likely to vary among the different regions in the country. In some, accessibility/availability might be important and in others culture may be an important determinant.

Your Excellencies, please permit me to use more specific examples to drum home the challenges that we jointly have to face in order to move Nigeria towards the achievement of the Millennium Development Goals.

In terms of the distribution of health facilities, the Northern States are not at any great disadvantage compared to the Southern States. On the average, there is a health facility to about 6,000-8,000 Nigerians. Table 1shows the availability of health infrastructures in all parts of the country.

Major inequalities are however obvious in the distribution of health manpower and in the observed health outcomes. Table 3 shows the availability of health workers at Local Government Level whether in the private or public sector. The Northern States included in the study had far lower numbers than their southern counterparts. I will like to draw your attention to the relative shortage of Doctors, Nurses and Midwives in the Northern States even though there is an abundance of Community Health Workers.

The Human Resources for Health situation present a paradox of sorts – inadequately in number and yet unemployment and under-employment for qualified trained personnel. Based on the registers of health professions in the country, it is obvious that the population of health workers ratios are still far from ideal and yet unemployment and under-employment of health workers have been reported. As an example, despite the numbers of doctors graduating from medical schools there is a dearth of medical doctors in much of the Northern region of the country.

The statistics clearly show the absence of qualified medical personnel at the LGA level. Almost immediately I hope this situation can be redressed and LGAs be supported by the State Ministries of Health to employ and retain doctors through the provision of such incentives as performance based remuneration and accommodation.

As the 2003 National Demographic and Heath Survey report showed, 47% of mothers in the North-East and 59% of mothers in the North-West did not receive Ante-Natal Care, whereas in other regions, the proportion of the mothers not receiving ANC ranged from 1 – 25%. Table 4 shows clearly that the proportion of pregnant women receiving Ante-Natal care from a skilled provider was lower in the Northern States than in the Southern States. There are identified social and cultural factors that have contributed to this situation. It is my hope too that we can together identify some socially acceptable solutions, perhaps the setting up of maternity homes within easy distance of health facilities where women nearing the time of delivery can be housed in order that they are close to skilled attendance when the time comes. This may be particularly helpful for nomads.

As the statistics show, pregnant women in the Northern States were more likely to deliver at home and have the delivery attended by unskilled hands than pregnant women in the Southern States. The arguments that poor women or their families have a lower demand for professional health care assumes that they actually have a choice. In some settings, for instance, rural uneducated women deliver at home without professional care despite living in close proximity to maternity care facilities. Yet evidence from other countries suggests that poorer women tend to stop using traditional maternity care in contexts where medically trained, accessible, affordable and good quality professional care becomes available though they may be slower to adopt such care than rich women. This suggests that supply factors play an important role in explaining the huge poor-rich inequalities in healthcare delivery.

In some parts of Nigeria, health institution attendance among the urban poor is much higher than among the rural rich suggesting that availability, accessibility in rural areas is a problem. In contrast, in other parts of Nigeria health institution attendance among the urban poor is low as among the rural poor suggesting that other factors, such as costs, play a more important role. In other communities, cultural constraints might be of greater consequence.

Table 7 shows that the Northern Zones recorded lower immunization coverages for all vaccines compared to the Southern Zones. It is to be noted that immunization coverages did not meet targeted levels in all zones in the country.

Table 8 shows the disparities in health outcomes between the Northern and the Southern States. These outcome inequalities appear to align with the observed inequalitiesy in human resource distribution and in health care utilization.

Your Excellencies, the facts are indeed very clear and my presentation is essentially a call to action.

Health infrastructure appear to be well distributed in all zones of the country but it would appear that human resources for health care delivery are seriously insufficient with more than three times the current number of professionals being needed to achieve universal professional delivery attendance. The shortages are more acute in the Northern States. The States may need to provide incentives and job guarantees to facilitate a redistribution of health manpower from areas of super-concentration to areas of relative shortage.

We also need to note that cultural factors may be important determinants of uptake of health care in Nigeria. Professional health care providers may not be tolerant of the cultural beliefs and practices of the people. Sometimes, health care providers treat poor women with less consideration than richer or more educated women. Also, women may experience constraints on seeking care for themselves if relatives, particularly husbands or mothers-in-law, are heavily involved in the decision making process. Members of these poorer households may thus favour home-based health care delivery even if substandard. In some societies in Nigeria, this is related to norms of female seclusion. So, we need to reorientate health workers while we sensitize the public while on the benefits of health care and the processes for accessing it.

In some other societies, families may not be willing to spend money on women's health. Male doctors may also be a barrier for seeking facility-based healthcare. In contrast, richer and often better-educated women and their families may have a more modern world view and greater identification with the modern health care system, greater confidence in dealing with officials and greater ability and willingness to travel outside the community all of which may facilitate the use of professional health care. However, such cultural barriers may be fewer regarding children's health care.

The huge inequalities in health care facility attendance underscore the need for effective provision of services. Over the last decades, some countries have introduced various strategies to demand and improve availability, accessibility and affordability of professional health care delivery attendants. Some countries such as Indonesia, have focused on improving the availability of a narrow range of maternity care services (home-based midwifery in particular). Whereas others, such as Cuba, Honduras, Sri Lanka and Kerala, have sought to improve the availability of a broader range of health services including material care. Nigeria can take a cue from these.

Public sector facilities rarely address the poor-rich inequalities in professional delivery care. In absolute terms, poor-rich inequalities in the use of public facilities usually are larger than private sector inequalities suggesting that the public sector does not provide a safety net for the poor.

First Steps Forward

There are some strategies that can immediately be put in place. State Governments are encouraged to take advantage of the present leadership thrusts by aligning the State Ministries of Health with the Federal Ministry of Health and the MDG fund so that programmes and projects can be developed in line with the Federal Ministry to take advantage of the Conditional Grants Scheme. In September 2005, Nigeria successfully negotiated debt relief of roughly $18 billion from the Paris Club which translated to about $1billion annually in savings. In the 2007 budget, the Federal Government of Nigeria set aside N20billion for these debt relief gains towards pro-poor projects under the Conditional Grants Scheme (CGS). The Scheme is designed to channel these resources to expenditures on projects in four key areas: Primary Health Care, rural electrification, rural water supply, and sanitation and projects and programmes that support public-private partnerships in health, education and water.

Under the National Health Insurance Scheme, the first phase of the scheme, which covers core civil servants, staff of public corporations, police, military and uniformed paramilitary has achieved about 60% coverage of the civil servants and plans are underway for the implementation of the community social insurance scheme. The

strategy for community financing can be approached on the platform of public-private partnership as has been successfully demonstrated in Kwara and Lagos States.

I would also like to suggest that State Primary Health Care Development Agencies are established so that there can be closer supervision and monitoring of maximum impact. *This has been instrumental to the great changes in the health care delivery in Katsina and a few other States.*

CONCLUSION

In conclusion, Your Excellencies, reducing the inequalities in health care delivery is essential for achieving the MDGs. I am convinced that the only way we can make the desired progress is if we all play our roles diligently. You have the facts and I believe that together we will make this journey to improve the health status of Nigerians. I hope to leave here knowing that you will immediately put in place well thoughtout strategies to rapidly reduce the inequalities that have been highlighted. The Federal Ministry of Health is ever willing to partner with you on this agenda. We owe it as a duty to our people and we must not fail. I thank you for your patient attention. God bless.

Percent distribution of households by distance (kilometers) and time (minutes) to nearest facility, according to region, Nigeria 1999.

Distance Kilometres	NE REGION	NE REGION	SE REGION	SW REGION	Central REGION	Total
<1	51.2%	45.2%	35.7%	58.4	73.3	53.0
1-4	15.2	12.9	37.4	22.5	4.5	19.9
5-9	6.5	9.0	13.8	7.5	4.4	8.4
10-14	3.8	8.0	4.3	2.1	3.1	3.9
15-29	2.1	7.0	4.6	3.1	0.0	3.2
30+	0.0	5.5	0.0	2.6	1.5	1.8
DK/missing	0.0	1.4	0.0	0.7	0.0	0.4
No facility	21.2	11.0	4.3	3.0	13.2	9.4
Total	100.0	100.00	100.00	100.00	100.00	100.00

Source: NDHS, 1999, National Population Commission

TABLE 2: Number of Health Facilities

State	Primary (owned by LGA)	Compre-hensive	Secondary	Tertiary	Private	Mission	Performing Basic Surgery	Performing Compre'sive Obstetrics	Number of Bed Spaces	% Bed space for obstetrics
Abia	306	9	11	3	234	18	82	88	9526	35
Borno	331	10	14	4	50	12	60	18	5454	9
C. River	225	9	8	4	74	10	44	59	1570	12
Edo	262	19	13	3	297	6	47	49	4435	21
Imo	186	15	9	2	243	20	60	38	3021	10
Katsina	129	1	1	0	4	2	1	2	480	11
Kogi	472	3	23	2	144	18	62	70	2956	18
Lagos	163	5	15	2	416	19	39	42	292	23
Niger	306	1	4	0	200	5	43	28	1614	4
Ondo	295	26	16	1	310	75	74	63	1615	22
Sokoto	308	3	9	1	31	0	11	9	846	6
Taraba	579	6	18	1	130	45	49	39	4640	13
National Ave	297	9	12	1	178	19	48	42	2997	15

Dr. G.K. Osagbemi, Technical Report presented to World Health Organization March - April, 2007

Health Personnel

State	Total Doctors in the State	Doctors Employed by LGAs	Doctors with MPH	Nurses	MWs	CHO	CHEWs	Pharm. Tech.	EHOs	Pharm.	Private Doctors	Public Surgeons	Private Surgeons
Abia	114	2	1	227	202	79	618	27	118	5	69	0	0
Borno	159	6	6	340	86	78	571	3	428	3	28	16	0
C. River	394	0	0	338	312	164	1252	22	96	3	62	19	0
Edo	934	13	8	325	100	67	265	47	156	22	547	43	0
Imo	741	15	6	283	286	69	329	16	114	1	233	39	0
Katsina	4	0	0	18	14	14	158	3	53	2	4	0	0
Kogi	102	1	3	195	166	111	1061	22	160	22	53	24	0
Lagos	274	11	9	223	225	127	183	29	183	NA	176	8	20
Niger	89	2	0	161	102	80	955	24	93	6	57	0	0
Ondo	121	10	5	222	174	123	863	81	174	43	57	0	2
Sokoto	53	4	0	61	23	48	338	26	45	5	36	0	3
Taraba	71	0	0	379	85	101	1014	9	45	9	22	0	1
National Ave	255	5	3	231	148	88	634	26	139	11	113	12	2

Dr. G.K. Osagbemi, Technical Report presented to World Health Organization March - April, 2007

* MPH-Masters in Public Health
* MW-Midwives

TABLE 4: % Distribution of women who had a live birth in the 5 years preceding survey by ANC Provider for most recent birth

Region	Doctor	Nurse/ Midwives	CHEW	TBA	other	No one	Number of women
NC	23.8	50.0	0.5	0.0	0.1	25.3	575
NE	10.9	36.4	5.3	0.2	0.1	47.1	862
NW	5.4	31.5	1.9	1.6	0.6	59.0	1,341
SE	50.8	45.4	0.2	0.9	0.8	0.8	222
SS	38.8	33.3	0.7	10.0	0.3	16.8	544
SW	56.0	35.9	0.8	5.0	0.0	2.3	367

NDHS: 2003

TABLE 5: Place of Delivery

Region	Any Facility	Public Sector	Private Sector	Home	Other	Missing	Total	Number of Births
NC	45.4	27.0	18.4	54.6	0.0	0.0	100.0	897
NE	17.1	14.5	2.6	82.2	0.0	0.6	100.0	1,472
NW	10.4	8.8	1.6	88.6	0.0	1.0	100.0	2,161
SE	84.1	19.9	64.1	13.2	0.3	2.5	100.0	371
SS	53.2	29.5	23.7	45.0	1.6	0.3	100.0	789
SW	77.6	33.7	43.9	20.8	1.5	0.1	100.0	529

NDHS: 2003

TABLE 6: Assistance During Delivery

	ASSISTANCE PROVIDER								
Region	DOCTOR	NURSE/Midwife /Aux Midwife	CHEW	TBA	Relative/ Other	No. one	DK/ Missing	Total	
NC	9.6	39.0	1.5	6.1	34.7	9.0	[illegible]	[illegible]0.0	897
NE	2.4	17.4	2.2	25.4	31.7	19.38	[illegible]	[illegible]0.0	1,472
NW	0.8	11.5	0.7	24.3	31.0	30.5	[illegible]	[illegible]0.0	2,161
SE	20.2	67.3	0.2	3.0	6.2	0.4	2.8	100.0	371
SS	8.6	47.0	0.2	32.2	9.8	1.8	0.3	100.0	789
SW	23.9	57.0	0.7	9.0	8.4	0.9	0.1	100.0	529

NDHS: 2003

TABLE 7: Percentage of children fully immunized with valid doses by 52 weeks of age and by card sighted.

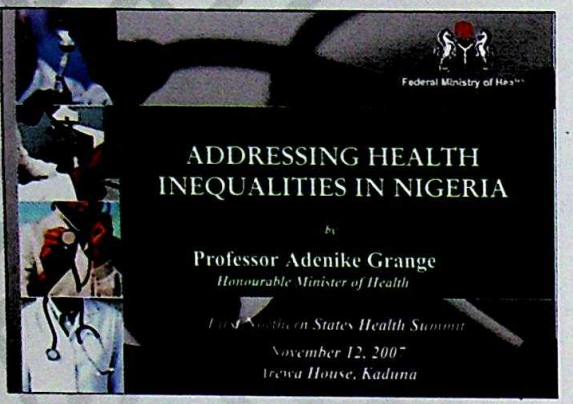
Zone	Fully Immunized	BCG	OPV	3DPT3	Measles
NC	3.9	26.1	15.8	16.3	16.1
NE	1.4	14.5	7.3	7.5	8.6
NW	0.6	4.3	2.1	2.3	2.4
SE	9.0	43.3	33.2	33.8	28.6
SS	6.0	33.3	22.9	22.9	21.4
SW	10.1	36.9	26.5	26.8	22.4

NPI, National Immunization Coverage Survey, 2003

TABLE 8: Regional Disparity in Health Indicators

Health Indicator	North	South
Total Fertility Rate (children per woman	7.0 *NE)	4.1 (SE)
Use of modern contraception (married women)	3% (NE,NW)	23% (SW)
Infant mortality rate (per 1000 live births)	112 (NE)	66 (SE)
Under-five mortality rate (per 100 live births)	269 (NW)	103 (SE)
Children fully immunized (may be crude rate)	3.7% *NW)	44.6% (SE)
Women who know how to avoid HIV	34% (NE)	52% (SW)
% population with access to safe water	21.6% (NE)	68.8% (SE)
% population will access to improved sanitation	5.0% (NE)	42.2 (SE)
Maternal mortality ration (per 100,000 live births) – estimates based on other surveys (not DHS)	2,400 (Kano)	700 (SE)

Dr. G.K. Osagbemi, Technical Report Presented to World Health Organization March – April, 2007



Health is of concern to everyone

Federal Ministry of Health

- President Shehu Musa Yar'Adua committed to making Nigeria a top 20 economy by 2020
- Development of human capital is key to that vision
- Health and education are the twin engines of human capital development

Ill-health contributes to poverty

Federal Ministry of Health

- Reduces productivity
- In Africa, 45% of household income is spent on questionable health care
- Improving life expectancy has an economic impact within 5 years

Federal Ministry of Health

Africa has lost about $100 billion to malaria in the last 35 years

GDP is 32% lower than it should have been

Health status is determined by...

Federal Ministry of Health

Human biology & inheritance

Environmental factors

System of health care

LIFESTYLE FACTORS

What is inequality in health?

Federal Ministry of Health

- Unequal access to health care
- Unequal use of health services
- Unequal treatment by health care providers
- Unequal expenditure for different populations groups

Who is affected?

Federal Ministry of Health

The poor...

- Related to the decline in economic indices
- Income inequalities, unemployment, workplace hazards, residential deprivation
- Attitude, awareness, motivations and lifestyles

"It is almost universally the case that people in lower social classes have more morbidity, disability and shorter lives" – World Bank

Table 1: Percent distribution of households by distance (kilometers) and time (minutes) to nearest facility, according to region, Nigeria 1999

Federal Ministry of Health

Distance kilometers	NE REGION	NW REGION	SE REGION	SW REGION	Central REGION	Total
<1	51.2%	45.2%	35.7%	58.4	73.3	53.0
1-4	15.2	12.9	37.4	22.5	4.5	19.9
5-9	6.5	9.0	13.8	7.5	4.4	8.4
10-14	3.8	8.0	4.3	2.1	3.1	3.9
15-29	2.1	7.0	4.6	3.1	0.0	3.2
30+	0.0	5.5	0.0	2.6	1.5	1.8
No facility	21.2	11.0	4.3	3.1	13.2	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: NDHS, 1999, National Population Commission

Inequalities in distribution of human resources for health

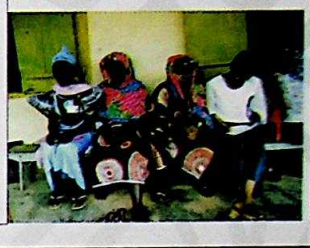
Federal Ministry of Health

- Northern states have far lower numbers of doctors, nurses and midwives
- There is an abundance of community health workers

Inequalities in access to antenatal care

Federal Ministry of Health

- Women in the Northern states are less likely to receive skilled antenatal care
- 47% of mothers in the North East and 59% of mothers in the North West did not receive antenatal care



Inequalities in access to skilled care at delivery

Federal Ministry of Health

- Evidence has shown that there is greater likelihood of poor birth outcomes when the birth is attended to by unskilled hands
- The likelihood of having a live birth was related to the type of health care provider that attended the delivery

Strategies to reduce maternal deaths

Federal Ministry of Health

- More women in the north deliver at home with unskilled attendants than women in the south
- Reduction of maternal deaths has been linked to 3 simple strategies
  - Access to effective, socially acceptable family planning services
  - Access to skilled care at delivery
  - Access to emergency obstetric care

Immunization coverage…

Federal Ministry of Health

- Immunization coverage did not meet targeted levels in all zones in the country
- Poorer coverage in the north compared to the south

Regional disparities in health status

Federal Ministry of Health

Regional disparities in health status appear to align with observed inequalities in human resources for health and healthcare utilization

A call to action!

Federal Ministry of Health

- Human resources for health are seriously insufficient
- Shortages in personnel are more acute in the north
- Incentives are needed to facilitate a redistribution of health manpower from areas of super-concentration to areas of shortage

Attitudes need to change…

Federal Ministry of Health

- Intolerance of cultural beliefs and practices of others can hamper use of health facilities
- Poorer, less educated women often treated with less consideration
- Health-seeking behaviour often predicated on poverty-determined decision-making processes
- Absence of female doctors…

Attitudes need to change…

Federal Ministry of Health

- Intolerance of cultural beliefs and practices of others can hamper use of health facilities
- Poorer, less educated women often treated with less consideration
- Health-seeking behaviour often predicated on poverty-determined decision-making processes
- Absence of female doctors…

First steps forward …

Federal Ministry of Health

- Lets team up… *Together Everybody Achieves More!*
- Align to develop programmes for the Conditional Grant Scheme
- Community financing through public-private partnerships
- State Primary Health Care Developmental Agencies

Federal Ministry of Health

Your Excellencies

Federal Ministry of Health

I thank you most profoundly for your kind attention

ANNEX 12

Address by the Chairman, Northern Governors' Forum

ADDRESS BY CHIEF SERVANT, DR. MUAZU BABANGIDA ALIYU, OON (TALBAN MINNA), THE EXECUTIVE GOVERNOR OF NIGER STATE AND CHAIRMAN OF NORTHERN GOVENORS' FORUM (NGF), AT THE FIRST NORTHERN STATES' HEALTH SUMMIT HELD AT AREWA HOUSE, KADUNA: MONDAY, 12TH NOVEMBER, 2007

PROTOCOL:

2. I am delighted to be here today and to welcome you all on behalf of the Northern Governors' Forum to this great event. I want to thank the Honourable Minister of Health for the personal and keen interest shown in what we are doing today, that is, holding the first Northern States' Health Summit which we hope will offer us the opportunity, for the first time in the North, to frankly and boldly reappraise the issues militating against the delivery of effective health care services to our people with the aim of eradicating the suffering and poverty that many millions of our people have been exposed to by acts of omission or commission of some of our past leaders.

3. We have come here today because we believe that there is no greater cause for us as leaders than to ensure that the people we serve - every man, woman and child - should be able to benefit from the best medical and health care service that is available in this era. Our vision today is to form a coalition to fight the ancient

scourges and reverse the unfortunate negative health indices of our States and the country at large. This unique and historical alliance, bringing together all the political leadership of the Northern States, renowned health professionals in this country, leading international development partners and other relevant stakeholders is an unprecedented coalition and it is our best chance, not only to sweep away the killer diseases in our communities but also to reverse the trend of alarming death rates in the Northern States of Nigeria.

4. Distinguished professionals, ladies and gentlemen, before I proceed, permit me to give honour to who it is due. I want to recognize the leading role played by UNICEF in bringing about what we are doing today. Just for the records, the idea of this Summit was re-confirmed during a meeting called by UNICEF with Secretaries to the Governments (SSGs) and Commissioners of some stakeholder Ministries of the Northern States held on 3rd September in Birnin Kebbi. The need for the Summit was reemphasized when I had the privilege to receive the UNICEF Country Representative, Kaduna Field Office during a farewell Courtesy Call to the Government House, Minna on 17th October, 2007, long after I had made personal observations of the deplorable state of our health facilities during the electioneering campaigns. It was at that visit that a decision was reached, on behalf of my colleagues in the Northern Governors' Forum with whom we share common passion and aspiration to improve the health status and the overall quality of life of the people we serve that this important Summit be called. I should therefore express our immense gratitude to UNICEF and indeed all other International development partners, donor agencies and national stakeholders for buying the idea and thus participating and supporting the Summit in different ways. Let me mention specifically the tremendous support and assistance of WHO, World Bank, MacArthur Foundation, dRPC and Packard Foundation.

5. Your Excellencies, Your Highnesses, ladies and gentlemen, you will agree with me that time is of the essence in organizing this Summit considering the very poor health indices of our country and the Northern States in particular. It is very sad to note that in this part of the world, for example, about half a million of our women still die in child birth unnecessarilyevery year – that is, one in every minute – and 10 million children do not reach their fifth (5th) birthday. Worst still, our average life expectancy keeps dwindling while we are fighting diseases with only a handful of

doctors, nurses and other health professionals. Certainly, these avoidable tragedies should touch the deepest places of our conscience.

6. Similarly, in our country, the poor health indices of the North portray a gloomy picture of a people highly undeveloped and neglected. We believe that this is most unfortunate and unacceptable especially when we recall with nostalgia that the North had been at the helms of political leadership of our great country for far longer than the other parts of the country. This begs the questions, as I have often asked: What does the North have to show for the decades of political leadership of this country? Where and when did things go wrong? Again, we recall with nostalgia the era of exemplary and incorruptible political leadership in the North of the likes of late Sir Ahmadu Bello, Sardauna Sokoto, late Sir Tafawa Balewa, former Prime Minister of Nigeria and Mallam Aminu Kano, the champion of the cause of the *talakawa*.

7. Therefore, each one of us here today is making a commitment by signing the health compact that we shall work assiduously in concert *to reduce the alarming death rates in our States* by effectively organizing and managing our health services to meet the real needs of our people. Our target is to join the world-leading attempt to reduce child and maternal mortality, conquer malaria, polio, VVF, tuberculosis, measles, pneumonia and eventually defeat HIV and AIDS. Unfortunately, these targets are not likely to be met by 2015, not even by 2025, unless there is genuine commitment on the part of the political leadership to improve the **funding** and **management** of the health sector. The stewardship role of government in driving forward the health sector reforms, to achieve the Millennium Development Goals (MDGs), is crucial in this regard. Over the years, we have observed that budgetory allocations to the health sector and donor financing of health programmes and projects are insufficient to turn around the fortunes of our health sector unless there is sound management of the resources and the political will at the highest level before the desired objectives can be achieved. That is one of the challenges we face today about the health sector in this country.

8. I am quite glad that the people gathered here today are very competent to x-ray all the problems and to suggest the road map for our collective action in addressing the situation of *alarming death rates in the Northern States of Nigeria*. The least we expect from this assemblage of experts is to come out with deliverable action plans for

addressing the problems with clear implementation and evaluation schedules for the short, medium and long terms. We assure all present that this Summit will not be treated like other 'talk shops' where communiqués that emerge are never implemented. We shall implement the recommendations because we are concerned. We shall implement them because we care. We shall act because it is our collective responsibility. All the Governors are resolved to do our best on the circumstances.

9. Similarly, may I use this opportunity to reassure our development partners of our collective resolve to insist on transparency, accountability and the application of due process in our dealings in our various States. We are not unaware of declining donor-confidence in most parts of the country due largely to poor counterpart commitment and diversion of funds in some States. We are confident and determined, at the Northern Governors' Forum, to ensure that whatever assistance provided by our development partners gets to the target populations always and promptly. We are prepared to fight and eradicate rabid corruption and indiscipline in our polity.

10. Your Excellencies, your Highnesses, ladies and gentlemen, we recognize that most of the health issues and diseases that we are talking about directly affect the lives of majority of our people at the grassroots, which brings us to the role of the Primary Health care in tackling a significant degree of our health problems. We have deliberately invited to this occasion both the political leaders in our Local Governments and the respected Traditional leaders of our various communities because we understand the pivotal role that the Local Government Councils can play in ensuring the delivery of effective Primary Health Care services to our people since Primary Health Care is said to remain the main thrust of health care delivery in our country.

11. This brings me to the important theme of leadership at the Local Government level and indeed leadership at all levels of Government and Governance. To my mind, the Local Government level is the place where the most serious activity that impacts on the lives of the people takes place. Hence, there is every need for us all to be sufficiently interested in what takes place at that level especially in ensuring that we get the right caliber of people at the helms of affairs in our Local Government Councils always. We all agree that the Local Government remains the foundation of development of the society as far as our present political and constitutional dispensations are concerned.

We must face the reality that the other parts of the country are moving ahead while we lag behind and engage in mudslinging, buck-passing and self-piety simply because we have been non-challant about what goes on at our Local Government levels, including allowing the leadership of that most important tier of government to be hijacked by few selfish and corrupt individuals, in most cases by charlatans who see politicking as a profession and as an avenue to steal public funds.

12. We must not tolerate leaders who are selfish and concerned about their personal interests and the welfare of their families and cronies only. We must seek out for selfless people, who will be servant-leaders, no matter where they may be or how reluctant they feel about taking up the challenge. That is the surest way we can collectively fight poverty, illiteracy, ignorance and general underdevelopment in the North and the country at large.

13. The biggest challenge before us today is to sensitise our people on the need to accept and elect only leaders with proven records of honesty, competence and personal integrity into leadership positions generally and especially at the Local Government levels if we must achieve our aspiration of transforming the lives of our people through the implementation and execution of good policies and projects including supporting Primary Health Care activities in order to assist us in *reducing the alarming death rates in our States*. After all, the real essence of government, to my mind, is about performance and service delivery and the people have the right to be served with dignity by men and women of conscience and real fear of God at the grassroots level.

14. With the benefit of hindsight, the important role of the Local Government was succinctly described in the foreword by Late (then) Brigadier Shehu Musa Yar'adua to the 1976 Local Government Reforms which states that "... the federal [military] Government was essentially motivated by the necessity to stabilize and rationalize Government at the Local level. ...Local Governments should do precisely what the word government implies i.e., governing at the grassroots or local level." The main thrust of that reform was to 'stimulate development at the grassroots' without necessarily 'reducing or abolishing the traditional functions of our Emirs, Obas and Chiefs whose 'organic unity' was consciously preserved.

15. Consequently, ladies and gentlemen, I must reiterate that all hands must be on deck to fish out and elect credible and competent people in to the Local government administrations in all the Northern States if we must attempt to meet up and close the gap between the North and other parts of the country. The idea of electing retired but not tired Nigerians or accomplished senior citizens, people with integrity and high sense of responsibility, into that level of administration is to be encouraged in our various States. For instance, in Niger State, it is on record that Prof. Shehu Bida offered to serve and was elected as the Chairman of Bida Local Government in 1986 long after he had been once a Commissioner in Niger State in 1976 and a Professor of Veterinary medicine in ABU Zaria for many years. Similarly, late Alhaji Bagudu Shettima also offered to serve and was appointed as the Chairman of the same Bida Local Government several years after he had retired as Chairman, Federal Civil Service Commission, and a position he held for over a decade. I must state that the achievements recorded in that Council during their respective tenures have not been matched to date. We really need to encourage people of such standing to come out and provide leadership at this most important level of Government.

16. I cannot end this address without paying tribute to excellent leadership style of President Umaru Musa Yar'adua, GCFR, who has made a significant difference as an honest, transparent and committed servant-leader who believes absolutely in the rule of law and observance of due process. We must therefore give all our support and encouragement to the President to strengthen him in providing purposeful leadership for our dear nation. **We must eschew corruption and indiscipline in our private and public lives to succeed in our aspiration** of *becoming one of the top 20 world Economies by the year 2020.*

17. Before I end my address, may I emphasise that the Northern Governors' Forum is deeply concerned with the general underdevelopment of the people we serve. Therefore, this Health Summit is just the beginning of the conscious steps that we are determined to take a positive difference in the lives of our people. We assure you all that very soon, similar Summits will be called to address issues in Education, Agriculture and the Economy in the Northern States. As a region we must begin to identify and recognize our CORE COMPETENCIES and enhance them. We must also identify and recognize our weaknesses and rectify them in order to compete favourably with other communities and societies.

18. Your Excellencies, Your Highnesses, ladies and gentlemen, on this note, it is my singular honour and privilege to declare open the first Northern States' Health Summit to the glory of Almighty Allah and for the benefit of Nigerians.

19. THANK YOU AND GOD BLESS.

ANNEX 13

Act Now That Our People Will Live and Not Die
Keynote Paper by Dr. C. L. Ejembi

ACT NOW THAT OUR PEOPLE IN NORTHERN NIGERIA MAY LIVE AND NOT DIE

Presentation by Dr. Clara Ladi Ejembi

Department of Community Medicine,
Ahmadu Bello University, Zaria
at the First, Northern States' Health Summit
held on 12th November 2007 at Arewa House, Kaduna

Protocols

Introduction

I wish to start by commending the Northern Governors' Forum for taking the bold initiative to convene this landmark Northern Governors' Summit on Health so as to examine the magnitude and causes of the high death rates in this part of the country with the aim of developing an agenda for stemming the tide. For those of us that have been working in the area of health in this part of the country and have watched with dismay the very poor health indicators in the region that appeared resistant to change. We are elated that, with this bold move by our Governors, the tide will begin to change. This is because, as Sir Rudolf Virchow asserted: **'health is politics and politics is nothing but health on a wider sphere.'**

The attainment of health, which is both a basic need and a basic human right, is within the realms of politics and social engineering. Political leadership, ideology, governance and committed stakeholders are critical to achieving good health.

Your Excellencies, Your Royal Highnesses, distinguished ladies and gentlemen, health, human security and development are tightly linked. Good health is intrinsic to human security since survival and good health are at the core of human security. Health is also instrumental to human security because good health enables a full range of human functioning. Health permits choice, freedom and development. Health is wealth. To create wealth at the individual, family, community and national levels people must be healthy. Without health, people cannot enjoy the wealth created. Health is therefore the entry point for breaking the vicious circle of ill health, poverty and underdevelopment and for converting it to the virtuous circle of improved health status, prosperity and sustainable development.

Recent research findings paint a distressing picture of the poor social sector development in Northern Nigeria. Studies show that the gap between the North, especially the core North and the rest of the country has widened significantly to the extent where, for certain key indicators (health, education and poverty), the Northern average distorts national trends and contributes to the widening political, socio-cultural and development gulf in the country. Your Excellencies, the fact that the Northern Zone of the country has the worst social indicators in the country is not a news. What is exciting is your current interest in tackling the situation frontally with an initial focus on health. **Indeed, stewardship for health, which is defined as the careful and responsive management of the wellbeing of the population, within a given socio-political environment, is the very essence of good governance.**

This presentation shall attempt to look at the magnitude and causes of the leading causes of mortality in northern Nigeria and propose possible solutions in the face of current challenges and opportunities. The focus will be on two of the three health-related Millennium Development Goals (MDGs). While all the eight MDG goals are all relate to health, three are directly linked to health. These are reducing child mortality (MDG4), improvement of maternal health (MDG5) and combating HIV/AIDS, malaria and other endemic diseases (MDG6). These three were identified as integral to development, peace, security and eradication of the many dimensions of poverty, with quantifiable targets, were set for attainment by the year 2015. However, the presentation shall focus on maternal and child health which are the focus of this Summit.

Magnitude of Maternal and Child Mortality

There can be no doubt that the health and wellbeing of women and children are critical determinants of social and economic development of any society. Maternal, infant and under five mortality have been identified as major contributors to the low life expectancy in Nigeria. WHO estimates that the disability adjusted life expectancy for Nigeria is 38.3 years ranking the country 163rd among 191 member countries.

Improvement of maternal health has been enshrined in the Millennium Development Goals (MDGs) as one of the essentials for sustainable development and poverty reduction. The outcome indicator identified for assessing maternal health is maternal mortality. The target is to reduce, between 1990 and 2015, maternal mortality ratio by three-quarters. Maternal mortality is a litmus test of the status of women, their access to health care and the adequacy of the health care system to respond to their needs.

Inclusion of maternal health in the MDG has brought to the fore again, a comparatively much neglected issue and a health problem that exposes more than any other indicator, the inequity between developed and developing countries and regional variations within countries. Maternal mortality has been described as one of the foremost and most neglected health problem and human rights abuse in the world-violating the rights of about 515,000 women to life annually with 99% of it occurring in developing countries. The gap in pregnancy-related deaths between developed and developing countries shows the greatest disparity of any human development indicator as maternal mortality is said to be a measure of a country's or a region's overall health and development status. Pregnant women in developing countries face a risk of maternal death that is 200times greater than for a woman in a developed country. Such a gap exposes the wider regional developmental inequities and presents major challenges to the attainment of the MDG goals

Nigeria has the second highest number of maternal and child deaths in the world second only to India in absolute numbers. Of the estimated 552,000 women that die each year from pregnancy-related causes globally, 55,200 occur in Nigeria. Thus,

Nigeria contributes 10% to the global maternal mortality burden even though we make up only 2% of the global population.

The Northern Zone of the country makes significant contributions to this dismal statistics. Indeed, looking at mortality generally in the country, maternal mortality shows the widest disparity between the Northern and Southern Zones of the country. The maternal mortality rate in the North-East Zone, of 1,599/100,000 live births is more than twice the national rate, almost 10 times higher than the rate of 165/100,000 found in the South-West Zone and seven times higher than the rate in the South East Zone. The North West Zone, with a rate of 1,025 /100,000 live births, is about six times higher than the rate in the South-West Zone and almost four times the rate in the South-East zone. **Your Excellencies, Royal Highnesses, ladies and gentlemen, to put it simply, each time a woman in the South-Western Zone of Nigeria dies as a result of causes related to pregnancy, childbirth or pueperium we are losing almost 10 women in the North-East Zone and 6 women in the North-West Zone to the same cause.**

As dismal as these statistics is, the maternal mortality in the rural areas is even worse almost twice the rate in the urban areas. In fact, a study, by Goni in 2004, found the maternal mortality rate in a rural area of Yobe State to be 3,200/100,000 live births more than 19 times the rate in South-West Zone.

Maternal mortality measures the risk of a woman dying from a single pregnancy. However, each time a woman becomes pregnant she faces the risk of death. The cumulative lifetime risk of maternal death, which is a measure that factors in the risk of maternal death and fertility levels shows that the lifetime risk of maternal death for Nigeria has been estimated as 1 in 13. A rate of 1 in 6 was documented by Goni in rural Yobe LGA with almost half of the women in the reproductive age group in that LGA found to be dying from pregnancy-related causes.

Your Excellencies, Royal Highnesses, Ladies and Gentlemen, pregnancy is not a disease. If women stop giving birth, the human specie will become extinct. The fact that our women, especially in the Northern Zones of the country, are dying in such disproportionately high numbers is a testament of the value we have accorded them.

Maternal death is not the only story, for every woman that dies from pregnancy-related causes another 16–20 suffer long term damage to their reproductive tracts. One of these is Vesico-Vaginal Fistula (VVF). VVF, commonly resulting from prolonged obstructed labour, is an abnormal connection between the bladder/urethra and vagina resulting in continuous dripping of urine. It is estimated that the prevalence of VVF in Nigeria marks the highest number of VVF cases globally. Of the estimated 2 million cases, 800, 000 are in Nigeria. A disproportionate burden of the disease shows that an estimated 70% is found in Northern Nigeria.

Our children in the Northern States of the country are also dying at higher rates. The infant mortality rate measures the probability of a child dying before reaching the age of one year and under-five mortality rate is the probability of death before five years. These are powerful indicators of child survival as children are more vulnerable in early years of life, particularly the first year. Both measures are indicative of the quality of child care including the prevention and management of major childhood illnesses. Information on infant and child mortality from a variety of different surveys in the country has consistently demonstrated large regional and rural-urban inequalities in infant and child mortality. In general, children living in the Northern Regions fare much worse than children in the South-East and South-West. Children born in the South-East and South-West are more than twice more likely to reach their fifth birthdays than children born in the North-West and North-East.

Why are our women and children dying in disproportionately high numbers?

The major causes of these higher mortalities are related to inequalities in access to knowledge, information, resources and services. These result in inequalities in utilization of health services. Thus, the factors could be grouped into factors related to supply of health services, health systems related factors and factors relating to demand and utilization of health services.

Health System- related factors

Adequate funding is central to the functioning of the health system. While funding of the health sector is generally poor in Nigeria, it is worse in the Northern States. The federal funding to the health sector has never reached the 5%of national budgets recommended by WHO and is well below the 2001 Abuja Declaration by the African Heads of State of 15% to meet the MDG-related health goals. WHO estimates that the per capita health expenditure on health in Nigeria is US$9 per head with up to two-thirds of the funding coming from out- of- pocket household expenditure. Most of the funding goes towards payment of salaries with little left to provide services. There appears to be no health care financing policy, no health plan and financially accountability is low. Generally, commitment to health and social development is low, especially at lower levels of government resulting in much lower funding at LGA level. The Northern States have the added problem of greater dependence on government funding sources, poorer exploitation of other funding options like social health insurance, donor funding and (poverty limiting) individual out-of pocket household expenditure funding options. The net result is that funding levels of the health sector is comparatively lower in the Northern States. To make up for shortage of funding, various cost-recovery policies have been introduced further alienating the poor who does not have the funds to purchase health services.

Health Facilities: Health facilities are classified as providing primary, secondary or tertiary level health care and are either owned by the public or private sector. For the public health facilities, except in a few cases, the federal government provides the tertiary health facilities, states governments provide the secondary level while the local governments provide primary level health facilities. As at 2005, the FMOH estimated that there were a total of 23,640 health facilities in Nigeria.

Primary Health Care facilities provide an entry point into the formal health care system. Of these, 85.8% are Primary Health Care facilities made up of 13, 000 public-owned and 7,000 private PHC facilities. **A larger proportion of primary level health facilities, 65% are found in the Northern Zones of the country, However, most of the PHC facilities in the North have been found to provide lower level health services from health posts, clinics**

and dispensaries where the scope of services are very limited to the rudiments of treatment and dressings. Approximately, half of the facilities in the Northern Zones are dispensaries and health posts compared to less than a quarter in the Southern Zones.

Wide regional disparities exist in the availability of secondary health facilities with significantly fewer general hospitals in the Northern States and majority of these facilities are government-owned. Overall availability of hospitals is three times higher in the Southern and North Central zones compared the North-West and North-East Zones. The population to hospital ratio is less than 50, 000 in the North-Central and Southern Zones and over 150, 000 in the North-West and North-East Zones. This disparity is largely due to a larger proportion of privately owned secondary facilities in the Southern Zones of the country where between 70 to 90% of the general hospitals are privately owned compared to 5% in the North-East and 24% in the North-West. **This means that State government is the major provider of secondary health facilities in the North with implications for funding.**

The situation translates to comparatively less availability and access to health services in the Northern States compared to the Southern States. The 1999 NDHS found 21%, 13% and 11% of the population in the North-West, North-East and North-Central did not have access to health services compared to 4% in the South-East and 3% in the South-West.

There is a dearth of skilled health personnel, doctors, nurses and midwives in the Northern States compared to the Southern States. Critical to maternal health is the availability of midwives. **Between 59-68% of Primary Health Care facilities in the Northern States offering antenatal and delivery services have no single midwife /nurse and a further 18% had neither a midwife/nurse nor community extension worker.** Also, less than 10% of these facilities had 4 midwives, the recommended minimum for the provision of 24 hour delivery services. There was an LGA I visited in one of the North-Western States that the highest trained health worker there was a community extension worker, they did not have a single midwife. In another LGA in a State in the North-West Zone, the LGA had only one nurse/midwife who was responsible for providing ANC in all the districts and also taking deliveries in the only comprehensive health centre they had.

Lack of drugs and equipment to work with are serious issues that compromise quality of care. **Critical shortages of essential equipment, drugs and supplies in our health facilities further frustrate the capacity of the health system to provide quality services.** Last year, UNICEF supported the conduct of supportive supervision to Primary Health Care facilities in the LGAs they support in the North-West Zone. In the more than 50 health facilities I visited during the period, most of the facilities lacked essential equipment for provision of maternal and child health services. What rudimentary equipment found available were donations from UNICEF. No equipment had been purchased for years by the LGAs for these facilities. Also, in all the facilities I visited, drugs had not been purchased by the Local Governments for more than three years. Staff, including attendants, had resorted to purchasing and selling their personal drugs the quality of which could not be guaranteed.

The scope of health services provided in the health facilities is limited. Fewer health facilities in the Northern States provide essential maternal and child health services compared to the Southern States. For example, less than a third of the PHC facilities in the Northern States provide antenatal and delivery services (17.3% in the North-West and 28.8% in the North-East) compared to about two-thirds in the Southern Zones and 20% more health facilities in Southern Zones provide immunization services than in the Northern Zones. What is important in saving the lives of women in the event of complications during child birth is availability of Essential and Comprehensive Obstetric Care Services. Only 0.4-5.3% of Northern states PHCs are rated Basic Essential Obstetric Care Centers (BEOCC) and 4.4-17.7% general hospitals as Comprehensive Essential Obstetric Care Centers. That means that in the event of complications most of the hospitals and PHC centers are ill-equipped to respond.

One is constrained to raise the question: Why should we encourage our people to go to health facilities when the facilities are hardly available, essential services are not there, staff are not available or poorly trained and the available facilities, especially at the Primary Health Care level, lack drugs and equipment?

Demand–related Factors

The demand–related factors work in synergy with illiteracy, ignorance, misconceptions, poverty and cultural practices inimical to health to limit utilization of available services. Inequalities exist in health services utilization between the Northern States and the Southern States. For example, a woman in the North-West and North-East Zone is more than 10 times less likely to go for antenatal care than a woman in the South-West Zone. Delivery under the supervision of trained health workers is much less in the Northern Zones than the Southern Zones. Trained birth attendants in North-West, North-East and North-Central Zones supervised only 8%, 13% and 47% of deliveries respectively. These figures were 13, 9 and 2 times respectively, lower than the rate of 73% obtained in the South-West Zone, the zone with the highest rate of supervised deliveries. Conversely, the rate of utilization of traditional birth attendants in the North was very high with as many as 5 to 6 of every ten deliveries being supervised by them in the North-West and North-East Zones of the country.

The rate of utilization of child health services is much lower in the Northern States compared to the Southern States. The 2003 NDHS found only 3.4% and 6 % of children in the North-West and North-East Zones of the country respectively received the full course of immunizations that protect children against the major killer diseases.

Challenges towards improving the health status of women and children

Generally, Nigeria lags behind in its progress towards attainment of the health-related MDG. For example, in the past decade it has reduced its child mortality by only 10% compared to an average of 30% for the rest of Africa. The Northern States are faring worse than the rest of the country in its progress towards MDG.

Your Excellencies, Royal Highnesses, Ladies and Gentlemen, the technologies needed to significantly improve the health status of our citizenry are well known and are simple and low-cost. The first challenge is securing meaningful political

prioritization of health and social development at LGA and State levels to invest in these interventions for the survival and development of our people. There must be demonstrable political commitment at State and Local Government levels in the face of the dismal statistics and the very poor social and economic environment in which the people of the North live that increases their vulnerability to infections and limits their access to information and services. The limited capacity of the populace to engage meaningfully with the politicians and ensure adequate situation of health and social issues on the political agenda of potential candidates limits accountability by our political leadership. Also, lack of leaders with credible qualifications to appreciate the importance of and make adequate investments in human development are other challenges that need to be overcome.

Secondly, for any meaningful health development in the Northern States, the next challenge is re-planning of the health care system de novo. Reforming the health system is a task that must be undertaken if we want to forge ahead. We need to take a fresh look at our health care system, determine where we are, what we want to achieve and how to get there. To this end, what policies we need to put in place regarding funding, minimum service delivery packages, infrastructure and facilities and roles and responsibilities of the different levels of government. **One major challenge is how to revamp Primary Health Care**. Without significant improvement in availability, access and quality of Primary Health Care, very little impact can be made on the health status. We need to think of innovative ways of getting our PHC services functional. We need to develop costed health plans that everybody will buy into. We need to determine what services government should provide free. Minimally, maternal and child health services should be provided free.

The third challenge is how to leverage additional funding for the health sector while ensuring equity and access. Innovative and flexible strategies need to be considered just as better exploitation of current strategies. We need to develop a health financing plan and costed health plans that could serve as resource mobilization tools. **As a starting point, both the State and LGA levels need to increase sectoral allocation to the health sector.** They also need to evolve strategies for greater engagement with development partners and for accessing the MDG funds. The current National Health Insurance Scheme provides additional avenues for funding

health services. Our governments will do well to explore how to maximally utilize this funding option. Public Private Partnership (PPP) in health is being promoted. This is one avenue for resource mobilization that should command the attention of our Governments.

In doing all these, our Governments need to determine what are the minimum service components that obligatorily they have to provide the citizenry and how to ensure the vulnerable population are not denied access to health services as a result of financing policies.

The fourth challenge is the promotion of positive health behaviors that will reduce vulnerability and risk of disease and improve appropriate health care seeking behaviors. Given the level of ignorance, illiteracy, poverty, misconceptions and cultural practices that are harmful to health, this is a major challenge. But, without overcoming this, what ever services are put in place will remain under utilized.

Whilst acknowledging that we have enormous challenges, there are visible opportunities for changing the status quo. A new political administration has taken over the leadership at all levels of governance. Some of them, as shown by this Summit, are demonstrating that it is not going to be "business-as-usual"; there must be change for the better and our Governors are beginning to put heads together to strategize for positive change. Such leadership needs all the encouragement and support to ensure they leave behind demonstrable, viable, sustainable and cost-beneficial health investments for their people. A lot can be achieved in the coming three years if there is commitment. Secondly, the populace is becoming increasingly aware and is beginning to hold the political leadership to account. Additionally, there is significant in-flow of funding. Donor funding to Nigeria has more than doubled, debt relief gains has brought in additional funding that is being invested in health so also is the NHIS. These could be harnessed by our Governors for health development. Finally, the NEEDS and SEEDS documents which have sought to domesticate the MDGs are tools for resource mobilization and present opportunities for promotion of ownership.

Your Excellencies, Your Royal Highnesses, Distinguished Ladies and Gentlemen, let me reiterate that the health status of people in the Northern States is in a deplorable state. Our women and children, especially, are dying needlessly at rates far in excess of other zones of the country. Our comparatively poor investment in health services, weak health systems and poor health care behaviours are major contributors to these high death rates. The challenges to acting and transforming the landscape are enormous but they are not insurmountable. Something needs to be done. Indeed, something can be done, something should be done and something must be done. All of us seated here must do something. We all have a contribution to make in our various spheres of influence to effect change. What is needed is commitment, transparency, unity of purpose and accountability. Together, we will succeed.

I thank you for listening.

Act Now That Our People Will Not Die

By
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Introduction

- Health is a basic need and basic human rights
- Health permits choice, peace, security and development
- Health is wealth

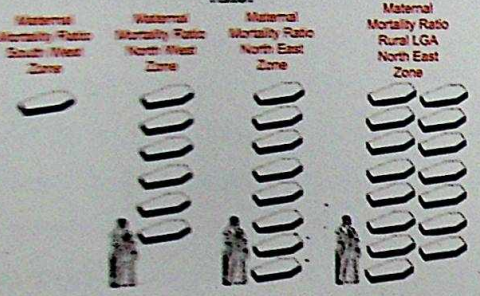
'Health is therefore the entry point for breaking the vicious circle of ill health, poverty and underdevelopment and for converting it to the virtuous circle of improved health status, prosperity and sustainable development.'

Health is politics

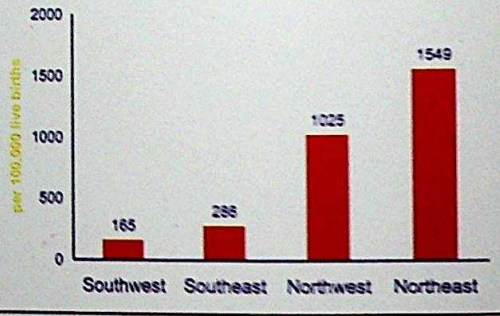
Stewardship for health is the essence of good governance

Mortality status in the Northern States

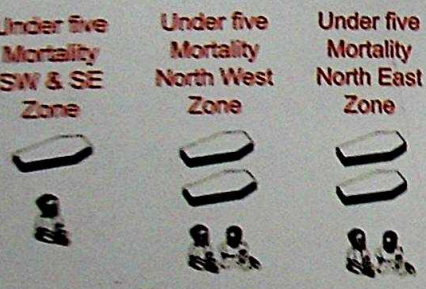
Maternal Deaths: Our women in the northern states are dying at an alarming rate!



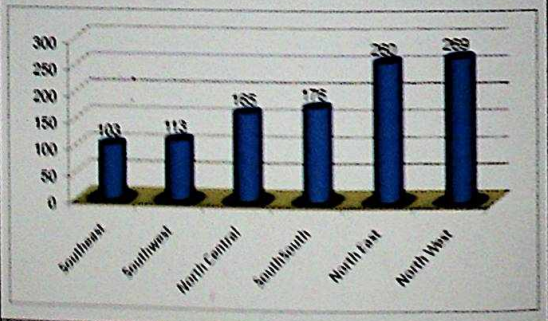
Maternal Mortality Ratio by Zone



_ and children too!

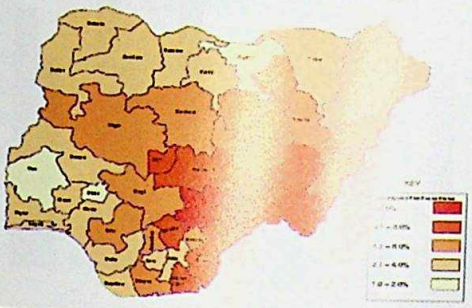


Under five Mortality by Zone

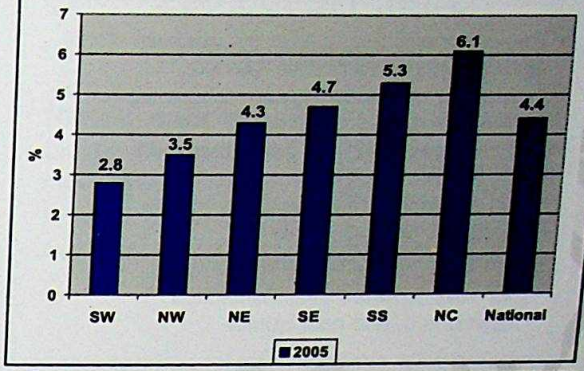


-- and HIV and AIDS is killing us

HIV Prevalence by State (Nigeria 2005)

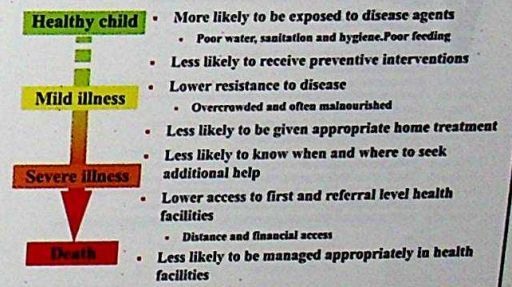


HIV Sero-prevalence by Zone, 2005

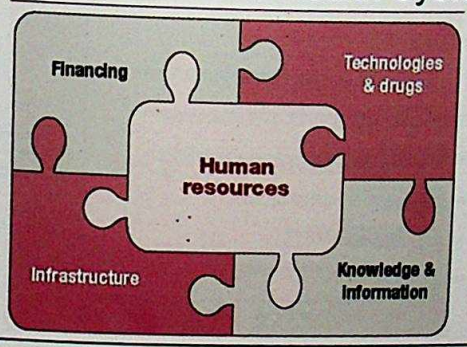


What are the causes of the high death rates?

Reasons why some children more likely to die?



The Fulcrum of the Health System



Health Care Financing Problems

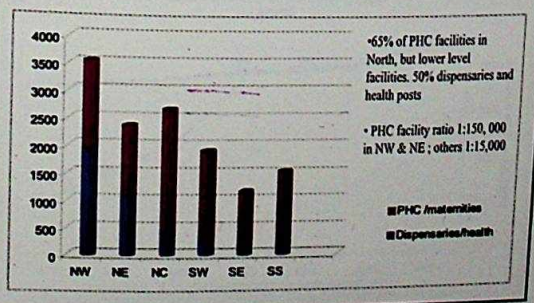
General

- Dependence on federation account
- Low funding of health sector at all levels
- Poor commitment to social development and funding at lower levels
- Most of funding go to salaries
- Lack of health care financing policy
- No health plan
- Accountability problems

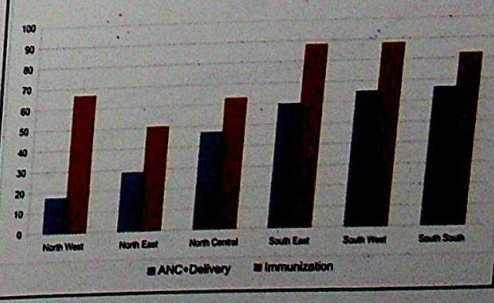
Northern zones

- Less funding on health
- Greater dependence on government funding
- Limited exploitation of other funding options
- Poverty limits extend of use of user fees
- No safety nets for the vulnerable

Health Facilities: PHC centres and health posts/dispensaries by zone

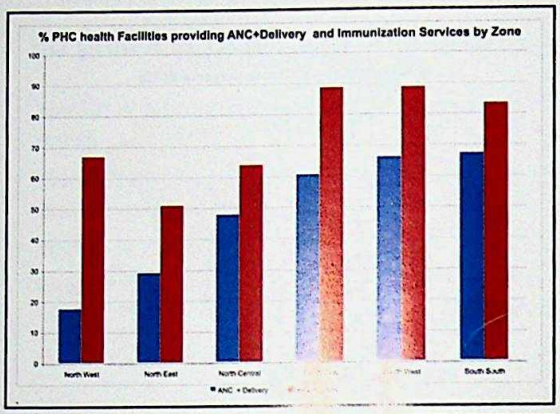


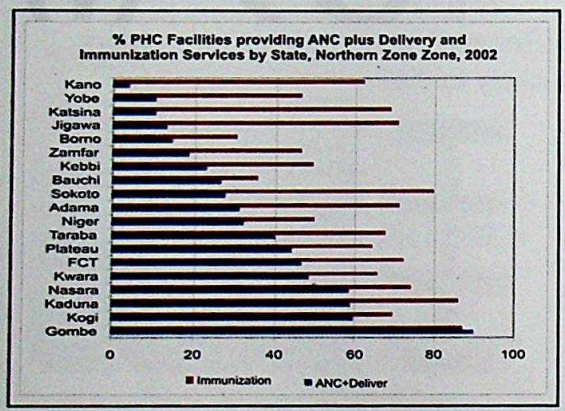
% PHC health Facilities providing ANC+Delivery and Immunization Services by Zone



Other Resources

- Fewer general hospitals in the northern states and majority government –owned
  - A third or less facilities government owned in southern states compared to 72 -90% in north
  - Facility population ratio 1:50,000 in south and 1:150, 000 in north
- Non availability of drugs and equipment, especially at lower levels
- Dearth of skilled health personnel
- Services provided of limited scope, fragmented and poor quality

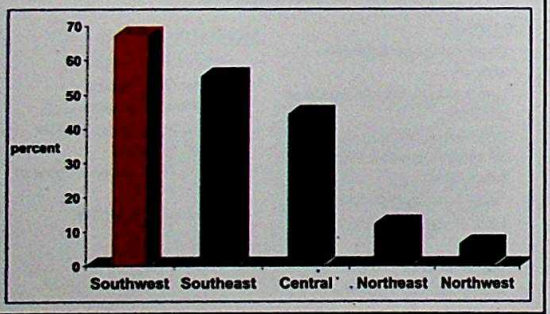




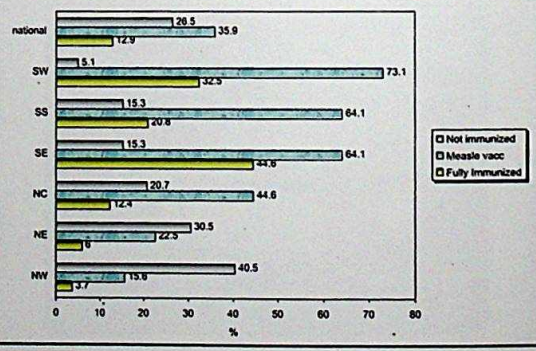
Other factors contributing to high mortality

- Poverty
- Ignorance
- Cultural practices inimical to health
- High cost of health services
- Low utilization of health services

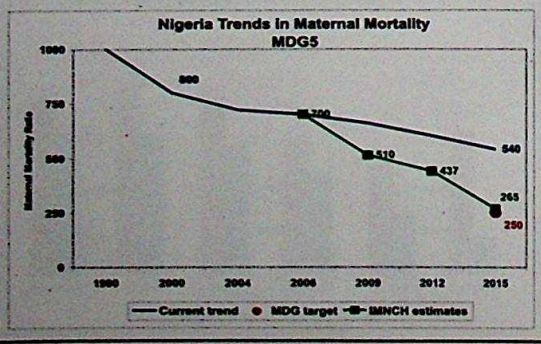
Leading to poor utilization: Facility Delivery by zone



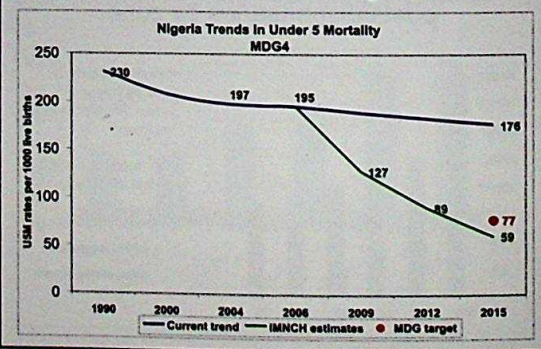
Immunization uptake by zone



Reaching MDG5 in Nigeria?



Reaching MDG4 in Nigeria?



Challenges

- Securing meaningful political prioritization of health and social development at LGA and states levels
- Re-planning the health system
- Exploring other funding options and ensuring equity in access
- Promoting positive health behaviour

Opportunities

- New dispensation
- Leadership being held accountable by more people now
- Increase inflow of funding
- Availability of NEEDS and SEEDS