THE BENUE HEALTH FUND PROJECT'S MICRO-ENTERPRISE FOR HEALTH MODEL AND FINANCIAL ACCESS TO HEALTHCARE IN SOME BENUE RURAL COMMUNITIES: AN APPRAISAL

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Abstract

This article is an appraisal of the Benue Health Fund (BHF) project's micro-enterprise for health (MEH) model for improving financial access to healthcare in some rural communities in Benue State. From the appraisal, it was discovered that while some of the MEH projects worked well, others did not. The factors, which were responsible for the success or failure of this model, were carefully analyzed. It is in my candid opinion that this model is pragmatic and possessed credible potentials for assisting the poor and vulnerable in accessing healthcare, if well planned, well implemented and properly monitored. The article concludes with recommendations, which, if adopted, could enhance the workability of this model in Benue State. One of such recommendations is that this MEH model should be replicated by the Benue State Government and its Local Government authorities in future community development efforts.

Introduction

The BHF project was a British Government-assisted health and social development initiative aimed at improving the health status of some of Benue's rural poor. The project was funded by the U.K. Department for International Development (DFID) without any counterpart funding from the State Government.

The BHF commenced project activities in the areas of primary and secondary healthcare from 1997 and ended in 2002. Within this period the BHF provided secondary health care (SHC) assistance to nine hospitals, namely, the General Hospitals at Gboko, Katsina-Ala, Otukpo, Oju, Okpoga, Adikpo; the NKST Hospitals at Mbaakon and Anyiin; and the St. Vincent's Hospital Aliade. Primary health care (PHC) assistance was provided in 160 clinics in seven focal local government areas, namely, Gboko, Otukpo, Logo, Tarka, Ohimini, Vandeikya and Katsina-Ala, while 33 rural communities were assisted in the areas of physical and financial access to healthcare (BHF, 2002). It is in the area of assistance in financial access that this paper intends to dwell.

The BHF project assisted some communities in Benue State to improve their access to healthcare based on the recommendations of the Bamako Initiative (BI), an African initiative formed after the World Health Organization Regional Committee held in Bamako, Mali, in September 1987. The initiative placed responsibility for healthcare management at the grassroots level with the grassroots people. This involved community action in the management and financing of peripheral health services for the well-being of the grassroots population (Jarret & Ofosu-Amah, 1992). The BI advocated a new approach to healthcare that emphasized the introduction of user fees in healthcare development and access to micro-credit/enterprise for health, and for development generally (WHO, 1998). In other words it was the thinking of the WHO that with the introduction of user fees, the micro-credit/enterprises for health would provide financial access for the poor and vulnerable to healthcare. The BHF project opted for micro-enterprises rather than the micro-credit approach. The difference between the two systems is that whereas the credit approach required the poor to repay loan facilities granted them, the enterprise approach required the poor to make minimum contributions to revenue generating poverty alleviation projects.

BHF'S MEH Model

The BHF's MEH model was another step in the series of activities by the project to ensure access to healthcare by the poor. The approach was to facilitate the establishment of micro-enterprise for health, a socio-economic strategy whereby small-scale income generating businesses were established by the poor and vulnerable groups, especially widows, to enhance their ability to meet their health needs. This was to help reduce financial barriers in access to healthcare and raise money for the poor to improve their

nutrition, increase availability of food through local food processing and thus generate income for Deferral & Exemption (D&E) schemes (BHF, 2002).

Therefore, the project's community resource persons (CRPs) prepared project applications for the benefiting communities. The community based organizations (CBOs) and communities initiated the projects, raised counterpart funding of 15% project cost, provided land for machine housing and constructed the housing. Thereafter, the BHF project provided 85% of machine costs, provided materials for the machine housing, designed the structures and supervised the construction process. Local non-governmental organizations (NGOs) with expertise in micro-enterprise for health (MEH) were contracted to provide training for Local Government Area (LGA) staff to enable them support community groups in the implementation and monitoring of MEH projects. Local architects were contracted to design and construct machine houses while local suppliers provided and installed grinding engines and other relevant equipment and also trained machine operators. Machine costs ranged from N73, 000 (mobile garri processor) to ?4301, 151 (rice milling) while machine housing ranged from *$445,* 550 (com grinder) to &16, 660 (fixed garri processor). However, in some communities existing structures were provided at no cost (BHF, 2002). After these efforts, series of trainings were carried out for CBOs, local NGOs and LGAs' monitoring and evaluation (M & E) officers covering topics such as team building, micro-enterprise, environmental sanitation and waste management, gender, participatory M & E, marketing, financial management and so on.

The MEH projects were monitored by the intermediary organizations, (CBOs, LGAs M&E officers and village development committees (VDCs). The following indicators were agreed upon as yardstick for evaluation:

i) Number of women who were able to have access to quality healthcare as a direct benefit from the MEH project.
ii) Average increase in income per household benefiting from the project.
iii) Value of financial contribution made to the community's D&E scheme by the project.
iv) Rate of clinic utilization by members of the target group, the very poor" and vulnerable, especially the widows.
v) Proper financial records kept by the MEH group (BHF 2002).

In all, 21 MEH schemes were established in 16 'communities in six of the focal LGAs in Benue State, supporting the income generating capacity of about 1,120 members of the CBOs and their families (about 5,500 people in all) at a cost of over N8 m to BHF and over N.5m to the communities (excluding value of land and labour which was provided free) (BHF, 2002). According to the BHF project five of the 16 communities supported D&E schemes. Also, the BHF believed that involvement of CBOs in MEH projects had empowered women especially widows and enhanced participation by women in community activities (BHF, 2002).

An Appraisal of the MEH Model

In appraising this model, field trips were undertaken to the benefiting communities with a view ascertaining the workability or otherwise of the projects. The tour of focal communities took me to Tyemimongo and Tsar in Vandeikya LGA. Tyogbenda Udende and Abaji Kpav in Kastina-Ala LGA, Iwendyer, Ugondozua and Abeda in Logo LGA and Ukazo and Abetse in Gboko LGA. Others included Asukunya and Akpa in Tarka LGA, Otukpo-Nobi and Opa-Adoka in Otukpo LGA, and Onyagede in Ohimini LGA. In these LGAs I was able to sample the efforts of the BHF project in MEH and CBOs. It was discovered that apart from Tarka LGA, which did not have a MEH project, the rest had. The reason(s) for the absence of MEH projects in Tarka LGA were not too clear, but according to a source, which preferred anonymity, Tarka people wanted the projects free. According to this source they felt that since the Governor of the State was from this place, with or without BHF the facilities were going to be provided. Some of the indigenes interviewed simply said that the communities could not be mobilized early enough to request for the projects (Duger & Ibu, 2003).

Many of the MEH projects performed well. A particular case that deserves mention was the corn

processing mill installed for Kasev Mbanor Association, a widows' association at Iwendyer, Logo LGA. They were able to generate revenue from the mill enough to assist their members and also built an annex to the PHC clinic in the community. The treasurer of the association who is also a widow informed me that the installation of the machine alleviated their sufferings in a tremendous way. According to her, they used to trek five kilometers to access the nearest grinding mill but that the situation was different now. She said further that all widows ground without payment. She lamented that during the season when pounded yams were eaten over and above corn food, they recorded low patronage at the mill (lordye, 2003). As a matter of fact, this was a general complaint in the Tiv-speaking communities where corn milling and garri processing machines were installed. Another complaint was that poverty usually caused people in rice producing zones to sell their rice unprocessed (Kyuekaa, 2003). Some of the communities had more than one machine. Whereas others had both corn milling and garri processing machines, others had both rice and corn milling machines, depending on their need and their ability to pay the counterpart funds for the machines.

Another success story was the corn-milling machine installed by the Mbategh Widows Association, Abetse, Gboko LGA. According to the secretary of the association, the mill generated money for the widows to enable them find healthcare access. Also, widows who were members of the association ground their corn free of charge (Atir, 2003).

Although the communities that recorded successes in the MEH project scheme accepted that their living conditions improved, none gave the impression that D&E schemes were supported except the Ukazo community in Gboko LGA that was able to do this. The corn-milling machine at Ukazo was said to be very viable to the extent that D&E schemes were supported through it.

While some of the MEH projects worked well and generated funds to cater for both the health and socio-economic needs of the poor and vulnerable among the rural poor, others did not work well due to several reasons. For instance, the corn-milling machine installed at Abaji-Kpav in Kastina-Ala LGA did not function well due to prolonged intra-communal clashes that set the people against each other. The secretary of Kpav Women Development Association who granted us an interview said two factors militated against their progress since the machine was installed. The first was the prolonged communal feud already mentioned and the unfaithfulness of the operators {Kpaakpa, 2003). The communal clashes factor underscores the point that communal conflicts retard efforts towards development. The Iwendyer community also suffered this fate. According to them, the Tiv-Jukun crisis of 2001/2002 sent them packing from their villages, which are on the borderline between Benue and Taraba States.

The issue of the unfaithfulness of machine operators featured in many communities. For instance, Ugondozua community's MEH project suffered this fate. In an interview with the secretary of Uke-Uke Youths, the CBO that owned the project, and the operator of the rice-milling machine, it was discovered that the revenue realized was embezzled by the operator (Tsavnum & Jime, 2003). Apart from this, the community, which is cosmopolitan lacked unity of purpose for concerted efforts to ensure that the project succeeded. Eventually, the machine was abandoned. In some communities the story was neither that of communal crisis, nor lack of unity, nor even the unfaithfulness of operators, but rather the problem of faulty machines and lack of operators. For example, the gari processing machine at Onyagede, Ohimini LGA, rather than generate revenue, drained the resources of the Onyagede'Widows Association, owners of the machine. According to the chairperson of the CBO, the machine was installed with a mechanical defect that made it work epileptically, and drained resources. She informed us that the machine was up for sale so that whatever could be realized from the sale would be added to some other monies to enable them purchase a new one (Idrisu, 2003). The case of Otukpo-Nobi was that of lack of an operator for the corn milling/gari processing machine. Therefore the machine lay fallow as at the time I visited the community (Ondoma, 2003).

Recommendations

Based on the appraisal of the BHF MEH model, which we have examined, it is hoped that if the following recommendations were adopted, it would assist both the State and Local Governments in using micro-enterprise/credit models for poverty alleviation among the rural and vulnerable groups.

Just as Odejide's (1997) study on micro-credit revealed that the scheme could be a powerful anti-poverty tool for self-help among the poor, especially women in rural areas, the BHF micro-enterprise model in Benue State proved to be a vital tool for poverty alleviation especially among the womenfolk. Be that as it may, the scheme did not fully bring about the desired results. In other words, while the scheme succeeded in some communities, failure was the story in others. It is with this in mind that the following recommendations may be imperative:

1. Since widows and poor women in rural Benue consistently identified income generation as their priority health needs (BHF 2002), there was need for project activities to have been concentrated more in the MEH than in other areas. This was not the case because the MEH project activities were among the last to be carried out before the BHF wound up its assistance in the State. The State and Local Governments should pick up the mantle where BHF stopped by assisting their communities in the micro-enterprise/credit schemes, using the BHF model.
2. In micro-enterprise, expertise and skills are needed, especially during the early stages of project planning, and throughout the project circle. Therefore, all the indigenes of Benue State trained by the BHF project in MEH activities should be identified by the LGAs that were assisted, for the purpose of using them as resource persons for similar activities. The trained resource persons could also be used to train others so that the knowledge gained during the BHF assistance could be retained for posterity.
3. Judging by the way some of the MEH machines were underutilized, it was clear that not much economic feasibility studies, were put in before their installation. For instance, at Ityemimongo in Vandeikya LGA, the rice-processing machine was not properly utilized because, according to the people, poverty was so acute that rice farmers sold their rice unprocessed, as soon as it was harvested. Therefore, in future feasibility studies should be carried out before micro-enterprise/credit projects are established.
4. Although the BHF project claimed il trained community members in the maintenance of the machines, there was no indication that spare parts were also provided for the machines. It is suggested that in future MEH machines should be such that have available spare parts and repairers/mechanics locally.
5. It was discovered that some of the CBOs that owned MEH projects did not fully represent the interests of the poor and vulnerable. For instance, the Abaji Kpav Women Multi-purpose Cooperative was dominated by 'elitist' women in the society. While the chairperson was a principal of a college, the secretary was a tutor in one of the secondary schools in the community. It is unlikely that the interests of the poor and vulnerable groups were protected. Therefore, micro-enterprise/credit projects should be controlled by the real poor, if they are to alleviate poverty.
6. Corruption and lack of accountability can kill any system as could be seen from some of the MEH projects that collapsed. For MEH projects to ever produce the required dividends, corruption and lack of accountability among its members must be stemmed. This could be done through advocacy and sensitization programmes.
7. It was discovered that the MEH projects were not closely monitored after the BHF project closed. In future, the local government authorities in whose communities MEH projects are situated should closely monitor them to ensure their sustainability. The BFIF project monitoring and evaluation paradigm could be used.

Conclusion

It is a truism that the financial empowerment of an individual or a group of individuals has great potentials for poverty alleviation. It is also economically sensible and rational to conclude that given the availability of financial capital, all goods and services could be purchased, including health services. It is

with this at the back of our minds that we conclude that the facilitation of financial access of the poor and vulnerable groups in Benue State, more than any other poverty alleviation measure, should be vigorously pursued.

The micro-enterprise scheme, with its potentials for enabling the poor gain access to healthcare, has worked well in some communities examined in this article. Therefore, the replication of the model in more Benue rural communities possesses good chances of success.

Nevertheless, we must admit that a holistic poverty alleviation strategy, involving multifaceted and multisectoral approaches is more preferred for tackling the poverty 'pandemic' in rural Benue. Sudh strategies do not only require micro-enterprise/credit schemes, but also require measures such as the provision of rural infrastructure (roads, electricity, safe water, cottage industries, etc), social security, rural youth employment and so on.

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