Development Aid and Nigeria's Poverty Challenge: Millennium Development Goals 4 and 5 in Focus

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Declaration

I hereby declare that this dissertation is my own original work.

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Acknowledgment

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Abstract

The quest to eradicate poverty has been identified as the most critical challenge facing development in the world today. Women and children are disproportionately affected by poverty.

Nigeria is Africa's most populous nation. It is also one of the poorest countries in the world. Rapid progress in reducing poverty in Nigeria is dependent upon improved access to basic services, particularly health and education. If Nigeria fails to reduce poverty quickly enough, it is unlikely that the Millennium Development Goals will be achieved in Africa or globally.

This research spotlights UNICEF and the UK Department for International Development (DFID) efforts in Nigeria; assessing them through progress on MDGs 4 and 5 targets – reduce maternal and under-five mortality ratios; which are highly sensitive to poverty levels..

Findings reveal that only marginal improvements have been recorded. The problem is traceable to a combination of factors: aid administration processes and the adverse influence of women's poverty and cultural biases which reinforce gender inequality.

The methodology adopted was documentary review, involving sector-specific analysis of policy papers and related publications exploring a number of issues identified as critical to the attainment of the MDGs 4 and 5: poverty, human development, human poverty, maternal and child health and the role of aid/donors.

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List of Acronyms/Abbreviations

ASG	:	Africa Steering Group
AU	:	African Union
CBO	:	Community Based Organisation
CFA	:	Commission For Africa
CPA	:	Country Programmable Aid
DAC	:	Development Assistance Committee
DFID	:	Department for International Development
FCT	:	Federal Capital Territory
FGN	:	Federal Government of Nigeria
FME	:	Federal Ministry of Education
FMWA	:	Federal Ministry of Women Affairs and Social Development
GDP	:	Gross Domestic Product
HDI	:	Human Development Index
HDR	:	Human Development Report
HPI	:	Human Poverty Index
HSRP	:	Health Sector Reform Programme
IMF	:	International Monetary Fund
IMNCH	:	Integrated Maternal, Newborn and Child Health
LEEDS	:	Local Economic Empowerment and Development Strategy
MCH	:	Maternal and Child Health
MDG	:	Millennium Development Goal
NEEDS	:	National Economic Empowerment and Development Strategy
NEPAD	:	New partnership for Africa's Development
NGO	:	Non-Governmental Organisation
NPC	:	National Planning Commission
ODA	:	Official Development Assistance
OECD	:	Organisation for Economic Cooperation and Development

PATHS	:	Partnership for Transforming Health Systems
PHC	:	Primary Health Care
PPP	:	Purchasing Power Parity
PRSP	:	Poverty Reduction Strategy Paper
SEEDS	:	State Economic Empowerment and Development Strategy
SSA	:	Sub-Saharan Africa
SWCR	:	State of the World Children's Report
UBE	:	Universal Basic Education
UBEC	:	Universal Basic Education Commission
UN	:	United Nations
UN	:	United Nations
UNDG	:	United Nations Development Group
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund
UNISDR	:	United Nations International Strategy for Disaster Reduction

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African Mother and Child

Chapter 1: Setting the Scene of the Study

1.1 Background

The quest to eradicate poverty has been identified as the most critical challenge facing development in the world today; particularly for countries in the developing world. This is the number one Millennium Development Goal (MDG). Poor countries and poor communities, particularly women and children are disproportionately affected (DFID, 2006). Countries and communities are therefore being encouraged to place more emphasis on developing and pursuing a holistic approach in eradicating poverty especially as competing priorities and scarce resources place a limit on the spending capacity of poor countries (UNISDR, 2004).

1.2 Perspectives on Poverty

Poverty has many dimensions and the Human Development Report (HDR) 1997 published by the UNDP, mentions three of them:

- Income perspective: This is strictly applied when a person's income level is below the poverty line; defined as living on less than $1/day (UNDP, 1997).
- Basic needs perspective: This applies in conditions of deprivation of material requirements needed for minimum acceptable fulfilment of human needs. These requirements would include food, health, shelter, education and employment.

- Capability perspective: This applies when there is the absence of some basic capabilities to function. These capabilities would include being well nourished, adequately clothed and sheltered and avoiding preventable morbidity.

The HDR also elaborates on the concept of human poverty as being distinct from human development, which is a process of widening people's choices and raising the general level of wellbeing achieved. Human poverty on the other hand, focuses on the poverty of lives and opportunities. Human development centres on progress in a community as whole, while human poverty zeroes in on the situation and progress of the most deprived people in the community. The human poverty concept therefore assumes significance in the evaluation of development when one adopts a 'deprivational perspective', which examines in detail how the poor and deprived fare within each community. A continuing "lack of progress in reducing the disadvantages of the deprived cannot be "washed away" by large advances – no matter how large – made by the better-off people." (cited in UNDP, 1997, p. 15)

The world today enjoys unprecedented progress in development. People are living much longer and better lives, fewer mothers die at childbirth; fewer infants die from preventable diseases; and in the past 50 years poverty has fallen more than in the previous 500 years (UNDP, 2008). Yet, inspite of these laudable achievements, it is acknowledged that the global advances have been uneven, marred by setbacks and the number of people living in poverty continues to grow (UN, 2008; UNDP, 2008). Poverty remains stubbornly pervasive as 1.3 billion people worldwide continue to live in extreme poverty. Women are disempowered and severely constrained by lack of access to education, health care and productive assets. These heighten their inability to fend off poverty for themselves and their families. Of the 1.3 billion living in extreme poverty, almost 70 per cent of them are women; giving rise to the notion that poverty has a woman's face (Kabeer, 2004; DFID, 2006).

At the dawn of the new millennium, the largest-ever gathering of heads of State and Government adopted the United Nations (UN) Millennium Declaration, which committed both rich and poor nations to the values and principles of the UN and the pursuit of several key

objectives which include “peace, security and disarmament; development and poverty eradication; protecting our common environment; human rights, democracy and good governance; protecting the vulnerable; meeting the special needs of Africa and strengthening the UN”. The Millennium Development Goals (MDGs) emerged from that Summit and were hailed as the blueprint designed to galvanize unprecedented efforts to meet the needs of the world’s poorest. A target date of 2015 was set for their attainment (UN, 2000, p. 1).

Nigeria is Africa’s most populous and diverse nation with an estimated population of over 140 million; over 200 ethnic groups, 500 indigenous languages and two major religions (Christianity and Islam). Nigeria currently has one of the weakest economies in Africa (GDP per capita (PPP) rank 158 out of 177); and is also one of the poorest countries in the world with approximately 90 million people living in absolute poverty (only China and India have more poor people)(UNDP, 2008). It is considered that Nigeria’s success in the attainment of the MDGs will have considerable regional impact, since it influences, by its mere size, the whole of Africa. The attainment of the MDGs in Nigeria is in turn predicated on how quickly poverty levels can be reduced. Studies show that rapid progress in reducing poverty is dependent upon improved access to basic services, particularly health and education. It is reported that if Nigeria fails to reduce poverty quickly enough, given that it is still off track on a number of the targets, it is unlikely that the MDGs will be achieved in Africa or globally (DFID, 2004).

This research therefore focuses attention on the role of development aid in eradicating poverty in Nigeria from a human development perspective – poverty as denial of choices and opportunities for living a tolerable life among Nigerian women and children, assessed by the progress on reducing maternal and child mortality ratios. These two targets are geared towards improving overall human development:

Goal 4:	**Reduce child mortality**
Target 5	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
Goal 5:	**Improve maternal health**
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Source: World Health Organisation, 2009

Maternal and child mortality ratios for Nigeria are worse than the average for sub-Saharan Africa and are notoriously among the highest in the world (FMoH, 2004). In researching into measurements of impact on basic indicators of human development, scholars posit that since child mortality indicators respond quickly to higher consumption and improved health services, they can be considered a flash indicator of improvements in economic conditions of the poor (Boone, 1996; Morrissey, 2004). Furthermore, a proper focus on the human development perspective on poverty is relevant to policy makers as it draws attention to the causes of poverty which can then lead to the development of strategies of empowerment and other specific actions required to enhance opportunities for everyone (UNDP, 1997).

1.3 Global Development and Poverty Eradication

According to the HDR (1997), there have been two great ascents from global poverty and human deprivation. The first occurred in Europe and North America predicated on the industrial revolution, which saw most of them enjoying full employment and welfare states by the 1950s. The second Ascent occurred in the developing countries catalysed by the end of colonialism which resulted in dramatic declines in poverty (viewed as being more of political than socio-economic progress) and offering the possibility of replicating these gains globally. However, despite the progress already recorded worldwide, poverty remains pervasive. In order to address this lingering challenge, the HDR expressed optimism that the prospect of eradicating absolute poverty within the first decades of the 21st century is not only feasible; the report considers the quest to be both affordable and a moral imperative. Six areas of priority action were identified and they include:

1. “Everywhere the starting point is to empower women and men – and to ensure their participation in decisions that affect their lives and enable them to build their strengths and assets.

2. Gender equality is essential for empowering women – and for eradicating poverty. This is said to mean “focusing clearly on ending discrimination against girls in all aspects of health...starting with survival” (cited UNDP, 1997, p. 7)

3. Sustained poverty reduction requires pro-poor growth in all countries.

4. Globalisation offers great opportunities – but only if it is managed more carefully and with more concern for global equity.

5. In all these areas the state must provide an enabling environment for broad-based political support and alliances for pro-poor policies and markets.

6. Special international support is needed for special situations – to reduce the poorest countries’ debt faster, to increase their share of aid and to open agricultural markets for their exports” (UNDP, 1997, p. 19).

This research essentially addresses aspects of the first two priority action points outlined in this UNDP report.

The study examines the development aid interventions of two principal donors in Nigeria – the United Kingdom’s Department for International Development (DFID) and the United Nations’ Children’s Fund (UNICEF); assessing the impact of their activities in the health sector with particular emphasis on the maternal and child mortality ratios. The research methodology adopted is a desktop study involving extensive reviews of scholar, practitioner and organisational publications in the area of the research focus. Observations and findings are compared with information available in literature and points of agreement and variance are noted. Discussions are grouped under major categories identified in the research objectives.

Findings reveal that the Nigerian government has devoted time and resources to identify and clearly articulate the development needs of the nation under the National Economic Empowerment and Development Strategy (NEEDS) and the health sector needs (Health Sector Reform Programme – HSRP); clearly delineating desired areas of intervention for interested development partners. Since the return to democracy in 1999, the government has also made remarkable efforts in creating an enabling policy and operational environment in the country; improving deplorable governance conditions and encouraging active private sector participation in development efforts. Participation of development partners has also been encouraged and welcomed and consistent efforts made to ensure local counter-part obligations to programme and project requirements are timely honoured. The donors on their part have been generous in their contribution of development aid to Nigeria, increasing their volume and scope of activities in recent years.

However, inspite of these advances, only marginal improvements have been noted in Nigeria's maternal and child mortality ratios. This persisting problem is traceable in part to the manner in which aid has been administered in Nigeria (particularly in the last decade) as well as to the more subtle adverse influence of governance and institutional weaknesses pervasive within the Nigerian society. The lack of access to reproductive health facilities and women's continued inability to negotiate safe sex reinforces multiple and high fertility rates often resulting in pregnancy-related complications. Entrenched socio-cultural practices add to the litany of woes by venerating unsafe health practices among the poorer and less literate communities. The latter has served to undermine the ability of women and their dependent children in taking advantage of the meagre improvements in basic health services provided through development programmes and projects. These issues generally lie outside the purview of current development interventions and yet their fundamental role in undermining the gains of well thought-out development programmes can no longer be ignored.

It therefore becomes imperative for the government of Nigeria and the development partners to develop programme and project interventions which are truly holistic in nature and implementation. Globally, the available volume of development aid is on the decline particularly as most developed nations reel under the recent financial crises. Whatever resources are made available as development aid must therefore be optimally deployed and effectively targeted to achieve the aim of poverty reduction. The repeated squandering of scarce resources on the altar of regressive socio-cultural norms can no longer be condoned. If aid must go the full human development mile, it must be applied with an intention to directly address any and every challenge that is inimical to this objective. If development is not truly engendered, it is endangered. And if poverty reduction strategies fail to empower women, they will fail to empower society (UNDP, 1997).

1.4 Research Problem

Africa is the only region in the world where the number of extreme poor has risen over the past fifteen years (UN, 2007a). It is also said to be the only region in the world where not even a single country (particularly for sub-Saharan nations) is on the track to meet the MDGs (UN, 2007b). Education and health care are basic services essential in any effort to combat poverty and they are critical factors to achieving the human development MDGs. Women are disproportionately poor; disempowered and severely constrained by lack of access to these basic services and other productive assets..

Nigeria is a heavily populated country whose percentage of those living in poverty almost equals the entire population of the next most populous African country – Ethiopia (Joseph, 2008). In poor communities, women are particularly at risk with half a million dying each year in childbirth (UNDP, 1997). Nigeria's maternal and child mortality ratios are worse than the average for sub-Saharan Africa and are among the highest in the world.

Africa is the most aided region in the world and poverty reduction is generally agreed to be the core motivation for most development interventions. Maternal and child health (MCH) are inextricably linked together and this research seeks to understand the extent to which the

billions already deployed in foreign aid have served to impact on poverty reduction in Nigeria with particular focus on the deplorable maternal and child mortality ratios.

1.5 Research Aim

To assess the effectiveness of development aid in addressing Nigeria's poverty challenge as reflected in the human development MDGs – reducing maternal and child mortality ratios (MDGs 4 & 5).

1.6 Research Objectives

- To identify key development partners/donors active in the health sector (MCH) of Nigeria
- To assess the reports on intervention programmes and projects aimed at improving maternal and child mortality ratios
- To identify where programme and project objectives have been less than successful
- To identify the barriers and challenges to attaining these programme and project goals and analyse the underlying reasons for the existence of those challenges
- To identify what must be done to effectively address the challenges and ensure sustainable progress towards attaining MDGs 4 & 5

1.7 Research Questions

In meeting the research aim and objectives, this study will attempt to answer the following questions:

1. How much have donors invested in Nigeria's health sector?
2. Have there been any significant changes in donor participation since the return to democracy in 1999 with the attendant improvements in the policy and governance conditions?
3. Which bilateral, multilateral and/or private donor are the most significant partners (in terms of volume of funds provided) in MCH development interventions?

4. How do these donors deploy the aid they provide (volume, disbursement conditions and volatility of funds)?

5. To what extent have their interventions supported or undermined government-led activities in the sector?

6. Has the trend in maternal and child mortality ratios been in tandem with the volume of development aid and expertise deployed to the sector in the last ten years?

7. What are the constraints to achieving sustainable progress towards the MDGs 4 & 5 among the poorest groups in Nigeria?

8. How can donor aid be better deployed to address these identified constraints and ensure that the truly poor benefit from programme and project interventions?

1.8 Synopsis of the Research Methodology

The research methodology employed in this study was the qualitative process of desktop document analysis.

1.9 Limitations

Being conducted as a desk top research, the author acknowledges several limitations that might be associated with this research. These would include:

- Paucity of data set and documents analysed: Since the available material used have been limited to the scope (depth and breadth) of the researcher's investigations and enquiries, there is a real possibility of the existence of other publications which present an entire range of views not fully accommodated in this research.

- Depth and quality of analyses drawn from the documents reviewed: This being the first desk top research of this magnitude to be conducted by the researcher, the possibility of inadequate indepth study skills exists. This might have limited the wealth of additional information that could have been mined from the resource materials reviewed.

Having acknowledged these limitations, the review and vetting of this research work with the assistance of a much more experienced supervisor and another senior colleague is thought to have mitigated these short comings were possible.

1.10 Dissertation Outline

This initial chapter contains the background to the study. It introduces the concepts of poverty, human development and the role of development aid as it pertains to this study. The complex interrelationship between poverty, human development, human poverty and the MDGs 4 & 5 are highlighted. Mention is made of the centrality of Nigeria's role in the global poverty equation and the implications of poverty being said to have a woman's face is emphasised. This chapter also contains the research problem, aims & objectives, questions, and issues surrounding identified limitations. The following sections provide an outline of the core of the thesis.

Chapter 2: Literature Review – Chapter two presents a review of the existing literature and studies in the area of the research. Emphasis is placed on the role of development aid and in addressing global poverty needs; the intersection of aid and sub-Saharan Africa's development needs; Nigeria's poverty challenge as reflected in the human development MDGs 4 & 5; gender and women empowerment. The review approach starts from a global perspective on these issues, narrowing to an African and finally to a Nigerian standpoint. This chapter essentially shows that the continued marginalisation of women across the globe and within societies persists despite well intentioned efforts to redress these inequalities. The continuing denial of choices and opportunities to women for living a tolerable life has dire implications for both maternal and child survival rates. Reasons for these lingering problems are advanced as well as findings which highlight the critical gaps in development aid being more effective in addressing Nigeria's poverty challenge.

Chapter 3: Methodology – Chapter three is a detailed description of the methodological approach adopted in this study: a desk top study conducted through document review. The specific methods for data collection, selection of data set, techniques and issues related to

these are also explained. The methodology chapter mentions the limitations identified in carrying out the study, the issues surrounding the researcher's positionality and the steps taken to remedy such problems. The outcome of this chapter provides the information from which answers to the research questions were extracted; thereby fulfilling the dissertation's aims and objectives.

Chapter 4: Findings - The fourth chapter contains the findings from the data collected grouped around the research questions. Points of agreement and variation on each question are identified and suggestions on the summary of findings in each segment teased out. These summaries of findings form the basis of analysis and discussions in the next chapter.

Chapter 5: Analysis and Discussion – In this chapter, the Nigerian national context is briefly reviewed as it holds implications for the analysis of the data obtained. The summaries of findings from chapter four are then regrouped under major categories reflecting the focal areas outlined in the research objectives. Each category is discussed in detail outlining the implications it holds for the Nigerian poverty challenge and the country's attainment of the MDGs 4 & 5. Chapter five concludes by attempting to relate findings and analysis to the research aim and objectives and the existing literature on the research area.

Chapter 6: Recommendations & Conclusions – This final chapter presents a concise summary of findings, analysis and discussions. It essentially situates Nigeria's condition on addressing the human development MDGs 4 & 5 within the existing body of literature. Chapter six confirms that the continued marginalisation of women stems from a myriad of factors; prominent among which are: the lack of political commitment to address root causes of the problem and donors' failure to flexibly deploy their aid more effectively so as to benefit the truly poor. Suggestions proffered on ways forward to achieve effective and sustainable progress towards the MDGs 4 & 5 are presented. Final remarks to end the dissertation are also included here.

Chapter 2: Literature Review

2.1 The Big Picture

Poverty is more than just a lack of material things (CFA, 2005). It manifests itself in the deprivation of lives that people lead (UNDP, 1997). Over the last decade, a consensus has emerged that poverty is multi-dimensional and that the reduction of poverty is a recognised objective of development aid and the principal reason for public support of aid giving (White, 1995; Devarajan and Reinikka, 2004; Mosley et al., 2004). Scholars acknowledge that a principal challenge in the development of interventions for poverty reduction lies in being able to identify who the poor are, why they are poor and what can and should be done toward the reduction of that poverty. In a 1997 White Paper on International Development – focused on eliminating world poverty - the United Kingdom's Secretary of State mentioned two key elements required to be in place if the fight to eliminate poverty were to succeed. First, was the need for a clear set of internationally agreed policies and principles which promote sustainable development (these now exist in the MDGs); and the second was the need for political will to address the problems of international development both in poorer and richer countries.

Foreign aid is one of the instruments available to the international community in addressing the development needs of the poor nations.

> *"International development cannot succeed without the necessary political will in the developing countries. Nor can it succeed without the full support of the international community."* (cited in DFID, 1997, p. 77).

In times past, aid was seen as a global 'hand-out', something 'we' do for 'them' and this approach has been attended with mixed successes. Today it is the norm to consider aid as a 'hand-up' that backs real efforts by poor countries to eradicate poverty. Inspite of views held to the contrary in some sectors, scholars insist that aid does matter and that the major challenge is to evolve solutions to improve its effectiveness in meeting clearly articulated development objectives (Johnston and Manning, 2005).

2.2 Development Aid and Poverty Reduction

Foreign aid in its broadest sense has been defined as consisting of all resources – physical goods, skills and technical know-how, financial grants (gifts), or loans (at concessional rates) and support in international negotiations – transferred by donors to recipients. Lancaster (cited in Lancaster 1999, p. 490) also defines foreign aid as a "transfer of concessional resources, usually from a foreign government or international institution, to a government or non-governmental organisation in a recipient country. It may be provided for a variety of reasons, including diplomatic, commercial, cultural and developmental." However, development aid encapsulates a narrower and more restrictive definition being seen as the "types and forms of foreign aid from rich countries to poor countries, and to poor people, which help to address acute human suffering and which contribute to human welfare, poverty reduction and development" (cited in Riddell, 2007, p. 17). In all cases, it is noted that the definition of aid (whether foreign or development) is largely donor-driven and based on the intentions of those giving the aid rather than those using it, the recipients. This uncontested, donor-driven approach has remained the norm and also manifests in the fact that it has always been the donors who decide how much aid to give and the form in which it is to be given (Randel et al., 2000; Riddell, 2007). Be that as it may, great progress has been made in reducing global poverty (as percentage of the population) over the last forty years and official development assistance (ODA) from rich countries has helped (Hermias and Kharas, 2008). Billions of dollars have been pledged and remitted and the available statistics in literature attest to this:

"With great fanfare, the leaders of the G8 countries reaffirmed at Heiligendamm in June 2007 that they would meet their commitments to increase aid by $50 billion by 2010, with half going to Africa" (cited in Kharas, 2007, p. 1);

"The total sum of international official development assistance now tops $100 billion per year, with Europe financing almost two-thirds...EU members directly provided $49 billion of bilateral ODA in 2006 and, through multilateral bodies, another $19 billion... In sub-Saharan Africa, EU countries contribute three-quarters of total ODA" (cited in Hermias and Kharas, 2008, p. 1);

Development aid is therefore clearly recognised as an instrument that can contribute towards human development (of which poverty reduction is a vital component) either directly or indirectly. However, this increase in development aid has been accompanied by a curious increase in the levels of poverty noted among developing nations of the world. The gap between rich and poor continues to widen and the seeming inability of the billions of dollars already deployed to stem this tide of deprivation remains an intractable dilemma (Randel et al., 2000).

2.3 Aid Effectiveness and Country Programmable Funds

2.3.1 Aid Effectiveness – Donor-side

The reasons often advanced for donors' motivations in providing development aid are multiple and varied. Studies reveal justifications ranging from: to help address emergency needs; to assist recipient nations achieve their development goals (Riddell, 2007); to promote donor country political and strategic considerations - rather than real needs of the receiving countries (Alesina and Weder, 2002; Burnside and Dollar, 2000; Kharas, 2007a; Alesina and Dollar, 2000); to support trade and commercial flows (Knack and Rahman, 2004; Kharas, 2007a); to promote relationship with former colonies; to encourage or reward common voting patterns in the United Nations (Randel et. al., 2000). Schraeder et al. (1998), studying the determinants of aid flows in Africa easily reject an altruistic vision of donors' motivation. A view upheld in Easterly (2002), which posits that official development partners

have been known to keep providing funding even when development objectives are not being promoted; because multilateral and donor agencies are often rewarded for volumes of assistance rather than results. According to Svensson (2002), one reason for this is that aid is not always given for poverty alleviation purposes. Evidence suggests that incentive systems exist which reward both donors and recipients for reaching a high volume of resource transfer. Since non-disbursed amounts may lead to reduced allocations for the next fiscal year, emphasis expectedly shifts to disbursement volumes and results are measured against volume figures without regard for the quality of development impact. White (1995) concurs that the donor country commercial and political interests occasionally determine aid volume and patterns and this serves to corrupt the purely developmental objectives often professed by the donors themselves.

Whether borne out of altruistic reasons or self interest, it is clear that rich nations have firm reasons for continuing to commit vast resources to address the challenge of international development among developing countries of the world and these reasons are known to influence aid programmes. The effectiveness of aid is also reduced by the low share going into country programmes, donors' fragmentation into small and often disconnected projects, and by the significant volatility of aid over time. Presently, hundreds of official agencies are trying to promote development. 46 governments run bilateral aid programmes administered through multiple agencies; these governments also fund about 233 multilateral development agencies; add to these the thousands of international NGOs and multiplied thousands of local NGOs and CBOs and one can begin to understand why aid has not achieved the necessary transformational impact – it is spread too thinly and inefficiently (Kharas, 2007a). Johnston and Manning (2005) counted more than 60,000 ongoing projects – triple the number in 1970 – of which 85 per cent cost less than $1 million. The problem of donor multiplicity has increased over time but this has not necessarily translated into recipients receiving more aid (Riddell, 2007). With the increase in the average number of donors per country, the attendant reduction in average project size implies a growing fragmentation of

aid (Kharas, 2007a). Poor countries, particularly in sub-Saharan Africa, are those that suffer from the highest degree of aid fragmentation (Hermias and Kharas, 2008). Studies show that only around 15 per cent of total aid is directly poverty-oriented (White, 1995). Other factors which combine to inhibit aid effectiveness include:

- **Increasing volatility of aid flows over time**: Volatility of aid flows has been rising and this factor is estimated to reduce the effectiveness of ODA by around 20 per cent (Knack and Rahman, 2004; Hermias and Kharas, 2008)

- **Donor collusion**: While harmonisation of donor activity is encouraged to counter the adverse effects of fragmentation, an unintended side effect is the evolution of collusion among donors. There is safety in numbers and when donors, acting in harmony, fail to achieve the goal of lasting poverty reduction, it is easier to point the finger of blame at the recipient country. Donors agencies therefore tend to feel no pain from their failures (Easterly, 2002; Hermias and Kharas, 2008; Easterly, 2007a)

- **Lack of accountability in a sectoral context**: Donor agencies' performance has been assessed in the light of individual projects rather than overall sectoral performance. This lack of enhanced accountability has led to numerous flash-in-the-pan 'success stories' which are really just 'development experiments' that fail to achieve the expected impact because of a lack of scaling up (Hermias and Kharas, 2008)

- **Aid recipients' preferences**: presently, very few development agencies undertake systematic client surveys and where these are done, the results usually have little bearing on actual programmes. Recipient countries are also not at liberty to substitute aid from one donor for a (more desirable) programme offered by another partner without losing overall aid resources (Hermias and Kharas, 2008; Lancaster, 1999).

- **Declining volumes of aid for the poorest nations**: Aid volumes available to the poorest have actually been on the decrease in recent times (Randel et al., 2000; Kharas, 2008).

- **Parallel systems for aid delivery and burdensome donor requirements**: On the premise of ensuring accountability and transparency in the utilisation of funds, donors continue to build parallel systems to deliver aid - even where recipient capacities are strong - taxing the limited administrative resources of recipient nations (Easterly, 2002; Kharas, 2008; Moss et al., 2006).

- **Lack of precise identification of project beneficiaries**: Because of a prevailing assumption that any rural-based development project is poverty alleviating, loopholes for diverting benefits from the poorest are created since the path to ensure their receipt of project dividends is not clearly specified (Mosley, 2002; Knack and Rahman, 2004; NPC, 2006).

- **Country approaches** that inadequately address the underlying causes of poverty (Randel et al., 2000; Knack and Rahman, 2004; Lancaster, 1999).

- **Lack of political will and leadership in some of the largest donors**: Contributing one-fifth of the world aid total in 2007, the United States is the single largest aid donor. But the US approach to development is clearly focused on bilateral cooperation and it displays indifference to the Paris Declaration and the Accra Agenda for Action which calls for improved aid coordination. Japan is another large donor which finds the Paris Declaration to be tangential to its development efforts (Randel et al., 2000; Kharas, 2008a)

- **Poaching** of skilled local staff from key government agencies and lack of government ownership of development programmes and projects (Birdsal, 2005; Knack and Rahman, 2004; Moss et al., 2006).

- **Tying of aid** (Knack and Rahman ,2004; Randel et al., 2000).

Others donor handicaps as presented by Lancaster (1999) include the frequent lack of a proven technology for achieving project goals; relatively little knowledge about the societies

or institutions in which they are trying to bring about change (Riddell, 2007; CFA, 2005); and domestic and bureaucratic politics within the aid agencies themselves. The problems arising from the unproductive bureaucracy usually involved in the delivery of aid services to poor people in poor countries comprise the Cartel of Good Intentions criticised by Easterly (2002; Moss et al., 2006). Birdsall (2005) goes further to catalogue what she considers to be the 'seven deadly sins' of donors as a community. They include:

1. Impatience (with institution building)
2. Envy (collusion and coordination failure)
3. Ignorance (failure to evaluate)
4. Pride (failure to exit)
5. Sloth (pretending participation is sufficient for ownership)
6. Greed (unreliable as well as stingy transfers)
7. Foolishness (underfunding of global and regional public goods).

2.3.2 Aid Effectiveness – Recipient-side

Mosley et al. (2004) show that the differential impact aid might have is dependent upon the recipient country's characteristics which include corruption, inequality and the composition of public expenditure. It has been argued that development assistance availed developing countries does not often reach the really needy on account of the corruption of the bureaucracy and of the officials of developing countries. According to the World Bank (cited in Alesina and Weder, 2002, p. 1126): "there is no value in providing large amounts of money to a country with poor policies". Recipient countries are more often than not beleaguered by poor institutional development, inefficiencies and bureaucratic failures (Alesina and Dollar, 2000; Riddell, 2007). A chronicle of the challenges they face would also include:

- Weak institutions and policies (Dollar, 1999)
- Conflict (Randel et al., 2000)
- Lack of commitment to pro-poor strategies (Knack and Rahman, 2004)
- Limited absorptive capacity (Killick, 1991)
- Shortage of skilled manpower: Less than 10 per cent of aid recipients are considered as having the sound frameworks required to monitor and assess development results and less than a quarter link their development strategies with their national budget (Kharas, 2008)
- Poor incentive to work in rural (and the most impoverished) parts of the country (Devarajan and Renikka, 2004; Mosley, 2002)
- Lack of participation of beneficiaries in initiating poverty-focused projects (Mosley, 2002)
- Lack of access to available services (Birdsall, 2005)
- Lack of precision in public spending: Most studies of the incidence of public spending in health and education reveal that less than 20 per cent of the benefits reach the poorest; most accrue to the rich and middle class (Devarajan and Reinikka, 2004)

2.4 Country Programmable Aid (CPA)

"Although total aid in 2005 was over $100 billion, only $38 billion was for investment in development projects and programmes – and of this perhaps half actually got to the intended beneficiaries" (cited in Hermias and Khara, 2008, p. 2);

"Most ODA is for special purpose needs which do not translate into funds available for development projects and programs... Sub-Saharan Africa is especially hard hit by this wedge between ODA and CPA. It only received $12.1 billion in CPA in 2005, showing almost no increase over the preceding two decades" (cited in Kharas, 2007a, p.1).

In the context of the MDGs, the donors as a group can be called stingy, at least relative to their commitments. “Only Denmark, Norway, Sweden and the Netherlands have met the goal of aid as a share of GDP of 0.7 per cent to which all committed at Monterrey, Mexico (confirming earlier commitments) in 2002” (cited in Birdsall, 2005, p. 17). According to Kharas (2007a), development aid covers a multitude of different types of transfers but not all of them go directly to poor countries. Special purpose flows such as administrative overheads of development agencies; their domestic advocacy efforts to raise more assistance; debt forgiveness on non-concessional flows; emergency assistance and food aid; and technical assistance are all considered in donors’ books as aid. Not all of these resources are readily available to poor countries for application towards development projects and programmes. Therefore the net aid transfers (which are total aid less special purpose aid flows) are the funds available for specific investments, sector-wide support, budget support and many other forms of project and programme mechanisms aimed at promoting development. This proportion is what is known as country programmable aid - CPA.

Records show that in 1997, ODA to low income and least developed countries fell by $3.6 billion – more than 12 per cent (Randel et al., 2000). More recently, the OECD reported that aid provided by the 22 members of the DAC in 2006 fell by 5.1 per cent from 2005 levels and that the figures were expected to fall back further in 2007 as debt relief to Nigeria and Iraq tapered off (OECD, 2006). The world’s poorest countries are thus receiving lamentably low percentages of reduced aid – a smaller share of a smaller cake (Randel et al., 2000). After this sharp decline in the 1990s, total ODA volume has experienced a major increase in recent times. However, available data show that CPA has not enjoyed such a turn of good fortune. Available CPA was actually lower in 2005 than it was in 1985 in absolute terms; the same pattern holding true both for multilateral and bilateral agencies disbursements. The share of CPA in total aid has correspondingly declined to 37 per cent in 2005 from corresponding levels of 59 per cent in 1975. It has emerged that the $12.1 billion which

accrued to sub-Saharan Africa as CPA in 2005 was only marginally higher than the $11.6 billion which those countries received in 1985. Some scholars view this decline as a clear indication of a complete lack of will among rich nation governments to make the poorest people in the poorest countries a priority (Randel et al., 2000).

Kharas goes on to show that, taking all the official aid flows together (in excess of $100 billion), poor country governments receive just about $38 billion in net CPA. Of this amount, it is conservatively estimated that only $19 billion actually got to the final beneficiaries (the citizens of poor countries); although the percentage of it that actually filters down to the poor among them remains as yet unknown. This is because of the $38 billion provided, some funds are invested in administrative overheads and other reporting required by donors, some funds are illegally siphoned through corruption and some portion captured by rich citizens in poor countries. The 2005 revision of the Cotonou Agreement presses donors for 'upstream co-ordination' and for the delivery of recipient programmable aid (funds partner countries can use at their own discretion). To check aid volatility, the agreement also commits donors to a multi-annual financial framework from 2008 to 2013 (Hermias and Kharas, 2008). Judging by information available in literature, it will appear that donors are taking their time in heeding this advice. Instructively, a 2003 review of the distribution patterns by the six main bilateral donors (the US, Japan, Germany, the UK, France and the Netherlands) show that the three countries which together account for 64 per cent of the world's poor (India, China and Nigeria), each receive considerably less aid than would be merited by their populations and absolute poverty levels (Baulch, 2003). So what does this portend for poor people in poor countries?

What is clear is that the amounts that are actually received by poor people for development purposes are a small fraction of what gets financed initially. That only about $12.1 billion of the overall ODA takes the form of funds that sub-Saharan African (SSA) countries can use to invest in social and infrastructural development programmes certainly does not compare well with the $107 billion spotlighted by donor governments (Birdsall, 2005; Kharas, 2007). It

is also clearly indicative of the growing reluctance of rich countries to funnel their assistance in the form of programme or project support to developing countries (Kharas, 2007a). Even though the leaders of the Organisation for Economic Co-operation and Development (OECD) argue that the solution to getting the aid dollar to go the full development mile is not to reduce aid, but rather to link it better to local priorities; to help countries build competent systems over time; and to ensure the harmonisation and simplification of the aid delivery systems (Johnston and Manning, 2005); the challenge remains on how to structure the aid delivery system to ensure that resources flow through the most efficient organisations, to countries with the greatest need; where the corresponding capacity to programme and implement projects is highest, and where development concerns are pre-eminent (Kharas, 2007a).

'Tis folly in one Nation to look for disinterested favors from another – that it must pay with a portion of its independence for whatever it may accept under that character...'

- from George Washington's "Farewell Address" (1796).

2.5 Development Aid and Poverty in Africa

Africa is the only region in the world where the number of extreme poor has risen over the past fifteen years (UN, 2007a). It is also the only region where not even a single country (particularly for sub-Saharan nations) is on the track to meet the MDGs (UN, 2007b). At the September 2007 inaugural meeting of the MDGs African Steering Group (ASG), the UN Secretary General expressed grave concern over the status report on Africa and the MDGs target date and called for global assistance to help these countries to join the track.

Development is complex and multi-faceted and the challenge facing the governments of the world's poorest countries is formidable. For the daunting challenge of poverty elimination to be achieved among these nations constrained by limited resources, there must be a dynamic balance between policies and actions aimed at promoting human development, sustainable livelihoods and a better management of the natural and physical environment (DFID, 1997). Aid has been shown to be a tool that could be instrumental in addressing the

challenge facing developing nations but the reality of poverty in the 21st century is considered an indictment of the global order. At the end of the last century, the world was not only overproducing food, but also a wide variety of luxuries and amusements. Yet 1.3 billion people continued to wallow in poverty, being denied their basic human rights and needs. This state of affairs demonstrated - not the lack of generosity on the part of the comfortably off majority – but the failure of political leadership on a grand scale (Randel et al., 2000).

Aid to sub-Saharan Africa has been falling steadily since 1994 (Randel et al., 2000). Compounding this situation is the persisting crisis of governance in some SSA countries, which is a fundamental obstacle serving to further decrease the effectiveness of the aid that they receive. Scholars consider that the problem is neither technocratic nor is there any shortage of advice. The politics of it lie at the heart of the problem (Killick, 19991; Randel et al., 2000). The World Bank emphasises the view that underlying the litany of Africa's development problems is a crisis of governance (Brautigam and Knack, 2004). The Commission for Africa (2005) agrees, noting that without progress in governance all other development reforms and processes in Africa will have limited impact. Corruption and aid can become mutually reinforcing, as elites "whose livelihoods depend mostly on aid ... become an interest group that will fight for continued aid ... to ensure themselves continued privileges and income" (Degnbol-Martinussen and Engberg-Pedersen, 1999, p. 273 cited in Knack and Rahman, 2004, p. 17). "The aid and the processes surrounding its delivery create incentives and informal institutions – patterns of behaviour, norms, codes of conduct – both in donor organisations and in countries receiving high levels of aid. Once in place, these incentives and institutions have proven quite resistant to change" (cited in Brautigam and Knack 2004, p. 258).

Studies show that the very poorest people find themselves excluded even from the sources of help provided by governments, development aid as well as the informal support systems of their local community. Within these poorest, women and young people constitute the

largest percentages. The position of the women continues to attract particular concern because of the greater contribution which they make to economic life (more than their male counterparts) and yet they have no voice in most decisions which affect their lives and wellbeing. Expanding the opportunities available to people and helping them to shape their own lives and fulfil their potential with dignity remains the primary aim of human development. It has intrinsic value and constitutes a basic right, which social justice demands a collaborative approach to ensure it is delivered for the development of society as a whole. In laying a strong emphasis on the evidence that development works better when no one is left out, the Commission For Africa insists that unless the exclusion faced by women is tackled across the board, Africa's poverty challenge will not be effectively addressed (CFA, 2005).

2.7 New Partnership for Africa's Development (NEPAD)

Under the NEPAD, African leaders pledged - on the basis of a common vision and a firm shared conviction - that the pressing duty to eradicate poverty and to place their countries (both individually and collectively) on the path of sustainable growth and development was essentially their responsibility (NEPAD, 2003, p. 1). A number of sectoral priorities for development were identified which included bridging the infrastructure gap, tackling health, education, environment, agriculture and gender challenges. The NEPAD secretariat was charged with the responsibility of preparing the various sectoral strategies and to present these to the AU for consideration and adoption. The adopted strategies would then form the basis of designing development interventions and negotiating with international development partners (NEPAD, 2003).

Consequent on the poverty, social exclusion, marginalisation and lack of sustainable development in Africa, health is one of the most serious casualties. The urgent need for improvements in the health sector is therefore recognised as a priority area for action. The NEPAD health strategy was adopted by the AU in 2003. This strategy highlights the interrelatedness between health and human development, and is incorporated within the

broad framework for human resource development in the region. The mortality and morbidity rates for Africa are deplorable and the situation in SSA is the worst in the world. Poverty and weak health systems are considered both the cause and the consequence of this appalling development.

To ameliorate the situation, a number of regional and international goals and targets have been set in recent years and they include: the Abuja Declarations; the Health-for-All Policy in the 21st Century in the African Region: Agenda 2020; and the health-related MDGs. As a whole, Africa is not on track to meet any of these goals and targets and the reasons advanced for this include:

- Health systems and services which are too weak to support targeted reductions
- Inability to achieve safety in pregnancy and childbirth
- Widespread poverty, marginalisation and displacement on the continent
- Benefits of health services not reaching those with the greatest disease burden equitably
- Mismatch between disease control programmes and the scale of the problem
- Paucity of resources
- Lack of empowerment on the part of the people to improve their health
- Migration of skilled health workers to northern countries

In proposing an intersectoral and integrated approach to health development, the NEPAD health strategy recognises that achieving its objectives will be predicated on the multi-dimensional determinants of health – social, economic, political and cultural influences (NEPAD, 2003). Essentially, the NEPAD health strategy embraces the spirit of the Rio Declaration and that of the World Summit on Sustainable Development, that:

"Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature." (cited in NEPAD, 2003, p. 33).

Table 1: Human Poverty in Developing Countries (millions of people)

Region	Illiterate adults	People lacking access to health services	People lacking access to safe water	Malnourished children under 5	People not expected to survive to age 40	Maternal mortality rates (per 100,000 live births)
All developing countries Of which:	**835**	**766**	**1202**	**157**	**503**	**471**
Arab States	59	29	54	5	26	380
East Asia	167	144	398	17	81	95
Latin America and the Caribbean	42	55	109	5	36	190
South Asia	407	264	230	82	184	554
South-East Asia and the Pacific	38	69	162	20	52	447
Sub-Saharan Africa	122	205	249	28	124	971

Source: DFID, 1997 (adapted by author)

2.8 The Nigerian Context

Nigeria presents a paradox. The country is rich but the people are poor (World Bank, 1996). Nigeria is one of the biggest and poorest countries in Africa and has immense development needs (UNDG, 2006). The majority of the population lives in the rural areas. Following years of political and economic stagnation, Nigeria embarked on a comprehensive reform programme during the second term of the democratic administration (Okonjo-Iweala and Osafo-Kwaako, 2007). The reform was based on the National Economic Empowerment and

Development Strategy (NEEDS); Nigeria's home-grown Poverty Reduction Strategy Paper (PRSP). The document focuses on the Nigerian people – their health, education, employment, happiness, sense of fulfilment and general wellbeing. In articulating Nigeria's poverty challenges, the NEEDS document acknowledges that poverty in Nigeria varies widely by sector, gender and region; and that the social exclusion of and continued discrimination against women inhibits their ability to fully participate in the development of the nation (NPC, 2006).

The conceptual issues addressed in the NEEDS document are predicated on four goals:

1. Poverty reduction
2. Wealth creation
3. Employment generation and
4. Value re-orientation

Failing to overcome poverty is a matter of political choice not necessity. The goal is neither economically nor technically beyond our current reach (cited in Randel et al,. 2000, p. 17).

The framework designed for the actualisation of these goals is anchored on three pillars, the first of which is: Empowering people and improving social delivery.

With the return of a democratic government in Nigeria in 1999, measures were subsequently put in place to review past poverty alleviation programmes, harmonise sectoral efforts and streamline poverty-related institutions. Reasons advanced for the limited success (or outright failures in some instances) of past government efforts at poverty reduction were listed as including:

- Poor coordination
- Absence of a comprehensive policy framework
- Excessive political interference

- Ineffective targeting of the poor
- The unwieldy scope of programmes
- Duplication of functions
- Lack of sustainability mechanisms
- Lack of involvement of beneficiaries in project design, implementation, monitoring and evaluation (NPC, 2004).

The challenge in Nigeria is significant particularly with respect to the MDGs 4 and 5. In 2000, the World Health Organisation ranked Nigeria's overall health system performance in the 187th position out the 191 Member States. Primary health care facilities only serve about 5 – 10% of their potential load. Partnerships between the public and private sectors are largely non-existent or ineffective. The activities of donors and other development partners were poorly coordinated. In response, the Nigerian Federal Ministry of Health in 2003 developed the Health Sector Reform Programme (HSRP) to set the tempo and direction for strategic reforms and investments in key areas of the national health system, within the overall framework of NEEDS (FMoH, 2004).

The HSRP rightly views the rates of maternal and child mortality in the country as being unacceptably high and concedes that widespread poverty impedes the capacity of citizens to access medical care. Data and statistics from surveys and research in Nigeria also show that development is a gendered exercise, impacting differently on women and men, girls and boys. This factor, in addition to the ruling social norms endemic in any particular society determine how different groups in the society benefit from development gains (FME, 2007). As obtains in most developing countries, women in Nigeria are found to be more likely than men to be poor and the opportunities open to them for escaping poverty are fewer (NPC, 2006).

2.9 MDGs 4 and 5 Status in Nigeria

A progress report on Nigeria's PRSP commissioned by the International Monetary Fund in 2007 cited the following statistics with regards to the human development MDGs 4 and 5:

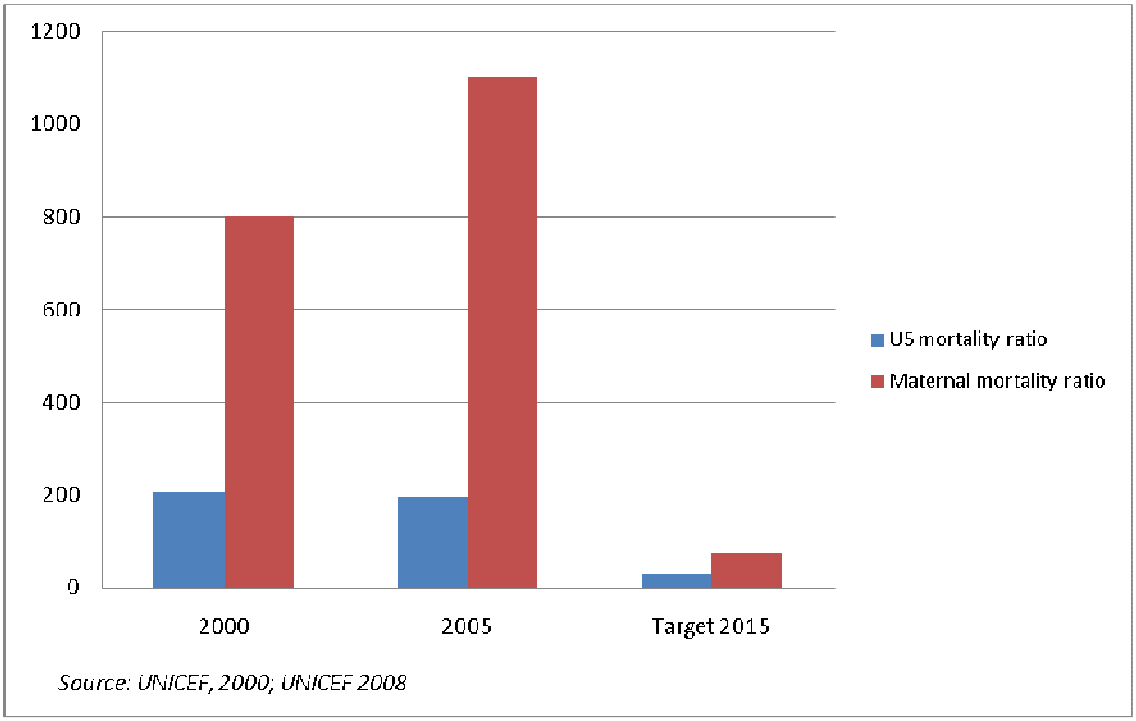
> **"'Goal 4: Reduce Child Mortality:**
>
> The results under this goal fall far short of expectations ... The under-5 mortality rate improved marginally from 201 per 1000 births in 2003 to 197 per 1000 live births in 2005.
>
> **Goal 5: Improve Maternal Health**
>
> There was not much significant progress made in respect to this goal. An increasing maternal mortality rate of 800 per 100,000 live births was reported in 2004 as against 704 in 1999" (cited in IMF 2007, p. 34 - 35).

Reduction of child mortality has remained a key challenge in Nigeria's development. There are wide disparities between rural and urban centres, with the rural areas posting more deplorable statistics. Low maternal education, weak primary health care system and high incidence of poverty and inequality are among the factors responsible for these high mortality rates. More importantly, child survival is highly dependent on parents' ability to understand and react appropriately to a child's needs; a factor which is inexorably influenced by female literacy levels, empowerment and status (NPC, 2006a).

Maternal mortality rates in Nigeria is unacceptably high and together with child mortality rates remain one of the most serious development challenges in the country. The incidence is considerably higher in the rural areas and northern part of the country. The official estimates are that about 2 million of the 27 million women of reproductive age do not survive pregnancy, childbirth or the immediate six weeks post-delivery. Attaining rapid improvements in these statistics continues to be challenged by long-standing cultural, social and economic factors. Social norms which combine to limit women's knowledge and access to skilled services must necessarily be addressed. Thirty-eight per cent of rural dwellers

specifically cite prohibitive costs as the greatest challenge to accessing health care (NPC, 2006a).

Figure 1: Nigeria's Status at a Glance[1]



The role of gender equality in reducing poverty levels, improving health and living standards as well as enhancing efficiency of public investments is now a globally accepted strategy (FME, 2007). Yet women in Nigeria remain seriously disadvantaged in terms of equal access to health and other productive resources. The entrenched patriarchal social system translates into male domination and subordination of women in both private and public spheres, which results in the construction and perpetuation of gender inequality (FME, 2007). Nigeria's situation therefore calls for a change in development programmes that must begin to respond to women's needs in concrete terms; with real action and less lip service (Lucas, 2000). The MDGs' call for change must be accompanied by demonstrable action

[1] The IMF and UNICEF figures on U5 and maternal mortality ratios in Nigeria differ slightly (due to the different dates of the publications and probably different interpretation of meager basic information), but point to the same negative result of MDG 4.

and strategies designed to create the conditions to make real change possible for the poorest and the marginalised. The formulation of gender- responsive policies to fight the feminisation of poverty is imperative (FGN, 2007); and failure to holistically address the root causes of the problems that the MDGs are supposed to rectify will only serve to ensure that these goals remain an illusion (MADRE, 2005; Birdsall et al., 2004). Most scholars and development practitioners consider health care and education to be the basic services essential in any effort to combat poverty (Castro-Leal et al., 1999; Verschoor, 2002).

This research is therefore focused on the impact of development aid on primary health care services in Nigeria because developments in that sector are critical to the achievement of the human development MDGs 4 and 5.

2.10 Conclusion

Available literature shows that poverty is more than just a lack of material things. Foreign aid is one of the instruments available to the international community in addressing the development needs of the poor nations. Development assistance from rich countries (DAC members) to poor countries topped $100 billion in each of the last two years, reaching a record high; but curiously this has also been accompanied by increasing levels of poverty among developing nations of the world. Possible explanations have been advanced for this phenomenon, which include issues arising from dwindling aid volumes to the poorest nations, donor and recipient characteristics and shrinking percentage of country programmable aid. More importantly, gender is recognised as a key principle in the distribution of valued resources in any society; and the fact of females' profound marginalisation and vulnerability has remained the bane of global development. Gender discrimination remains pervasive in many dimensions of life in Africa and the implications of this trend assumes a greater significance when considering what it portends for the human development MDGs 4 and 5 - the focus of this research work. Maternal and child mortality ratios in Nigeria are higher than the average for sub-Saharan Africa and are among the highest in the world. The Nigerian political climate has improved in recent years and the

country is signatory to several regional and international instruments focused on achieving improved health services for the poorest amongst the poor. Ultimately, a fundamental transformation of social institutions, norms and practices is required to achieve the empowerment of women in Nigeria and their improved access to human development resources. The challenge for the country is to convert rhetoric into effective action.

The next chapter focuses on the methodologies; how the data for this study was collected, collated and analysed.

Chapter 3: Methodology

3.0 Introduction

A study which attempts to assess the extent to which development aid has been effective in addressing the poverty challenge in a nation as large, as populous and as poor as Nigeria can be a complex process. Assessing the effectiveness of development aid through document review by its nature can turn out to be a political undertaking, given that the documents reviewed are initially produced with a given objective in mind. It requires a method which takes into account these complexities. This chapter outlines the methodology that was adopted in assessing the extent to which progress towards the targets of the MDGs 4 and 5 in Nigeria have been supported by development aid and its related programmes. The chapter covers the methods, selection of data, analysis and limitations of the study.

3.1 Method

The methodology adopted for this research was a documentary review, involving sector-specific analysis of policy papers, relevant documents and related publications exploring a number of issues identified as critical to the attainment of the MDGs 4 and 5. These issues include poverty, human development, human poverty, maternal and child health and the role of aid/donors in Nigeria's development challenge.

The qualitative method of documentary review is considered to be a major method of social research that is both meaningful and appropriate as a research strategy (Mason, 1997).

A typical modern organisation is thoroughly dependent on paperwork with personnel at all levels regularly engaged in extensive production and consumption of various types of documents (Atkinson and Coffey, 1997).

Some scholars consider extensive documentation to be the defining attribute of Western industrialisation particularly with the development of a modern bureaucracy that is heavily reliant on written rules and administrative records (Perakyla, 2008; Finnegan, 2006). Documents are produced for a number of reasons: internal documents for record keeping and preservation of institutional memory; and external documents aimed at presenting the organisation to the public, competing for market share or justifying its existence to its Board or to the general public. In order to understand any organisation, therefore, no researcher can afford to ignore the documents produced by such a body (Atkinson and Coffey, 1997; Finnegan, 2006).

Documents come in various types. Some documents already exist such as books, reports and journals. There are some other documents which are generated for, through or during the research, such as charts, lists and tables. Documents may also be available in different formats such as print or as electronic/online publications. Most of these documents are text based, but other non-text based documents exist such as photographs, sculpture and films. Whatever the format or type, documents constitute a pervasive means of data storage in present day social settings and provide great insight to the realities of the past and present day. In considering the social facts presented by documents, a researcher is required to exercise due caution as to what this information can and cannot be used for. Scholars have often expressed reservations over ‘official’ records being treated as firm evidence of what they report; particularly information such as statistics on crime, suicide, deaths and the like. It is recommended that since such data represent social facts, they should simply be recognised as such and treated very seriously, examining their place in organisational settings and the cultural values attached to them (Atkinson and Coffey, 1997).

Again, no document ever emerges as a result of any automatic natural process. They are 'written' by individuals or groups under certain conditions and within given historical, social and administrative constraints. They are also produced under certain assumptions, to achieve a particular objective and often with a target audience in mind. It is not unusual for 'authoritative' documents to have their own hidden agenda with evidence selected or 'twisted' to suit their own purposes (Finnegan, 2006; Atkinson and Coffey, 1997). The researcher will do well to bear these factors in mind when considering documentary information. The question of authorship is also a key feature. Unlike the works of individual or groups of scholars, official and organisational documents are seldom identified as the work of any singular author. There may be assumed ownership by departments and units but their very anonymity is considered part of the official production of documentary reality. Other characteristics of documentary data which influence the information that is produced and communicated include:

- *Rhetoric*: This goes beyond the mere decoration of speeches. Rhetoric is essentially about how texts persuade their hearers and readers, drawing from devices widely shared in culture to get a point of view across

- *Intertextuality*: This asserts that documents do not stand alone. They refer to other domains, realities and documents to varying degrees. Documents generally tend to make sense because they refer to other documents and it is in the dense network of cross-referencing that a powerful version of social reality is created (Atkinson and Coffey, 1997).

The decision to carry out a documentary review in this research was informed by the availability of the data addressing the various issues of interest to the researcher and yet the dearth of Nigeria-specific poverty studies independently assessing the effectiveness development aid on an MDG-by-MDG basis. It is considered that by foregrounding the maternal/child health-poverty-development aid connection, pertinent issues often glossed over in general assessments will be highlighted. Furthermore, an independent result-

oriented assessment of the effect of aid on the two critical indicators which are highly sensitive to poverty in a nation as significant as Nigeria is to the global poverty equation, will dispense with political rhetoric and better clarify the position of the country on the poverty reduction continuum.

3.2 Selection of Donors

The donors focused on in this research - UNICEF and DFID - were drawn from the relatively small pool of key development organisations that have been active in the research area of interest within Nigeria for a number of years. More so, when available reports indicate that both donors occupy the top two positions of agencies that have disbursed the highest amounts of ODA in Nigeria since the nation returned to democracy in 1999. Promoting the attainment of better health for the poor – particularly maternal and child health – are identified as crucial areas of intervention for both organisations and they are globally recognised as leading authorities in this field by scholars and practitioners alike. Publications routinely produced by UNICEF, DFID and other development partners have long informed decisions and activities in the maternal and child health sector worldwide. Their high ODA profile in Nigeria (disbursement wise) and long historical relationship with the country (Nigeria was a British colony till independence in 1960) further justified the reason for their selection. Therefore, in terms of depth of commitment, amount of disbursement, duration of involvement and sector-specific interest in poverty reduction and MCH pro-poor development, UNICEF and DFID easily rise to the top of the pack in Nigeria.

3.3 Document Analysis

To a considerable extent, all research projects involve the use and analysis of documents. This is particularly significant as the objective of data collection for this research is sector-specific and MDG-focused, which narrowed the range to only examining materials relevant to the particular set of issues earlier identified (Blaxter et al., 2001). Like many other qualitative approaches, textual analysis depends upon detailed data analysis carried out on

a given body of identified publications in order to focus the study on certain aspects of the identified data set (Silverman, 2005).

The selection of data came about through a snowballing effect (i.e. initial documents referred to other publications relevant to the research area and of interest to the researcher). This process was an effective solution to what might have proved a very difficult challenge of trying to sift through the large body of available literature on the various issues in focus in order to determine their relevance to the research. Referrals from peers and colleagues to the works of certain scholars and authors also eased access to additional information, which complemented what was officially available on the donors' websites thereby enriching the quality of data collected.

3.4 Choice of Data Set

Data sources consist of existing public documents and publications relating to vital research areas such as: human development, human poverty, the MDGs 4 and 5, gender, UNICEF and DFID programme interventions and the role of aid in poverty reduction. A selection of relevant publications from international development organisations, scholarly articles from leading authorities in the research area, the Nigerian government – Ministries, Departments and Agencies - development partners and other NGOs were also assessed in order to triangulate the information produced by the focal donor organisations.

It is considered that by reviewing the range of opinions obtained from multiple organisations, scholars and practitioners involved in the research area, this will provide a strong indication of the pulse of the development community as far as the research objectives are concerned. All documents were carefully reviewed and the researcher tried to remain open and sensitive to all ideas expressed therein as they related to the research objectives. The information gathered from the volumes reviewed was found to be rich and exhaustive and thus the amount of data analysed is considered to be sufficient.

3.5 Analysis, Discussion and Recommendations

The qualitative structure of analysis employed in this research was based on the relevance of the information provided to the issues being explored in this study. Each document was read with as open a mind as possible, with the intention of grasping the overall content. Summaries of the views expressed were grouped into opinions and perspectives which addressed each of the identified research objectives. Points of agreement and variance were noted as well as the prevailing indications under each objective. Mention is made of some paradoxes of development identified by scholars and other organisations; including a range of possible solutions that will chart a way forward in a more effective deployment of development aid to assist the country's quest to reduce poverty through the attainment of the targets of MDGs 4 and 5. The final chapter is devoted to summarising the outcome of this research project, based on analysis of the data collected. It highlights the contribution of the research work to literature by adding to the limited body of independent, MDG-specific assessment of development aid in Nigeria. It provides material to guide policy makers and development practitioners on the need to re-consider how aid interventions are implemented in Nigeria. The research also proffers suggestions that will hopefully re-direct current development efforts from merely promoting a disbursement-based evaluation of ODA to achieving an anti-poverty approach in which donor organisations are held accountable for ensuring that every aid dollar goes the full development mile in addressing the Nigerian poverty challenge.

3.6 Positionality and Limitations

The question of the researcher's positionality in this study is a key factor. Being a Nigerian female and having lived through the negative impacts of the poverty that pervades the Nigerian space, the possibility of a subconscious bias having come through during the review of the documents cannot be overlooked. Qualitative research projects are never asocial, ahistorical events. No matter how objective one seeks to be, it is not possible to leave behind one's hopes, anxieties, blindspots, prejudices, class, gender, race, age emotions, historical positions, location in the global social structure when research is being

conducted (Wengraf, 2002). These factors constitute the status characteristics of all parties involved in the research process. The combination and interaction of these characteristics affect almost every part of the research project and can therefore affect the production of knowledge (Bailey, 2007). This research work is not an exception but deliberate effort was made to minimise the effects of these influences by adopting the measures listed in addressing limitations in Chapter One.

Since some of the data was selected through a snowballing effect, there is a real possibility that a number of the publications could adopt a similar perspective on the issues under consideration. But this 'universality of outlook' was checked by deliberately searching out and also reviewing referenced publications in which the authors challenged or outrightly disagreed with the viewpoint of the 'referencing' publication.

There is a dearth of adequate surveying and monitoring of social indicators at the national level in Nigeria. Most reports on the human development situation in the country are currently prepared by international agencies (incorporating the limited data available from local sources). In order to mitigate inconsistencies over the facts and figures, statistics from various authoritative sources were compared and points of agreement were identified and selected for use in this study. Where comparisons were not possible, clarifications have been provided regarding the researcher's position on the statistics cited.

Due to the researcher residing outside Nigeria during the period when this work was carried out, it was not possible to do field research for verification of data, confirmation of facts, ideas, etc. The dissertation was not checked by representatives of the Nigerian Health Sector but the findings and conclusions were crosschecked through a number of publications produced by reputable scholars, agencies and organisations active in the field of maternal and child health.

Finally, given that this study is the researcher's first individual work of this scope, the level of skill displayed in the selection of the data set, the manner of document analysis and

interpretation of the information provided might leave room for improvement. However, the review and vetting of the research work with the assistance of a much more experienced supervisor and another senior colleague is thought to have mitigated these short comings were possible.

3.7 Conclusion

The methodology adopted for this research is documentary review, involving sector-specific analysis of policy papers, reports and other publications which explores a number of issues relevant to the research. This research sets out to obtain a realist perspective on the effectiveness of development aid in addressing Nigeria's poverty challenge and the range of available data related to the specific interests of the study is considered adequate.

The selection of data sets largely came about through a snowballing effect with publications referencing the works of other scholars and research bodies considered to be relevant to the researcher. This served to ensure ease of access to equally competent sources of information, enriching the quality of data collected. The use of documentary review extracted information which addressed the various research objectives and the amount of data analysed is considered to be sufficient. The next chapter presents the findings from the review of the documents.

Chapter 4: Findings

4.0 Introduction

The Government of Nigeria has expressed the commitment to build a nation in which poverty is history and to achieving this objective by actively collaborating with international development partners; guaranteeing equal access to political, social and economic opportunities for women and men; and to the development of a culture that places premium on the protection of all including children (FMWA, 2006). Available literature suggests that in reality, a number of constraints continue to militate against enjoyment of rights and full participation of women and children on an equal basis with men in national development (FMWA, 2007). As a result, the history of development policies in Nigeria has been that of a general neglect of the gender variable in poverty reduction strategies. The aim of this study is to determine the effectiveness of development aid in addressing Nigeria's poverty challenge assessed on the platform of the human development MDGs – reducing maternal and child mortality ratios (MDGs 4 and 5). This assessment was done through document analysis and a narrowed emphasis on the programmes, projects and activities undertaken by the United Kingdom's Department for International Development (DFID) and United Nations Fund for Children (UNICEF) in Nigeria. It involved extensive exploration of printed and online publications documenting the efforts and impact of these donors towards the attainment of the focal MDGs. This chapter presents the findings.

4.1 MDGs 4 & 5 and the Health Sector Situation in Nigeria

The MDG 4 target calls for a reduction by two-thirds of the under-five (U5) mortality rate between 1990 and 2015. "The U5 mortality rate is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year to die before reaching the age of five if subject to current age-specific mortality rates" (cited in UNICEF, 2008, p. 3). Research shows that child mortality is closely linked to poverty and that advances in child survival have come slowly in poor countries and to the poorest people among them. A 63-nation analysis in developing regions of the world showed that child mortality is considerably higher among children living in rural areas and in the poorest households (UNICEF, 2008).

Maternal mortality ratio is defined as the number of maternal deaths per 100,000 live births. The MDG 5 target calls for a reduction in the maternal mortality ratio by three-quarters between 1990 and 2015. Here again, available data show that maternal mortality is highest in sub-Saharan African countries and Nigeria is a key contributor to the numbers (UNICEF, 2008a).

Nigeria's health situation is often described as being deplorable (FMoH, 2006). In a 2006 UNDP Report, the country was ranked 155th out of 177 countries in health status. Nigeria has one of the highest infant mortality, under-five mortality and maternal mortality rates worldwide and the grim statistics tell the story:

- Infant mortality rates is estimated at 100/1,000 live births
- Under-five mortality rate is estimated to be 201 deaths/1,000 live births
- Maternal mortality rate is put at 800 deaths/100,000 (year 2000) - for every woman that dies there are at least 20 others who come through pregnancy and child birth with severe disease and disability, often with lifetime consequences (FMoH, 2006; DFID, 2007c)

- Nigeria has over 10 per cent of all under five and maternal deaths globally – more than 1 million newborn, infant and child deaths and more than 50,000 maternal deaths every year[2] (PMNCH, 2007)

This state of affairs is among the worst in Africa and has not improved considerably in the last decade – actually reports indicate that things have worsened in some parts of the country, particularly in the northern region (PMNCH, 2007). The situation is clearly indicative of a major dysfunction in the provision of primary healthcare services and has spurred the development of a number of programmes and services aimed at redressing these issues but the impact of such vertically implemented efforts have been limited. Available data show that Nigeria's plight has not always been this dismal. In the early 1990s, the country accomplished significant improvements in child survival programming and attained some of the highest immunisation rates in Africa. Decades of increasingly corrupt military dictatorships truncated that progress and the continuing failure of the health system after almost a decade of democratic rule, is indicative of the lack of political commitment to redress this anomaly. The need becomes even more significant given that with Nigeria's huge population (approximately 2.5 per cent of the global population), the health situation in the country makes it a major factor in the global achievement of MDGs 4 and 5.

In the 2007/2008 Human Development Report, Nigeria is placed 158th out of 177 countries ranked in the Human Development Index (HDI). A comparison of trends in maternal and U5 mortality ratios between Nigeria and the six countries ranked closest to it (the three countries before and the three countries after it on the HDI) paints a revealing picture as Figures 2 and 3 below portray.

[2] These PMNCH figures seem exaggerated, but the trend is clear. Nigeria has a population increase of 2.2% = ~3 million new born per year, and a U5 mortality of 200/1,000,resulting in 600,000 children to die per year. An awful figure, but far away from "more than 1 million"; calculation for maternal deaths amount to 24,000 (on the 800/100,000 basis) or 33,000 (1100/100,000). Again, the situation is inacceptable but calls to question the PMNCH statistics.

HDI Ranking 2007/2008

155. Gambia
156. Senegal
157. Eritrea
158. Nigeria
159. Tanzania, United Republic of
160. Guinea
161. Rwanda (UNDP, 2008)

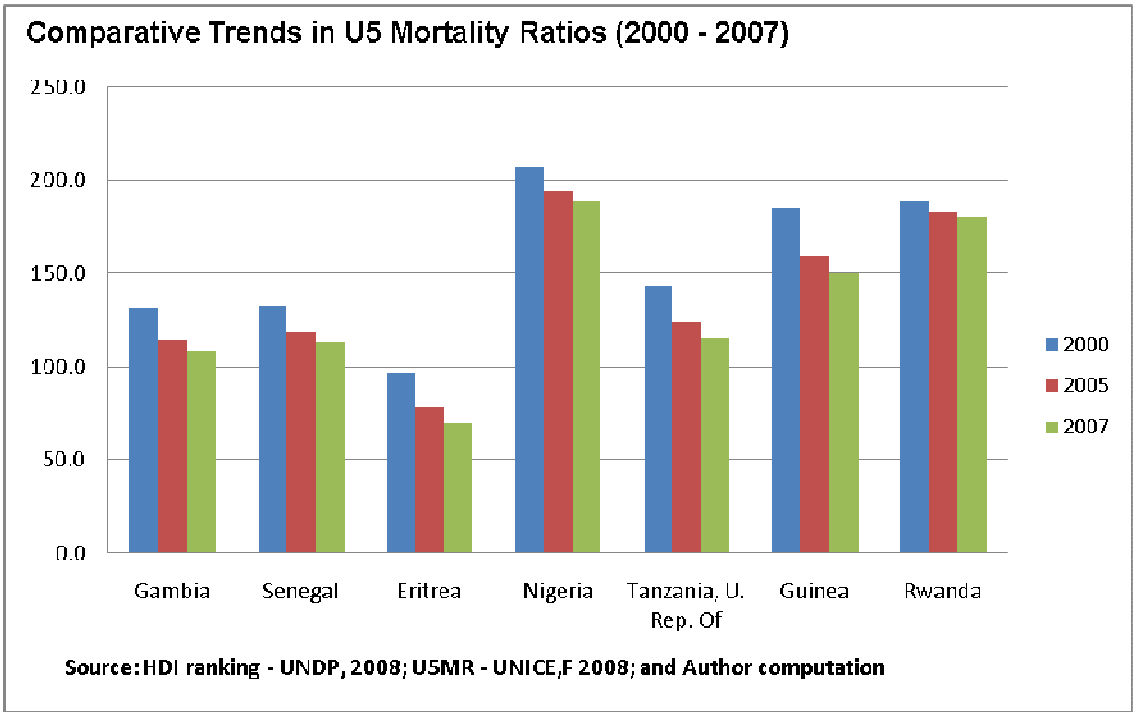


Figure 2: Comparative Trends in U5 Mortality Ratios – HDI Ranking

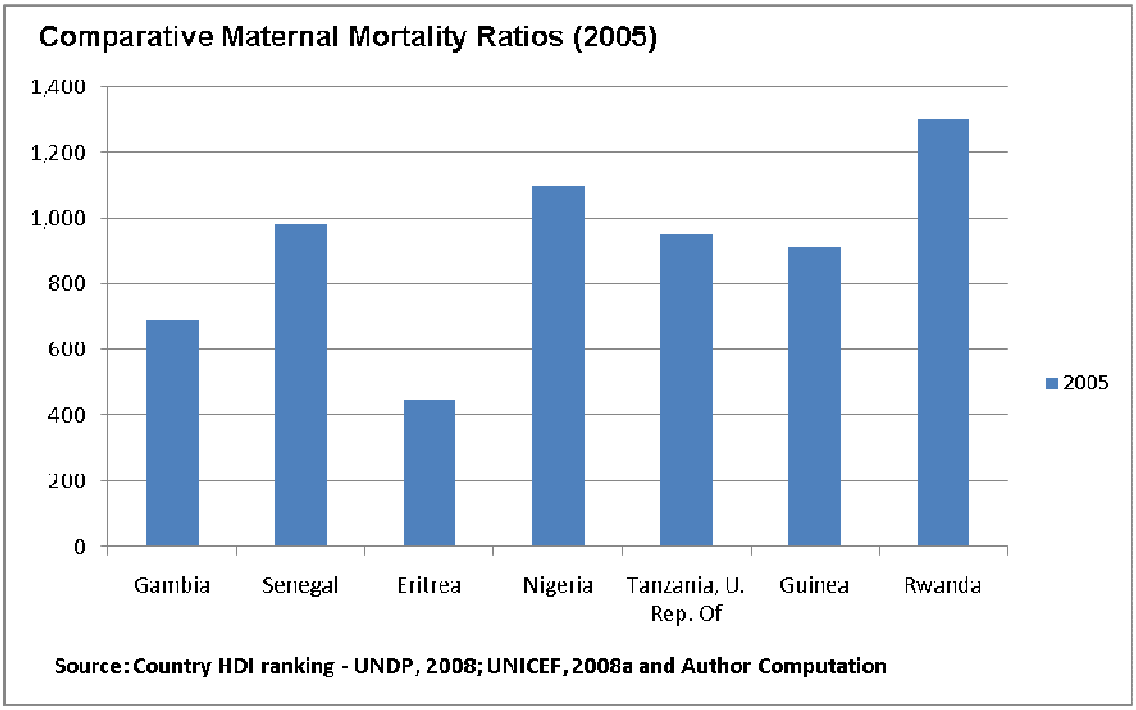


Figure 3: Comparative Maternal Mortality Ratios – HDI Ranking

Given Nigeria's huge population, these ratios translate to considerable figures in absolute numbers. For example the MMR of 1,100 = 59,000 maternal deaths in 2005 alone. It becomes evident that any made progress in Nigeria towards achieving substantial reductions in maternal deaths and child mortality ratios, will considerably lighten the burden faced by Africa and the rest of the world in achieving the MDGs (PMNCH, 2007).

A current thinking with the nation's health sector favours the adoption of an integrated maternal-newborn-child health intervention (IMNCH) that will see a more holistic continuum of care provided for women, newborns and children. The Nigerian Government, on its part has introduced a number of policies and programmes, which include: the National Health Insurance Scheme; Baby Friendly Initiative; Safe Motherhood; National Programme on Immunization and the Integrated Management of Child Illnesses. The country is also an active participant in the global Campaign to End Fistula, launched by the UNFPA in 2003 in response to an emerging body of evidence on the negative impact of obstetric fistula on

women's lives. The programme covers 45 countries located in sub-Saharan Africa, South Asia and some Arab states (UNFPA, 2003).

Poverty is closely associated with poor health and a vicious cycle quickly develops as ill-health becomes both a cause and a consequence of poverty. There are huge discrepancies between rich and poor countries, and even between the rich and poor within developing countries. Maternal mortality rates is seen as the most vivid illustration of the divide between the rich and the poor; highly sensitive to the poverty divide between and within nations (DFID, 2000).

4.2 The Impact of Gender Relations on MDGs 4 and 5

Equal gender relations are the key principles in the distribution of valued resources in any society. Gender inequality generally manifests as a pervasive division that channels access to social and economic resources away from women and towards men (Ahmed, 2004). The high incidence of poverty among women is associated with unequal access to productive resources and control of assets. This, in addition to poor health, lack of education, personal insecurity and limited participation in public life, result in the double disadvantage of poor women: 1 - because of their poverty; and 2 - because of their gender. This perpetuates gender inequality (DFID, 1997).

> *"It is difficult to exaggerate how vital gender equality is. It has nothing to do with political correctness, but everything to do with justice. It is not about tinkering with social conventions, but about unlocking more than half the world's poorest people from being trapped in poverty" (cited in DFID, 2007a, p. 31).*

A focus on poverty will necessarily mean a focus on women. In most nations of the world, females represent about fifty percent or more of the population and yet the fact of their profound marginalisation and vulnerability has remained the bane of global development (Wiest et al., 2004). Most women all over the world share a common feature of marginalisation in many spheres of life (Igbuzor, 2005). Poor women bear a disproportionately high burden of maternal mortality and morbidity and this is traceable to the lack of empowerment of women in accessing

healthcare. Their inability to exercise free choices that affect their own health and reproductive activities has far-reaching consequences for the women and for the well-being of their children. Maternal death or permanent disability places the welfare of her dependent children in considerable jeopardy (DFID, 2000).

The contributions of women to economic development are globally recognised. For example, it is known that "in rural Africa it is women – not trucks, not trains, not planes – who carry two-thirds of all goods that are transported" (cited in DFID, 2007a, p.1). Despite such barefaced examples, evidence abounds which indicate that mere recognition has not been enough to achieve gender equality and that past promises by nation states to address gender inadequacies have not been kept (Birdsall et al., 2004).

"Gender inequality... in the wider society, has multiple causes, which tend to keep reinforcing one another unless **integrated efforts** are made to **tackle all** of them." (cited in Swainson et al., 2003, p. 4)(Author emphasis). Gender-neutral policies continue to undermine development (Obbo, 2005), and the socio-cultural fabric of a country or state must ensure equality of women in all areas of life (Mitra, 2007). The drive to achieve gender equality can no longer be considered an 'optional extra'; and in many countries who report progress in this area, evidence shows that this is still stronger at the policy level than at the programming level (Randel et al., 2000).

"The world is unequal and it is most unequal for women and girls. Most of the poorest people in the world are women and part of what makes them poor is the discrimination they face purely because of their gender" (cited in DFID, 2007a, p. 1)

The effectiveness of development policies is fundamentally undermined by gender inequalities and development assistance programmes have been implicated in the promotion of the gender bias against women. The programmes have been criticized for perpetuating the bias, not directly, but rather out of expediency by inadvertently reinforcing a deeply ingrained notion of sexual difference that is part of paternalism. This bias has found

comfort in the patriarchal attitudes and patronage of many societies needing assistance (Wiest et al., 2004).

In Nigeria, gender relations are biased against women and this increases inequality and the feminisation of poverty (NPC, 2006). The overarching reason for the shortcomings in meeting the MDGs in Africa is traceable directly to the failure of government policies and their implementing mechanisms to adequately address these gender dimensions of inequity (UN, 2007b; Simwaka et al., 2005).

4.3 The Work of the Selected Donors on MDGs 4 and 5

Box 1: Headlines

- "Maternal mortality remains unacceptably high in DFID-supported countries and access to skilled attendance is low
- The main barrier to improving maternal health remains poor access to good quality, comprehensive health services
- Maternal health has long been neglected and underlying the failure to act are broader social, cultural and political factors: the low status of women; the failure to fulfil their sexual and reproductive rights; and the lack of political commitment to address the problem" (cited in DFID, 2007c, pp. 3 – 4).
- "Research has shown that around 80 per cent of maternal deaths could be averted if women had access to essential maternity and basic health-care services
- There are also basic factors such as poverty, social exclusion, gender discrimination and political insecurity that serve to entrench the direct and underlying causes of maternal and newborn mortality and morbidity" (cited in UNICEF, 2009, pp. 5 – 6).

4.3.1 The United Nations Children's Fund (UNICEF)

UNICEF considers maternal mortality to be one of the world's most neglected problems and an area in which progress on reducing the mortality ratio has been far too slow. Of the over 500,000 women who die globally because of complications related to pregnancy and childbirth, almost half are in sub-Saharan Africa. The high death toll is a direct consequence of limited or no access to health care and the poor quality of care where it is available. Closely linked to this problem are the gloomy child mortality statistics. Records show that of

all the children born alive globally in 2007, 9.2 million of them died before their fifth birthday and most of these children lived in the developing countries (UNICEF, 2008).

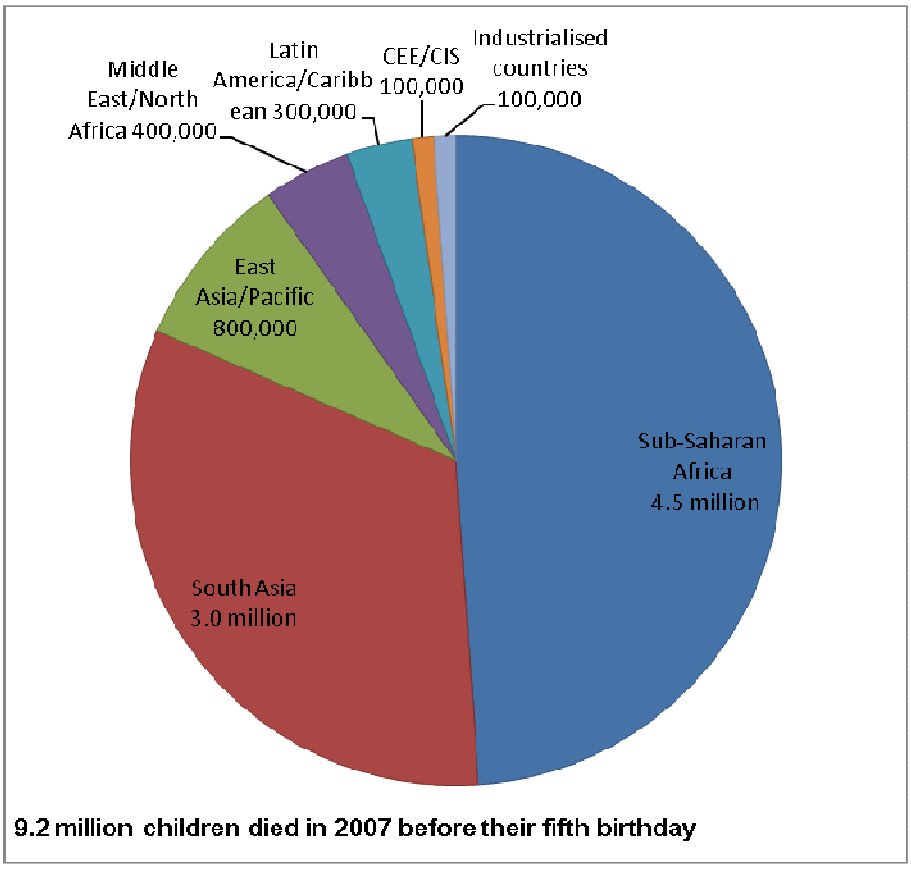


Figure 4: Distribution of Child Mortality by Region (2007) *Source: UNICEF, 2008*

Poverty, inequity, women's low status and attitudes towards women and their needs are some of the underlying factors which exacerbate the situation. The lack of progress on maternal health has implications for global human development and the continued high risk faced by sub-Saharan women is considered an infringement of the human rights. What is more disheartening is not only that the causes of maternal mortality and morbidity are so clear (and so are the means to combat them), but that these problems have remained unaddressed for so long. UNICEF concludes that this can only be a direct outcome of women's disadvantaged social, political and economic status in many societies (UNICEF, (2008b).

The list of countries with the most maternal deaths predictably tilts towards those with the largest populations of poor people and Nigeria features prominently in this group. Although global estimates suggest a 5.4 per cent reduction in maternal mortality between 1990 and 2005, there has been no substantial progress in sub-Saharan Africa and West/Central Africa fare the worst (see Figure 5 below).

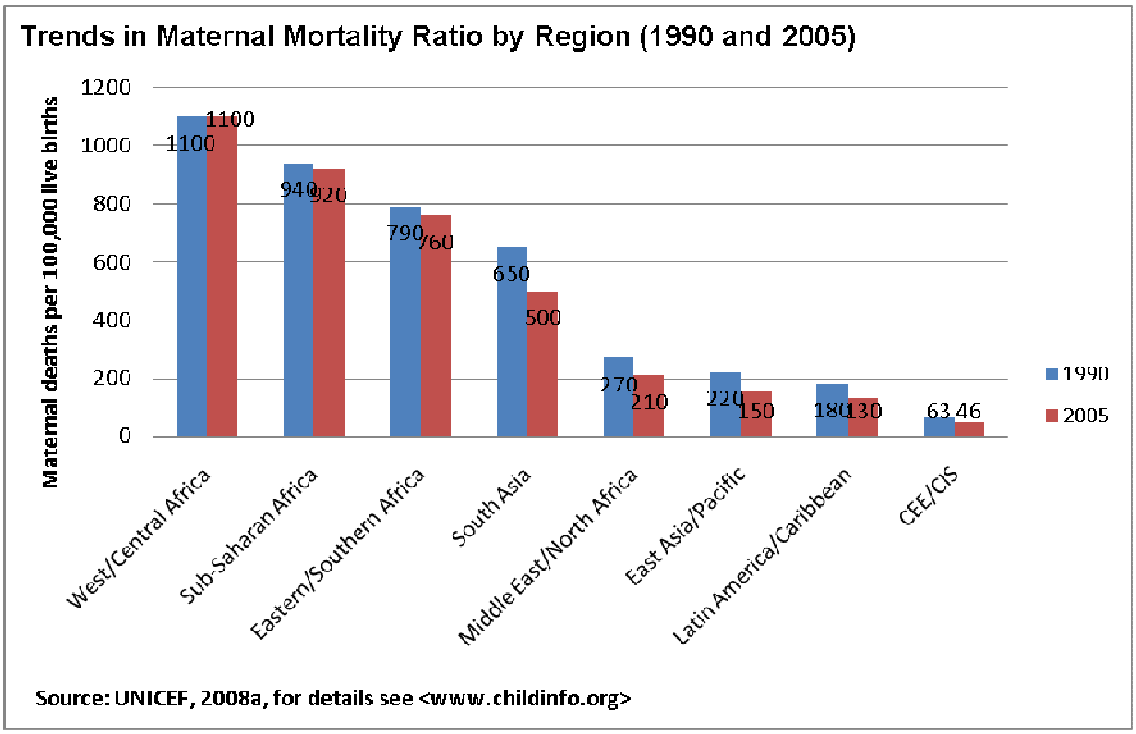


Figure 5: Trends in Maternal Mortality Ratio by Region

West and Central Africa account for more than 30 per cent of global maternal deaths and within this sub region, Nigeria, Niger and the Democratic Republic of Congo produce two thirds of the figures. These three countries jointly account for approximately 20 per cent of the global total of all maternal deaths (UNICEF, 2008a). Given that the DRC has been embroiled in a long drawn out war for decades and that Niger has been facing intermittent drought for almost as long, one might understand the indices from those nations. But, Nigeria? The situation gives utmost cause for concern.

A recent publication by the National Planning Commission (NPC) of Nigeria, reviewing the performance of overseas development assistance (grants only) in Nigeria from 1999 - 2007, based on donor records (those who participated in the exercise) indicate that there are twelve major donor countries/agencies supporting Nigeria. The largest contribution came from the UN System ($5,593,285,438 for the period under review), and within the UN, UNICEF is the biggest contributor having provided 41 per cent of the total disbursed grants. UNICEF's leading contribution is followed by DFID who provided 17 per cent of disbursed funds. Interestingly, the health sector featured prominently as the major sectoral recipient of donor funding (NPC, 2008a). See Figure 6.

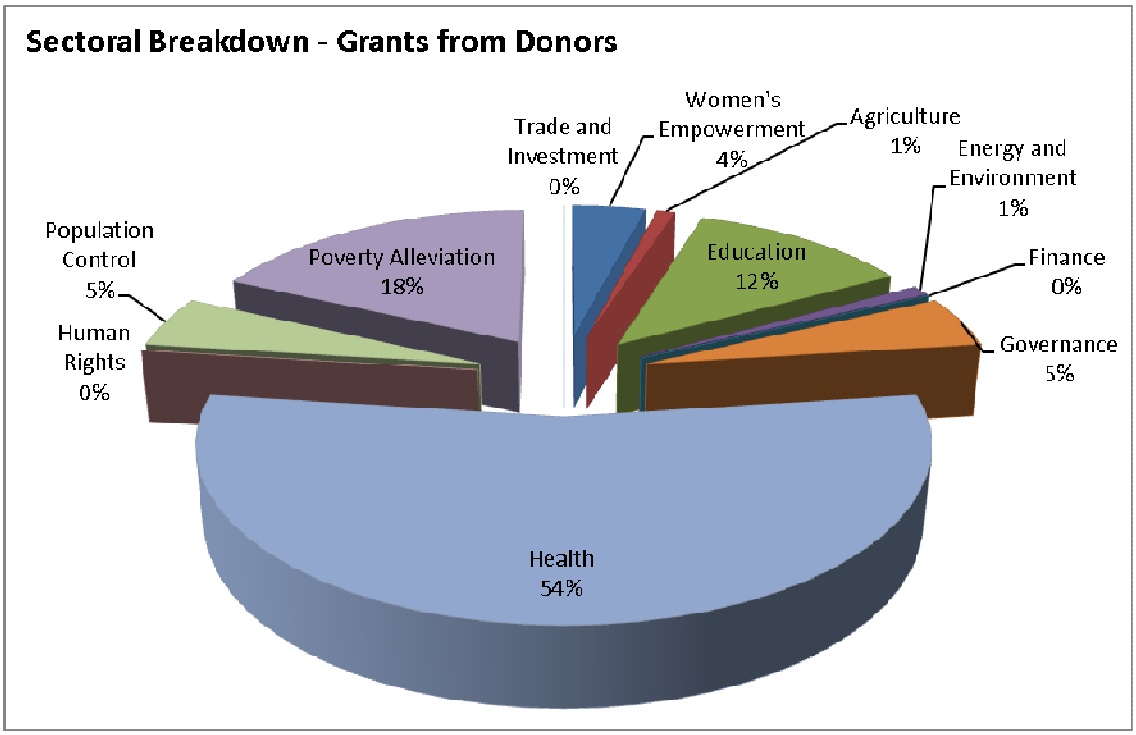


Figure 6: Sectoral Breakdown of ODA in Nigeria (1999 – 2007)

Source: NPC, 2008a and Author computations

Almost all the donors operating in Nigeria feature in the health sector as shown in the breakdown of disbursed funding in Table 2 below:

Table 2: Breakdown of Health Sector Grants (1999 – 2007)

Health Sector Breakdown – Grants			
Donor	**Focus**	**Amount**	**Amount %**
EU	Immunisation	83,572,896.00	6.56
UNDP	HIV/AIDS	8,785,772.50	0.69
USAID	HIV/AIDS	246,138,791.00	19.32
	Malaria	11,678,124.00	0.92
	Maternal Health	16,937,947.00	1.33
	Reproductive Health	44,991,427.00	3.53
WHO	HIV/AIDS	3,969,368.00	0.31
	Malaria	1,361,216.00	0.11
	Other	64,672,862.00	5.08
UNICEM	HIV/AIDS	120,000.00	0.01
UNICEF	Unspecified	578,737,141.00	45.42
CIDA	Unspecified	129,120,000.00	10.13
DFID	Unspecified	84,100,000.00	6.60
Total		**1,274,185,544.50**	**100.00**

Source: NPC, 2008a

UNICEF clearly leads all other donors in the ODA amounts disbursed in Nigeria's health sector in the last decade but the exact detail of how the funds were spent was not specified in their response to the NPC enquiry.

4.3.2 Department for International Development (DFID)

"DFID's aim is the elimination of poverty in poorer countries" (cited in DFID, 1997, p. 19). Globally, DFID is seen as a leading advocate in the area of promoting improvements in maternal health and has developed a strategy specific to that objective. DFID identifies access to good quality comprehensive health services as the main barrier to improving maternal health. The organisation also considers maternal deaths as just a tip of the iceberg – stating that for every maternal death, reports show that there are at least 20 additional women who suffer serious pregnancy-related complications that can cause lifelong

disabilities. DFID is therefore committed to ensuring that maternal health, nutrition and antenatal care is considerably improved in order to ensure the health and survival chances of both the mother and the newborn (DFID, 2007c). As an active member of the global Partnership for Maternal, Newborn and Child Health (PMNCH), DFID identifies the need for the political will to tackle the problems; improvements in the status and rights of women, as well as increasing all women's access to essential maternal health services as areas of priority concern. The organisation recognises that the failure to assure women's rights underlies the high levels of maternal death and disability. Other manifestations of the problem include: poor access to information and care; restricted mobility, women's low status and heavy physical workloads and the low political priority and resources given to their health. In order to overcome these problems would mean challenging the cultural and political norms and legal frameworks that limit women's ability to make informed choices about, and take appropriate actions to ensure healthy sexual and reproductive lives (DFID, 2008a).

In Nigeria, DFID's work in the health sector is executed on six platforms:

Table 3: DFID Nigeria Current Programmes

Programme Duration and Cost	Programme/Project Focus	Collaborating Government Agencies/States
Partnership for Transforming Health Systems (PATHS) £56m over 6 years (June 02 – June 08)	Promotion of sustainable health benefits for the poor by addressing the deep-seated systemic constraints to effective health service delivery. There is an explicit focus on areas that will have maximum impact on reducing child and maternal mortality	Federal Ministry of Health, Jigawa, Kano, Kaduna and Enugu States. Exited from Ekiti and Benue States
Health Commodities and Equipment Procurement (HCP) £30m over 4 years (Mar 05 – Feb 09)	Provision of drugs and equipment to State Government and NGO health facilities, in conjunction with the system strengthening work being done by PATHS. The project includes the strengthening of sustainable procurement and logistics systems.	Kano, Kaduna, Enugu, Jigawa States and FCT. Exited from Benue State
Health Reform Foundation of Nigeria (HERFON) £3.5m over 4 years (Feb	Support to HERFON (an NGO) a leading "think-tank" whose core objective is health reform. HERFON is constituted to promote, facilitate and monitor sustainable reforms towards better	

05 – Jan 09)	health outcomes for Nigerians	
Save the Children Fund (UK) Nigeria £3.6m over 4 years (June 06 – May 10)	Rehabilitation of primary health care delivery services in three local government areas in Niger State, including the initiation of HIV/AIDS care and support	Niger State
Revival of Routine Immunisation in Northern Nigeria (RI) £20m over 5 years (Oct 06 – Sept 11)	Support for the re-establishment of routine immunisation services in several low-coverage States in the North of the country	Jigawa, Katsina, Yobe and Zamfara
Malaria Project £50m over 2007 – 2011 Contract being issued in Nov 07)	This will support the National Malaria Programme and include expanded support for marketing Insecticide Treated Nets nationwide, using a total market approach. The project will be expanded to cover other areas of malaria control, including treatment, prophylaxis and operations research.	

Source: DFID, 2007b

Box 2: Health systems strengthening in Nigeria

DFID provides £55 million to the PATHS Health Systems project to improve the quality and management of health services, increase consumer awareness and strengthen the oversight role of the government in partnership with six state governments. This has led to significant improvements in immunisation coverage, attended deliveries and uptake of emergency obstetric care.

In Jigawa, Safe PATHS provided funds through the Ministry of Health to improve maternity, laboratory and operating equipment for eight facilities. Fifteen midwives were trained to train additional midwives. The initiative worked closely with communities to select emergency transport drivers to provide free transport in collaboration with the State's Road Transport Workers Association.

PATHS also established a network of "Community Identifiers" to link emergency cases to Safe Motherhood Centres. The cost of emergency obstetric care was tackled through an emergency loan fund that uses an existing scheme in the villages to which everyone contributes.

Key to the success of the Safe Motherhood Initiative is the **partnership** formed with local Islamic religious leaders whose support is essential in breaking down the barriers to women attending hospital. Most Imams now make the case to husbands unwilling to let their wives to go to hospital and also publicise the benefits when lives are saved.

In less than a year, the numbers of women in the two pilot Emirates attending hospital for emergency obstetric care has risen by 50%. A £16 million extension of this project is planned for 2006.

Source: cited in DFID, 2007c, p. 13

4.4 Conclusion

The findings of this study reveal that considerable activity has been recorded over the years in Nigeria within the primary areas of focus of the MDGs 4 and 5 – reduction in maternal and child mortality ratios. The health sector in Nigeria is the highest beneficiary of overseas development assistance, receiving three times more funding than the second highest benefiting sector between 1999 and 2007. UNICEF emerged the lead donor in contributions and disbursements for both the health and poverty alleviation sectors. DFID is considered a leading advocate in the area of improving maternal health. Several policies, programmes and related interventions have been initiated by the Government of Nigeria to improve maternal and child care within the broader context of health sector reform. There has also been no shortage in the number or variation of strategies designed to achieve the goals of MDGs 4 and 5, whether government-led or those initiated by the focal donor agencies. An analysis and discussion of the critical factors identified by these findings as they relate to the research aim and objectives is explored and presented in the next chapter.

Chapter 5: Analysis and Discussion

5.0 Introduction

Reports suggest that the risks associated with initiating any reforms in Nigeria is high and that the working environment is extremely difficult (DFID, 2007d). Donor interventions aimed at promoting the attainment of MDGs 4 and 5 appear to lend credence to this notion. Although available statistics indicates that donors have spent an estimated $568 billion on aid in Africa in the last four decades, the fact of persisting poverty and the increasing vulnerability of the black continent continues to be seen as a global indictment (Easterly, 2006; CFA, 2005; Randel et al., 2000). A number of institutional, political and development processes have been initiated. Efforts to translate these into sector wide strategies remain largely a work in progress and more effort, time and consistency required before the Nigerian poor can declare '*uhuru*'[3]! Implications of the findings presented in the previous chapter as it relates to the research objectives is considered here with a view to generate discussion on what it means for the Nigerian poverty challenge. UNICEF and DFID have invested considerable funds in Nigeria's health sector, but it would appear that under a poverty-efficient allocation mechanism, Nigeria has received far less funding than is required to effectively address her development challenges. More worrisome is the report that donor activities in Nigeria have not kept faith with the Paris Declaration[4] objectives and are implemented outside the nation's budget system. The implications of these and other developments are explored as a guide to the discussions that will follow.

[3] *Uhuru* - Kiswahili term meaning freedom
[4] Paris Declaration – An international agreement endorsed in 2005 by over 100 nations and agencies committing them to principles aimed at improving the effectiveness of development aid.

5.1 Identify key development partners in maternal and child health sector

In the last ten years, a total commitment of $6,277,010,522 has been made to Nigeria as ODA. Of this amount, only about 50% has been disbursed. Instructively, 54 per cent of the total ODA disbursements went to the health sector with almost all donors contributing on one platform or the other. Leading in the total ODA disbursements is UNICEF – providing 41 per cent or $1,346,093,278. Of this amount, UNICEF disbursed a total of $578,737,141 (43 per cent) to the health sector (NPC, 2008a).

5.1.1 UNICEF

UNICEF has been operating in Nigeria since 1953 to address the needs of Nigerian children. The country programme is implemented in all 36 States of the Federation and the FCT. The organisation has four field offices in Kaduna, Bauchi, Lagos and Enugu; and a country office in Abuja. They pursue a 5-pronged programme approach in Nigeria:

1. Survival and Early Child Care programme, which seeks to support Nigeria achieve MDGs 4 and 5
2. Basic Education programme, which targets the achievement of MDG 2 – to ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
3. Water, Sanitation and Hygiene programme
4. Protection and Participation programme addressing development protection and participation among youths
5. Planning and Communication programme focusing on analysing social statistics for advocacy and policy development (UNICEF, 2006; UNICEF,2004).

All UNICEF programmes are represented in at least three Local Government Areas in every State and their Nigerian operations is currently one of the largest UNICEF country programmes in the world (UNICEF, 2004).

5.1.2 DFID

The second highest contributor to ODA disbursements in Nigeria over the last decade is DFID, providing 17 per cent or $559,981,950. Of this amount, $84,100,000 was spent in the health sector during the period under review. Although DFID did not specify the details of this health sector disbursements in response to the NPC enquiry (2008a), other available reports show that DFID's health sector interventions in Nigeria is pursued on six platforms with different implementation cycles as follows:

1. **PATHS**[5] - £56M over 6 years (2002 – 2008)
2. **HCP**[6] - £30m over 4 years (2005 – 2009)
3. **HERFON**[7] - £3.5m over 4 years (2005 – 2009)
4. **Save the Children (UK) Nigeria** - £3.6m over 4 years (2006 – 2010)
5. **Routine Immunisation** - £20m over 5 years (2006 – 2011)
6. **Malaria Project** - £50m over 4 years (2007 – 2011). (DFID, 2007b)

> *"When a woman dies, the chances of her newborn surviving are much lower"* (cited in DFID, 2007c, p. 1)

The £56m DFID commitment to the PATHS programme is the highest programme funding allocation out of its 30 multi-sectoral development interventions in Nigeria; a clear indication of their strong intention to effect changes in this area.

5.2 Impact of health sector interventions on maternal and child mortality ratios

According to the most recent State of the World's Children (SWC) Report released by UNICEF (UNICEF, 2009a), Nigeria is ranked as 8th among countries with the highest number of U5 deaths in the world. In a study, comprising 5,959 registered births in Nigeria in 2007, it emerged that 19 per cent (or 1,126) of those children died within the same year. This development assumes greater significance when one considers that for six consecutive years (1999 – 2004), Nigeria was placed in the 15th position in global U5 mortality rankings;

[5] **PATHS** – Partnership for Transforming Health Systems
[6] **HCP** – Health Commodities and Equipment Procurement
[7] **HERFON** – Health Reform Foundation of Nigeria

it fell to 13th position in 2005 and 2006 respectively; recorded a slight adjustment to the 14th place in 2007; worsened as the 12th country in 2008 until the recent plunging to the 8th position in the 2009 report (UNICEF, 2009a).

UNICEF's operation in Nigeria is strategically set to identify and assist the most vulnerable in the society by implementing concrete interventions at the community level. Directly operating in over 220 communities nationwide, the organisation adopts an integrated approach based on individual assessment of the local situations. Since 2003, UNICEF has been responsible for procuring all routine immunisation vaccines on behalf of the Federal Government of Nigeria. Other impacts of the organisation's activities include:

- Building capacity of Local Government health systems so that outreach services are expanded – UNICEF spends approximately $2 million during each immunisation round
- Support to the National IMNCH strategy inspired by UNICEF's accelerated child survival and development strategy
- Support to national measles immunisation campaign with other partners leading to a dramatic drop in number of reported measles cases in Nigeria for 2006 – 2007
- Support to Immunisation Plus Days with other partners leading to 75 per cent reduction of wild polio virus cases in 2007 compared to same period in 2006
- Increased coverage in excess of 60 per cent in most States in the northern region that had previously reported very low immunisation coverage
- The focus on eliminating iodine deficiency disorders enabled Nigeria to become the first African country to achieve universal salt iodisation
- Significant investments to improve the cold chain supply and provide freezers and fridges, which has impacted positively on routine immunisation (UNICEF, 2004)

DFID's reports on the impact of the PATHS programme include the following successes:

- The numbers of women in two pilot Emirates attending obstetric care rose by 50 per cent
- Significant improvements in immunisation coverage and attended deliveries
- Fifteen midwives trained to train additional midwives
- Establishment of the effective Gunduma health system in Jigawa State
- Support to FMoH in the development of the Health Sector Reform Programme
- Support to the Integrated Maternal Newborn and Child Health strategy
- Major restructuring of health sectors at the State level and increased voice for the poor in managing and demanding accountability for health services (DFID, 2007c; DFID, 2006a; DFID, 2007d; DFID, 2006b; LATH, 2009)

WHO, UNICEF and UNFPA concede that maternal mortality is both difficult and complex to monitor, particularly in settings (like Nigeria's) where maternal deaths are highest and vital registration systems are incomplete, inadequate or non-existent. However, they developed model-based estimates for nations which lack reliable national-level data and this approach adjusts for misclassification and underreporting of data (UNICEF, 2008a). From these reports, the trend in maternal and child mortality ratios for Nigeria over the last decade is presented in Table 4 below:

Table 4: Trends in Maternal and U5 Mortality Ratios (1995 – 2007)

	Maternal Mortality Ratio (MMR)		Year	U5 Mortality Ratio (U5MR)
1995	1,100		**1995**	230.0
2000	800		**2000**	207.0
2005	1,100		**2005**	194.0
			2007	188.8

Source: UNICEF, 2008a

Reports indicate that, inspite of the successes reported by UNICEF and DFID, Nigeria's U5MR and MMR clearly remain a sore point of reference in global statistics and the relative 'improvements' shown in Table 4 above, taper off into insignificance when reviewed from a global perspective (UNICEF, 2008; UNICEF, 2008a; DFID, 2008a; PMNCH, 2007; UNICEF, 2008b; UNICEF, 2009). While the available data would suggest a gradual reduction in the child mortality ratios, the pace of improvement is considered too slow to make any substantial impact in the quest to attain the targets of the MDG 4 and the global ranking of Nigeria's U5MR has actually worsened (DFID, 2000; UNICEF, 2004; UNICEF, 2008; UNICEF, 2009a). The figures for maternal mortality also present a query of sorts. Questions would arise as to the possible explanation(s) for the dip in figures noted for the year 2000 and the reasons for the dramatic rise in maternal deaths in 2005. It is hardly a coincidence that Nigeria's global U5MR ranking also started to nosedive in 2005. Were there actually improvements recorded in MMR prior to this time? Can the improvement recorded in 2000 be supported with verifiable data (DFID, 2007d)? Or can the figure be attributed to the measurement procedures adopted for countries where comprehensive and reliable data is not available at the national level? Other thoughts on the issue are open to exploration.

Furthermore, given the significant disbursements of ODA in the Nigerian health sector in the last ten years (and bearing in mind DFID and UNICEF's stated commitments to promoting maternal and child health care at the basic level), one would question if the resultant 12

percent reduction in U5MR (and the apparent worsening of indices in Nigeria's MMR and global U5 mortality rankings), justify the combined purported disbursement of **$662,837,141** (NPC, 2008a) by both donors in the ten years under review.

This question becomes more pertinent when available reports indicate that Nigeria did not actually enjoy budget support in the last decade; but that all monies being considered here as ODA purportedly "came into Nigeria and were managed and disbursed directly by the donors and **not by the government"** (cited in NPC, 2008a, p. 4). This issue and its implications will be explored further in a later section of this chapter.

5.3 Identify where programme objectives have been less than successful

UNICEF's reports show the variable distribution of the maternal and U5 mortality ratios by region in Nigeria. The North East Zone has the highest maternal mortality rate (presenting almost a 10-fold difference when compared to the South West Zone). The highest U5 mortality rates are also found in the North East and North West Zones of the country. UNICEF's efforts have been considerable and consistent for a number of decades and a major limitation experienced in attaining the targets for MDGs 4 and 5 is identified as the low coverage of effective interventions. Immunisation services are not being delivered to the populations in need at high enough coverage and efforts have been largely fragmented over time (UNICEF, 2004). Also a major set back was recorded in 2003 – 2004 when some northern states suspended their participation in the national immunisation campaign. This led to resurgence of the wild polio virus and throughout 2004, Nigeria had the highest number of wild polio virus cases in the world. Worse still, fourteen other neighbouring African countries that had attained a polio-free status were re-infected by the virus from Nigeria; undoing decades of progress within the continent. Routine immunisation coverage rates are still very low and reports indicate that only 18 per cent of Nigerian children between 18 and 23 months can be considered to be fully immunised. Furthermore, malaria is known to be responsible for 11 per cent of maternal deaths and 25 – 30 per cent of U5 mortality. The use of insecticide treated nets has been found to reduce malarial deaths by about 25 per cent;

yet their use is reported to be only 2 per cent across the nation among the target group. Lack of access; inadequate coverage and poor quality of health care services; poverty and illiteracy all continue to hinder people's access to health care (UNICEF, 2005; UNICEF, 2004; NORAD, 2007)

Reports from DFID concedes that while the PATHS programme has attained some measure of success, there still remains a long way to go in scaling up services and the overall likelihood of sustainability of initiatives remains low in partner States. A review of the work in Benue highlighted the importance of giving attention to developing general management capacity and to ensuring continued recurrent funding. The work in Enugu also experienced operational difficulties arising from early disappointing indications from the public-private-partnership initiative for emergency obstetric care; DFID's informal freeze on inputs; under-financing of the demographic and health survey and other difficult relationships on the ground. A review of progress of PATHS in 2005 also found that there had been very limited progress in improving service delivery on any substantial scale. PATHS responded by scaling up services in most States and a 2006 output to purpose review states that even where service utilisation has improved, overall coverage remained low and the quality of service provided was still a concern. Wider problems continued to limit the attainment of substantial service delivery in Enugu and overall system wide reforms in all States moved very slowly. At the State level, the limited capacity of ministries and other partners to effectively manage initiatives and improvements supported by PATHS was a persistent problem; and underfunding of the health system (particularly the non-wages recurrent elements) remained a big problem at both State and local Government levels. DFID admitted that despite the considerable good work done by PATHS in many areas, Nigeria remains an extremely difficult environment in which to bring about sustainable change in the fundamental problems underlying a poorly performing health system (DFID, 2006b).

5.4 Identify barriers to programme goals and analyse reasons for the challenges

Poverty remains one of the most critical development challenges facing Nigeria today and the rising population growth rates have meant a steady increase in the number of the poor (UNICEF, 2004). Studies indicate a number of barriers which continue to inhibit the attainment of programme and project goals, which are in line with the MDGs 4 and 5 targets – to reduce by two-thirds, the maternal and child mortality ratios. These barriers include:

5.4.1 Poor Governance and Political Will

An analysis of available literature on the fundamental challenges encountered by donor agencies operating in recipient countries, lists poor governance, weak policies and institutional development at the top of the ladder (CFA, 2005; Easterly, 2006). Nigeria is no exception. Insufficient investment levels in Nigeria's infrastructure and basic services are traceable to years of military dictatorship, political instability and poor governance. The high cost and increased risk of doing business in Nigeria is a direct manifestation of institutionalised corruption which made the country unattractive to investors (UNICEF, 2004). Two decades ago the World Bank argued that underlying the litany of Africa's development problems is a crisis of governance (Brautigam and Knack, 2004). It is common knowledge that Africa's development is held back by having the weakest policies in the developing world (Dollar, 1999). For decades, these assertions held true as much for Nigeria as they did for Africa, but in Nigeria changes are taking place.

With the return to democracy in 1999, the development of the NEEDS, SEEDS and LEEDS documents; the passage of the anti-corruption bill; the establishment of the Independent Corrupt Practices Commission and the Economic and Financial Crimes Commission; and sector wide policy reforms in conformity with the 4-pronged thrust of NEEDS, the Nigerian government has clearly demonstrated a break with the past and bold commitment to building a nation where the rights and welfare of all will be promoted and upheld (UNICEF, 2004; Okonjo-Iweala and Osafo-Kwaako, 2007; NPC, 2006a). However, findings indicate that

these recent changes are yet to trickle down sufficiently to drive the pervasive transformations required at the grassroots where the poorest reside.

Maternal and child health prospects in Nigeria continue to be a controversial subject because of the laissez-faire attitude of government and the general populace to the issue. This negativism is predicated on factors which include: ignorance, poverty, apathy, lack of commitment, illiteracy and corruption (Okereke et al., 2005). Challenges remain in the poor quality of institutions, weak rule of law, poor accountability and tight controls over information. Scholars argue that at the heart of the problem is politics and that the solution to this rests in the hands of the people of Africa. Aid projects are known to help the poor when both donors and recipient governments are committed that it should do so (Killick, 1991; Randel et al., 2000; CFA, 2005). Key lessons from several decades of aid indicate that the impact of aid is mediated by the policies and institutions of the recipient government (Lancaster, 1999).

In view of the fundamental and crosscutting effect that challenges in governance pose for the effective implementation of development interventions (and given Nigeria's infamous history in that regard) it is encouraging to note that all donors in Nigeria are present in the governance sector. What is surprising however is that disbursements in the sector amount to only 5 per cent of total ODA expended in the past ten years. Of this percentage, the European Union is the highest donor (providing 73.13 per cent), out of which 51.2 per cent was spent on the 2006 national census exercise alone! It would therefore appear that capacity building in government to address the fundamental and multi-dimensional challenges arising from weak governance and political institutions is the least priority of donors (NPC, 2008a). One would naturally question the rationale behind this level of aid when it is well known that aid is more likely to have its intended impact where governance and policy provide a solid foundation for development (Brautigam and Knack, 2004). Perhaps the manner in which donors have channelled their funding in Nigeria might shed

light on their apparent aversion to the pursuit of rigorous interventions in the governance sector.

In preparing the review of ODA performance in Nigeria from 1999 – 2007, the National Planning Commission (lacking both the capacity and history of such extensive data) relied entirely on data provided by the development partners. Some donors were more cooperative than others in responding to the detailed enquiry but the report clearly states that "as Nigeria does not enjoy budget support, all monies that purportedly came into Nigeria were managed and disbursed directly by donors and **not by the government"** (cited in NPC, 2008a, p. 4). This situation raises a number of pertinent questions:

- Should the government of Nigeria rightly be required to account for resources that side stepped its budget altogether?
- When such significant funds are disbursed directly to the populace as project interventions, to whom will the people owe allegiance for their welfare?
- Where basic services are provided by donors, to what extent can the citizenry hold their own government accountable for budget expenditure and (mis)management?
- To what extent has the high technical assistance component (characteristic of direct project interventions) served to strengthen or erode the capacity of state institutions?
- When donors persist in implementing a 'parallel budget', what incentive does the recipient government have to create a policy environment conducive to increase its own absorptive capacity for additional aid?

The questions abound. Moss et al. (2006) posit that there is a link between loss of accountability and aid particularly in Africa. Considering Nigeria's scenario, it is not difficult to understand why.

What has been obtaining with the aid delivery process in Nigeria in the last ten years would no doubt have created incentives and informal institutions both in the donor organisations

and in the country itself. These incentives and institutions cannot possibly augur well for the strengthening of Nigeria's weakened governance and political systems and will prove quite resistant to change (Brautigam and Knack, 2004); further compounding the nation's development problems. The donors who so frequently urge policy reforms in developing countries clearly need also to reform their own policies and operations in Nigeria (Killick, 1991).

5.4.2 Negative Socio-Cultural Norms and Practices

It is no longer in contention that among the poor, certain groups are more vulnerable than others; experiencing poverty in harsher dimensions. These groups are the women, children and the aged (DFID, 2000; CFA, 2005; UNICEF, 2009). Gender inequality is one of the most pervasive forms of inequality found at all levels in most societies. It also cuts across other forms of inequality, being constructed through both the formal laws and statutes that comprise the official ideologies of a society and its institutions. Gender inequality finds relevance within the unwritten norms and shared understandings of a society and these help shape everyday behaviour in the real world (NPC, 2005). It is the cultural and social traditions which reinforce everyday discrimination in developing countries like Nigeria. Consequently, women, who could be helping to overcome poverty, are denied the opportunity to make that difference (DFID, 2007a). Like race and ethnicity, gender is a social construct which defines and differentiates the roles, rights, responsibilities and obligations of men and women. Nigeria is a highly patriarchal society and men dominate all spheres of women's lives. As a result, Nigeria falls short of the desired, development-oriented result of giving both males and females equal opportunities to advance socially, physically, educationally, politically and economically (FMWA, 2005).

> *"Creating a supportive environment for maternal and newborn health requires challenging the social, economic and cultural barriers that perpetuate gender inequality and discrimination"* (cited in UNICEF, 2009a, p. 7).

DFID has made addressing the gender dimensions of poverty a priority concern in all its development interventions. The organisation recognises the crucial role of women in efforts to end world poverty; viewing the promotion of gender equality as both a moral and a pragmatic argument (DFID, 2007a). In Nigeria, it has formed significant partnerships with local Islamic religious leaders whose support is vital in breaking down the barriers women face in accessing healthcare. This has proved particularly relevant in the northern parts of the country where the maternal and child mortality ratios are comparatively worse, and where religious leaders wield significant influence in the communities. UNICEF is equally vocal in its calls for the Nigerian government to put measures in place to address the deeply entrenched gender discrimination prevalent across the nation. Representatives of the organisation seize every opportunity to raise awareness of the problems and the advantages associated with women empowerment. Notably, UNICEF's efforts under the basic education programme (as anchor donor for the Girls' Education Project in Nigeria) have greatly improved Nigeria's prospects in attaining other MDG targets (UNICEF, 2004; UNICEF, 2008). To establish the required continuum of care, UNICEF outlines 7 areas that require more focused attention in the continued efforts towards improved maternal and newborn health. They include:

1. Enhancing data collection and analysis
2. Expanding the primary and maternal/newborn health-care workforce
3. Mobilising societies
4. Establishing practical, equitable and sustainable financing
5. Investing in infrastructure, logistics, facilities and management capacity
6. Enhancing the quality of maternal, newborn and child care
7. Concerted support and commitment of health administrators, national leaders and international partners (UNICEF, 2009a)

The efforts of both donors in this regard have been highly visible and most commendable in Nigeria. They were also instrumental to the increased participation of women in the last national elections as well as in the development of the National Gender Policy in 2007. However, widespread, tangible change has been very slow and success remains a far-fetched objective within the Nigerian society. It is recognised that reversing the effects of generations of discriminatory practices against women and correcting the social bias in upbringing has no quick fix that can be attained in a generation. Such systemic changes are gradual and long-drawn out and the solution is to sustain and deepen commitment to confronting the challenges on all frontiers (cultural and political norms, and legal frameworks that fetter women); ensuring that the voices of women are not only heard, but that women take their rightful place in making the decisions that affect them, their communities and their country. This is considered the ultimate solution to defeating poverty (DFID, 2007a, UNICEF, 2009; DFID, 2000; UNICEF, 2008b; DFID, 2007c).

5.4.3 Non-adherence to Principles of the Paris Declaration

The Federal Government of Nigeria (FGN), the United Kingdom (home government of DFID) and the United Nations System are all signatories to the Paris Declaration, signed in 2005; committing donors and recipients to principles aimed at achieving improved aid effectiveness. The commitments focus on Ownership; Alignment; Harmonisation; Mutual accountability; and Management for development results.

In recognition of the role of an enabling policy environment in enhancing development, the FGN has made considerable efforts since 1999 to initiate and implement reforms; in addition to producing policy documents articulating their vision and providing legal backing to development efforts. The NEEDS document, the Health Sector Reform Policy and the 2007 policy on Official Development Assistance are good examples. The UK

> *"Without actions to address gender discrimination and inequities that are perpetuated against women and girls, actions to support enhanced primary health care risk being much less effective, sustainable or even possible"* (cited in UNICEF, 2009, p. 6).

Government, DFID and UNICEF publications are quite clear in their stated intentions to cooperate with and lend support to the leadership provided by the Nigerian government in achieving poverty reduction and other development goals (UNICEF, 2004; DFID, 2000; DFID, 2008). However, given the manner in which ODA has been disbursed in Nigeria in the last decade, the actions of the donors remain largely at variance with the Paris Declaration's principle of ***ownership.*** In side stepping the Nigerian budget completely (NPC, 2008a) it is quite difficult for the country to claim ownership of the development process that has been pursued with these disbursements. One might wonder what persuasions inform the decisions and actions of the donors:

- Are they guided by the notion that institutional weakness in developing countries often entrench the exclusion of the intended beneficiaries by funding hospital services which the really poor hardly access? (DFID, 2000; UNICEF, 2004; Castro-Leal et al., 1999)

- Are they trying to ensure that inequalities in health within recipient countries are minimised by offering assistance directly to communities? (UNICEF, 2004; Mosley, 2002; Morrissey, 2004)

- Should their actions be interpreted as a vote of no confidence in the leadership of the FGN to effectively implement development objectives? (Brautigam and Knack, 2004)

The considerable technical assistance component of the PATHS programme also calls to question how effective such a procedure has been in strengthening the weak health care system. DIFD states that the programme goal of PATHS "**is that Nigeria's own resources are used efficiently and effectively to achieve the MDGs"** (cited in DFID, 2008, p. 8)(Author emphasis). If this objective had been resolutely pursued, could it have led to mitigating the repeated concern expressed by DFID in its annual review (2006b) over the poor general management capacity at the local level to carry on interventions initiated under PATHS? Again, given that inadequate resource allocation and underfunding of the health

system was a long existing, and clearly identified problem at the time of donor intervention, one wonders what justification there could be for implementing programme cycles which entailed pulling out from States at a point when the likelihood of sustainability of initiatives remained low (DFID, 2006b). Is it possible that donors are still more focused on evaluating their programmes based on amounts disbursed rather than on the sustainable results achieved on the ground? (Easterly, 2002a). What purpose can be served by terminating a programme; designing a follow on programme (which includes a similar heavy technical focus) when such a process poses the unavoidable(?) risk of discontinuity in content and of a time gap between programmes? (DFID, 2007d). While technical assistance might have proved useful in certain contexts (DFID, 2006a), it sometimes considered a systematic destructive force which undermines the development of local capacity; since most of it is imposed and the demand for it is has been found to be largely on the donor side (Brautigam and Knack 2004). Scholars argue that international, local and government agencies should pool resources with a view to pursue a comprehensive maternal and child care policy with practical steps for a **long-term plan in Nigeria** (Okereke et al., 2005)(Author emphasis).

Instructively, on the issue of ***alignment*** of aid (so that it supports partner country priorities and plans and is channelled through country planning and financial systems), the NPC review emphasises Nigeria does not enjoy budget support. Furthermore, given the high priority accorded to needs in the energy and agriculture sector by the FGN, this priority is not reflected by donors' attention and involvement. Both sectors have received only 1 per cent of ODA disbursement respectively in ten years. The NPC concludes that the flurry of activities witnessed amongst donors operating in the various sectors of Nigeria's development has not succeeded in achieving any significant impact on the host community because the average amounts expended in each sector have been so small (NPC, 2008a).

For ***mutual accountability*** to be effective, a uniform, IT-driven development cooperation assistance management platform is required, but currently lacking in Nigeria. Owing to inadequate surveying and monitoring of social indicators at the national level, most reports

on the human development situation are currently prepared by international agencies (incorporating the limited data available from local sources). This has sometimes led to disputes over the facts and figures; such as the recent contention of the maternal and U5 mortality statistics assigned Nigeria in the 2009 SWC report published by UNICEF. At the launching of the report in Abuja in February 2009, the wife of the Nigerian President contested the health indices assigned to Nigeria. Nigeria's Minister of Information and Communication equally noted that reports she received from hospitals visited in the recent past indicated facts contrary to what UNICEF had presented about Nigeria (Daily Independent, 2009).

In order to achieve improved aid effectiveness, the position of the current administration in Nigeria is to use development funds to make progress and not to simply support good programmes aimed at the MDGs. The intention is to achieve progress by leveraging reforms within government itself, so that progress represents fundamental and durable change and not just the use of money to deliver (short term) results (PMNCH, 2007). It would appear that the view of donors operating in Nigeria remains at variance with this government objective.

The review conducted by the NPC revealed donor commitments in the form of grants to Nigeria in excess of $6 billion over the last ten years. While this figure might appear substantial at face value, a review of global aid allocations under Collier and Dollar's (1999) poverty-efficient perspective easily reveals that, given her considerable population of poor people, allocations to Nigeria have not been poverty-efficient and Nigeria is considered the most under-aided country in Africa (Moss et al., 2006; Jones and Kotoglou, 2005; NPC, 2008a; DFID, 2008b). Other scholars class the nation as an 'aid orphan'. An "aid orphan" is defined ... as a country "that receives (substantially) less aid than it should in comparison with what its share of aid would be under a globally optimal allocation of (a given level) aid" (cited in Jones and Kotoglou, 2005, p. 2). Baulch (2003) similarly finds that the three countries (Nigeria, India and China) who together account for 64 per cent of the world's poor receive considerably less aid than would be merited by their populations and absolute

poverty levels. The lack of an enabling policy environment and difficult operational environments has often been advanced by donors as reasons for limited interest in Nigeria (DFID, 2006b), but Randel et al., (2000) argue that even in situations where the policy environment might be considered sub-optimal (for a poverty efficient allocation of aid, say), an anti-poverty approach to aid allocation demands that poverty be addressed even in the most difficult situations. Easterly (2002) similarly argues that aid agencies will even have to work with local elites and problematic local government institutions who might not be committed to seeing their society achieve poverty reduction.

Whichever direction the argument flows, there is no downplaying the fact that Nigeria's poverty situation is a very significant factor in the global quest to reduce poverty and attain the MDG targets. Baulch's questions therefore remain as relevant today as they did when he first asked them in 2002:

"Why do all donors give considerably less money to the three most populous poor countries – India, China and Nigeria – than their contributions to the global poverty head count suggest should be given? Is it reasonable to exclude Nigeria's poor from international development assistance because of its governance record?" (cited in Baulch, 2002, p. 13)

Whatever the answers may be, it is certain that failure on the part of the international donor community to collectively and forcefully address the Nigerian poverty challenge through adequate and sustained funding levels has placed global progress towards achieving the 2015 target date in considerable jeopardy.

5.4.4 HIV/AIDS and Other Social Factors

DFID (2008c) reports that more than 33 million people globally live with HIV. Women make up almost 67 per cent of those living with the condition in Sub-Saharan Africa. Worldwide, 90 per cent of HIV infections are contracted either through sex or mother to child transmission. This becomes worrisome, particularly in the more conservative and religious communities of northern Nigeria (with the highest maternal mortality rates) where polygamy, the low

utilisation of contraceptives and women's inability to negotiate safe sex often to lead to one man infecting many women and many women infecting many children with the virus (Ujah et al., 2001; Lindroos, 2004). There are a number of prevention methods which can reduce the risk of mother to child transmission – such as antiretroviral care, caesarean section delivery and bottle feeding – but these are often quite expensive and unaffordable; and poor access to potable water complicates the alternative feeding option.

Inadequate access to and poor quality of health facilities have not helped address the prevalence of other social characteristics indicted in generating high maternal and child mortality ratios. These factors include:

- Reliance on traditional birth attendants and faith healers. 69 per cent of Nigerian women still give birth at home or in a church (to ensure protection from witches and other evil forces). Traditional birth practices persist in the rural areas and are neither equipped to provide emergency obstetric care nor do they always operate in the sterile conditions required in labour and delivery (Umeora et al., 2004; Abdul'Aziz, 2008; Lindroos, 2004; Tukur et al., 2008)

- Female genital mutilation (FGM) and early marriages – justified as a means of preserving the 'honour' and 'chastity' of women before and during marriage, the various forms of cutting and the associated bleeding, infection and scarring from FGM are major risk factors for obstructed labour; leading to fistula and stillbirth in many cases. Early marriages are a means of reliving the financial burdens of parents, supported by the taboo that a girl must not menstruate in her mother's house (Ujah et al., 2001; Umeora et al., 2004; Tukur et al., 2008; UNFPA, 2003; Lindroos, 2004).

- Religious and cultural myths – deep-rooted cultural myths and misinterpretation of religious doctrines impede progress in achieving the behavioural change required to improve maternal health. In some areas it is believed that a pregnant woman eating

chicken leads to the child becoming a thief; that prolonged labour is an indication of a woman having been unfaithful; and that women cannot seek medical care without the permission of the husband. Such beliefs combine to deny women access to adequate nutrition and delay the decision to seek obstetric care when complications arise (CEDPA, 2007; Abdul'Aziz, 2008; UNFPA, 2003).

5.5 Identify what must be done to address the challenges and ensure progress

Reviewing the impact of public social spending in Africa and to what extent the poor benefit from this, Castro-Leal et al. (1999) find that allocation of spending across services within the health sector usually does not favour the poor. The poor generally do not patronise hospital-based services to which government expenditure tends to allocate significant shares of their health budgets. In order to achieve a pro-poor health target, therefore, it might prove more effective to spend additional funds on primary facilities (ensuring greater coverage of rural areas where most of the poor live) and less on hospitals. Improvements in both access and quality of these primary health facilities are equally important. Particular attention should also be given to the social, cultural, economic and political causes which often combine to produce irregular use of these health services by poor women (DFID, 2007c). Supporting this view, the UK Government's White Paper (DFID, 1997) emphasises that simply constructing more health centres will not necessarily translate to reduction in the death rates among children and pregnant women. These ratios will remain quite high in poorer countries until there are significant improvements in access to good quality obstetric care, ability to travel to them quickly; and more importantly, ensuring that women are in a position to choose to use these services without requiring the approval or authority of others to do so. It is this persisting denial of choices and opportunities that reinforce the high human poverty among women in Nigeria (FMWA, 2007).

Donors must also go beyond mouthing the rhetoric of support for the Paris Declaration and ensure that their operational activities line up with the five principles collectively signed up to in 2005. Every effort must be made to desist from donor practices which generate a catch-22

situation in Nigeria[8]. If the international community is as committed to the elimination of global poverty as they routinely profess to be, then their actions must reflect the considerably jeopardy which the deplorable Nigerian poverty situation (reflected by worsening maternal and U5 mortality ratios) places the global poverty reduction objective. They must immediately, resolutely and collectively respond in line with an anti-poverty approach to aid allocation which demands that poverty be addressed even in the most difficult situations (Randel et al., 2000; CFA, 2005).

5.6 Conclusion

This study set out to assess the effectiveness of development aid in addressing Nigeria's poverty challenge as reflected in the human development MDGs 4 and 5 – reducing maternal and child mortality ratios. In analysing and discussing the findings from the document analysis, evidence indicates that while many countries will succeed in halving their poverty rates by 2015, many countries in sub–Saharan Africa will not. More importantly, Nigeria's poverty situation will determine Africa's (and the world's) progress rate when the 2015 target date arrives. UNICEF and DFID are among a number of donors that have actively participated in Nigeria's development sector for nearly six decades. Although there have been a flurry of activities and changes have been noted in some quarters, the focal sectors of this research – reduction in maternal and child mortality ratios – have worsened in recent years and the country's position in the latest U5 mortality rankings speaks (sad) volumes. The limited impact of donor interventions in Nigeria are attributable to several reasons which include: inadequate donor funding; poor governance and political will; negative socio-cultural norms and practices and non-adherence to the principles of the Paris Declaration. The policy and development implications (both for the country and the donors) arising from this discussion, and recommendations on the way forward will be considered in the next chapter, which presents the conclusion of this research.

[8] Catch-22 situation: Donor practice of 'parallel budget' disbursements undermining governance and institutional strengthening in Nigeria; then donors refusing to channel funds through government budget processes because of poor governance and institutional weaknesses!

Chapter 6: Conclusion and Recommendations

6.0 Introduction

Nigeria is Africa's most populous nation and it is widely recognised that Africa's attainment of the MDG targets is predicated on Nigeria's success. Nigeria's success is in turn dependent on her ability to effectively reduce poverty levels, especially among women who are a particularly disadvantaged group. Assessing the progress made on the MDG 5 target – reduce maternal mortality ratios by three quarters – is partially linked to progress on the MDG 4 target – reduce child mortality ratios by two thirds; and both comprise the human development MDGs. The findings from this research indicates that although important efforts by the government and decades of development aid programmes have helped deliver some changes, the rate of transformation, the coverage and depth of interventions implemented are occurring at a pace that will not translate to significant impact by the 2015 target date. To a large extent, the Nigeria woman is not yet considered an equal partner in development; she is still somewhere behind. The programmes and activities of the focal donors have not kept faith with the principles of the Paris Declaration. Policy and institutional reforms initiated at the Federal level by the FGN are yet to trickle down to the grassroots where the pro-poor transformation is desperately needed. Maternal mortality ratios are worsening and Nigeria's global U5 mortality ranking has plummeted in recent years. Underlying all these development challenges is the intricacy of international and national politics, which ultimately determine the commitment of donors and national leaders to decisively address the critical factors which reinforce Nigeria's poverty challenge.

It is argued that unless and until these fundamental challenges are resolved, national policies and donor development efforts towards achieving the MDGs 4 and 5 will remain in jeopardy. 2015 – the globally agreed year of reckoning – is only six years away.

6.1 The Statistics Are Clear

- With a population in excess of 140 million, Nigeria is Africa's most heavily populated country. It also has the largest number of poor people in the Africa and one in every five Africans is a Nigerian (UNICEF, 2004).

- Nigeria possesses a stark dichotomy of wealth and poverty. Inspite of the country's vast oil wealth, the majority of Nigerians are poor with 71 per cent living on less than one dollar a day and 92 per cent on less than two dollars a day (UNDP, 2008).

- Health care and general living conditions in Nigeria are poor, especially for women and children (UNICEF, 2007).

- "Globally, more than 500,000 women die each year because of complications related to pregnancy and childbirth. Almost half of these women are in sub-Saharan Africa.

- The list of countries with most maternal deaths tilts towards those with the largest populations. Nigeria, Niger and Democratic Republic of Congo together account for approximately 20 per cent of all maternal deaths worldwide" (UNICEF,2008b, p. 9).

- Nigeria is currently placed in the 8th position on world U5 mortality rankings; a significant decrease in its U5 mortality rank of 15 in 2004 and prior (UNICEF, 2009a).

- The annual 0.1 percent rate of reduction in maternal mortality ratios is slower in sub-Saharan Africa (where the problem is most acute) than in any other region.

- The cause of most of these maternal and under-five child deaths is no mystery. It is as a result of no access or limited access to health care or because of poor quality of care where available (UNICEF, 2008b).

6.2 Nigeria's Needs Are Great and Desperate

Achieving a reduction in child and maternal mortality ratios in Nigeria will have a significant impact on the attainment of MDGs 4 and 5 in Africa. The identified challenges confronting Nigeria in this regard include:

- "A variable distribution of maternal and U5 mortality indices across the nation – with the highest needs in the North East and North West Zones; and among rural populations generally

"In many cases the gender inequalities or the denial of human rights are root causes of poverty (cited in Randel et al,,. 2000, p. 23).

- Low level of utilisation and trust in the public health system
- Collapse in the primary health care system – inadequate funding, equipment, personnel, drugs, planning and outreach
- Large and unregulated private sector
- Unregulated and poor quality drugs market
- Low levels of literacy – particularly female literacy
- Lack of public health authority, capacity and planning at State and Local Government levels" (cited in NORAD, 2007, p.1)
- High levels of female poverty, gender discrimination and negative socio-cultural practices.

6.3 Will promises be kept?

OECD countries promised to disburse $130 billion of total aid by 2010. $50 billion has been promised to Sub-Saharan Africa alone. There is reasonable cause to wonder if donors will meet this promise. Country programmable aid still constitutes a small portion of funding provided through ODA suggesting that it has proven easier to mobilise funds for things like technical assistance, debt relief, food aid and emergencies, than for real development projects. Donors therefore bypass the need to have well-designed and implemented

development projects when funds are provided in this fashion (Kharas, 2007). The ODA disbursement in Nigeria over the last ten years appears to lend credence to this assertion.

UNICEF has been operating in Nigeria since 1953; committed to working with the government and other partners to promote the rights of Nigerian children and women. Through direct assistance provided to over 220 communities throughout the country, UNICEF works by implementing concrete interventions at community level. DFID set up as a devolved country office in Nigeria in 2001. It is the only major bilateral donor with a specific strategy targeted at improving maternal health and has been active in the health sector of Nigeria on six platforms. Reports indicate that both UNICEF and DFID have provided a combined sum of $662,837,141 as ODA disbursed in the health sector programme interventions between 1999 and 2007. These funds were managed and disbursed directly by the donors and not the government of Nigeria.

There is little recognition that pro-poor development is ultimately about politics...you need to address power relations, the cultural and social interests that sustain the unequal access to economic opportunity and social resources (cited in Randel et al,. 2000, p. 18).

Emphasising the commitment of the UK Government to make a reality of the MDG targets (to which the UK and the rest of the UN membership are committed), the former Secretary of State, Clare Short said:

> "We stand ready to be judged against our delivery of this [MDG] strategy. And the whole development community – governments, international agencies, civil society organisations – should be judged collectively against delivery of the targets." (cited in DFID, 2000, p. 7).

Past the halfway line of the MDGs strategy, and after ten years of direct interventions in Nigeria (with significant technical assistance component, particularly for DFID programmes), the donors' own reports deliver the judgement (DFID, 2006b):

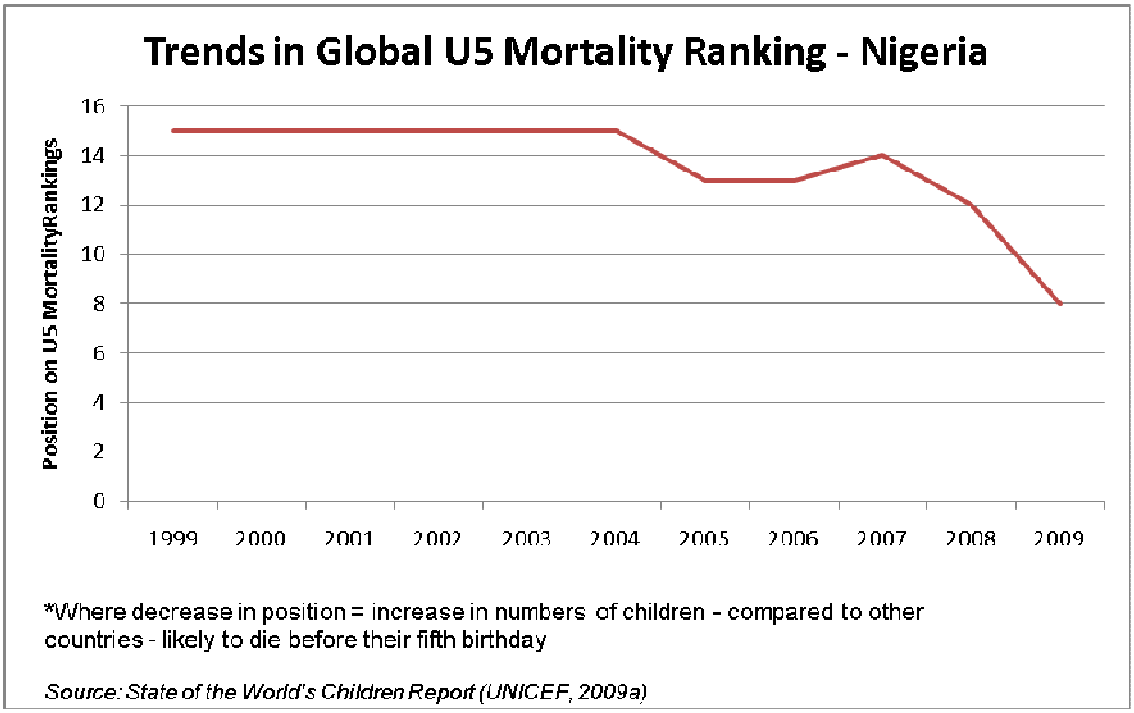


Figure 7: Trends in Global U5 Mortality Ranking - Nigeria

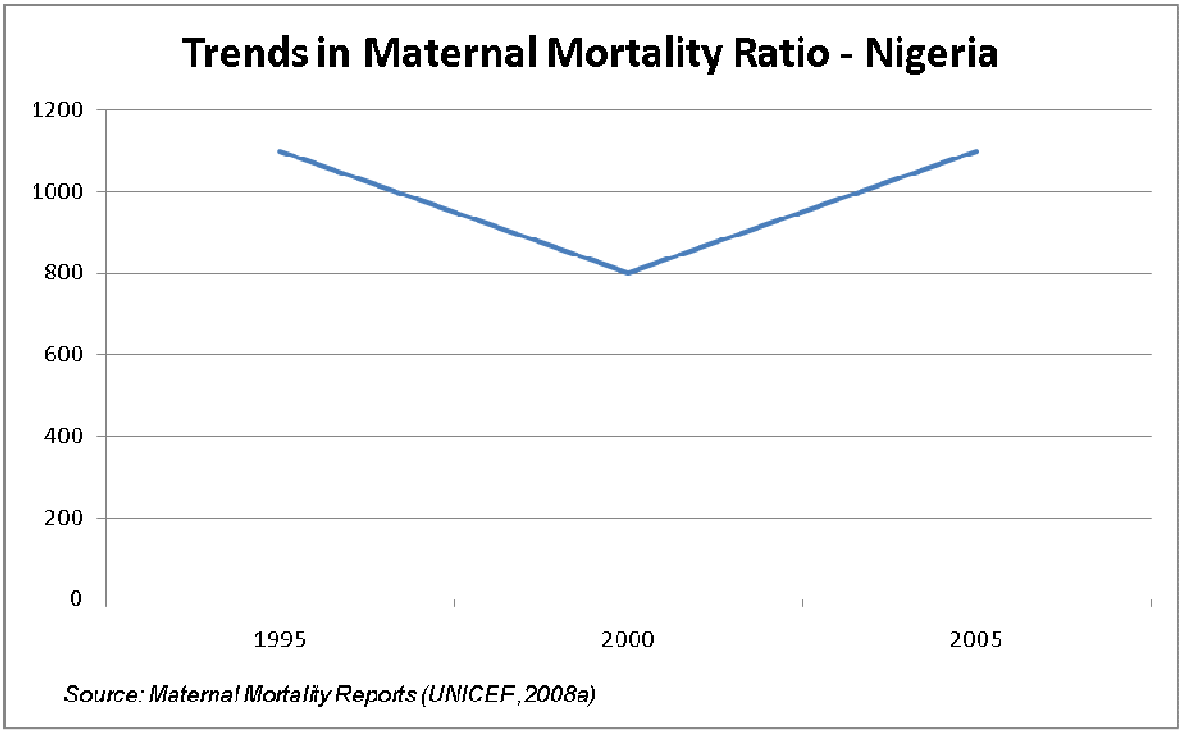


Figure 8: Trends in Maternal Mortality Ratio - Nigeria

The verdict is unfavourable and tends to mask some real improvements that have been recorded in some quarters on the ground. But the focus of this research is on assessing the extent to which donor aided interventions have moved Nigeria's development efforts towards achieving the much-needed continental and global impact on the MDGs 4 and 5 targets. These findings also raise a number of important questions with regards to the effectiveness of development aid in Nigeria and its impact on the MDGs, the most important of which is to reduce absolute poverty by half by 2015. As far as that perspective is concerned, the jury is in.

6.4 Going Forward, Looking Inward

One can surmise that development aid is a double-edged sword. It can prove helpful in supporting economic and social progress in recipient countries where the economic and political environment is right. It will likely have no positive effect and be wasted at best where that environment is poor. In the worst case scenario, it can actually impede development through the potential negative governance, institutional and political impacts it can have. More importantly, these negative aspects tend to manifest and increase in significance where donor programme cycles are not synchronised to recipient country's development plans, and where Africans are too little involved in the design and implementation of aid-funded activities (Lancaster, 1999).

A number of crucial points emerging from this research suggest that donors and recipients still have not learnt from the experiences of past decades or have chosen to remain obstinate in towing a line of action that is at variance with the professed poverty reduction objective of development aid programmes:

In order to ensure that every aid dollar goes the full development mile, donor support of recipient government-led programmes should not be compromised. It is also recommended that this be implemented using budget support, sector-wide operations or recurrent cost financing (Kharas, 2007).

Assessment and evaluation of donor interventions must maintain a focus on their specific impacts on poor people – particularly women and all other vulnerable groups and sectors, if reducing poverty is truly the overriding aim of all aid programmes and projects (Easterly, 2006; Randel et al., 2000).

1. The government of Nigeria will make more development progress if it gives more attention to meeting domestic reform obligations and ensuring that these changes take root at the Federal, State and Local government levels. Disproportionate focus on the failure of international donors to meet their commitments cannot be a substitute for other action. Similarly, donor countries must be determined to address the existing structural equalities which consign one quarter of the world's people to live in absolute poverty; and not think that mere disbursement of aid alone will translate to meaningful action in the global combat against poverty.

2. Aid is a scant resource that must not be wasted on programmes and projects which have little significance for the poorest people. International partners and all governments must cease the advancement of projects which suit donor or recipient convenience, enhancing their prestige at the expense of the poor (Randel et al., 2000).

3. The prevailing system of collective responsibility for multiple goals should stop. Aid agencies should focus on the sectors and countries they are best placed to help; and then be held accountable for their results, which will be evaluated by truly independent bodies and processes (Easterly, 2006).

6.5 Final Thoughts

"The problem is not that the Millennium development promise was wrong, the people unrealistic or the commitment unnecessary. It is simply that the world has been too slow in developing the means to honour it. Fulfilling the commitment requires urgent action." (CFA, 2005, p. 64). The long battle against global poverty is witnessing some changes as Africa begins to make progress. Nigeria is a notable leader in this regional effort. However, a stronger and more effective partnership between Nigeria and the rest of the rich world is required to sustain this progress. This will naturally entail action, and change on all sides, and the country must take the lead in this partnership; assuming responsibility for its problems and full ownership of the solutions, which must be homegrown if they are to be sustainable (CFA, 2005).

Aid alone is not the ultimate panacea for poverty; it is just a tool, which also serves as a basic indicator of the commitment of richer countries to ending poverty. When and where it is provided, aid must be adequate both in volume and duration and must be spent on interventions that benefit the poor directly and sustainably. Aid must also provide relevant support for improvements in the wider policy environment which will afford poor people opportunities to voice their interests.

> *"Failing to overcome poverty is a matter of political choice not necessity. The goal is neither economically nor technically beyond our current reach"* (cited in Randel et al., 2000, p. 17)

Politics (both international and national) continues to play a significant role in the quest to overcome absolute poverty in Nigeria and the world in general. Unfortunately, new political and economic developments since the adoption of the MDGs (particularly, combating terrorism and the current financial and economic crisis) do not augur well for a greater willingness to combat poverty. But until political leaders commit to replace rhetoric on poverty and partnership with a willingness to take sustained and effective action, achieving the targets of the MDGs 4 and 5 will be elusive (Randel et al., 2000; Easterly, 2006; Riddell, 2007) and Africa will remain a scar upon the conscience of the world (CFA, 2005).

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