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Impact Of Donor Agencies on the Improvement of Health Care Delivery Service. A Case Study of Bill and Melinda Gates Project (2000-2015).

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ABSTRACT: The public health sector in Nigeria is one that has been faced with numerous challenges thereby reducing its capacities at delivering the mandates given to it. To overcome its seemingly insurmountable huddles, donors have had cause to come in to remedy health care situations in the country. To this end, this study has made an attempt at assessing donor agencies and public health in Nigeria with reference to the Bill and Melinda Gates project in Gombe state. Pregnant women and newborn are the most vulnerable and had suffer common diseases like, Malaria, diarrhoea, Poliomyelitis, cholera, measles, tuberculosis, HIV/AIDS, and IVVF, among others have held sway on the country's citizens' health with several lives lost and many more incapacitated by the health attacks. The governments at all levels in Nigeria have made several efforts towards improving the public health delivery in the country, however, these efforts have not been able to take the country out of its high mortality rate index due to maternal and lots of child death at birth stage. This study discovered that the Bill and Melinda Gates is one donor that has invested so much in the public health sector of the country as a matter of international moral obligation, justifying the theoretical framework used. Data for the work were collected from both primary and secondary sources using both content analysis and simple percentage tables in the presentation of the collected data. Structured questionnaires were administered to respondents purposively sampled. The study concludes that, Bill and Melinda Gates as a donor agency has a strong significant positive impact on the improvement of health care delivery in Gombe state. It therefore recommends among others the need for the Nigerian governments to increase its efforts at tackling the health challenges facing the masses through the instrumentality of the traditional combined with orthodox medicine.

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Health is wealth because only a healthy spirit, body and soul can create and add value. Health is a fundamental driver for economic growth and development. In economics parlance, it is believed that health and education are the two important factors for human capital development and have been demonstrated to be the basis of an individual's economics productivity. As with economic wellbeing of individual households, good health is a critical input into poverty reduction, economic development at the scale of whole societies. (Sachs, 2001). As declared in the WHO constitution adopted in 1948, "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." Health is wealth goes the popular saying and therefore in every country, the health sector is critical to social and economic development, with ample evidence linking productivity to quality of health care. Economic development occurs when it has a trickle-down effect on the poor masses by enjoying all the basic necessities of life which are all embodied in having good health. In Nigeria, the vision of becoming one of the leading 20 economies of the world by the year 2020 is closely tied to the development of its capital through the health sector. (Osotimehin, 2009).

It is posited that, given poor health infrastructure, illness and disease shorten the working lives of people, thereby reducing their lifetime earnings. Strauss and Thomas (1998) and Schultz (1999) suggested that good health has positive effects on the learning abilities of children, which leads to better educational outcomes school completion rates, higher mean years of schooling, achievements and increases the efficiency of human capital formation by individuals and households.

Report of the Global Thematic Consultation on Health (2013) pointed out that "health is both a driver and a beneficiary to economic growth and development and a key indicator of what peoplecentered, right-based, inclusive and equitable development seek to

achieve. For economic development to occur in a country, its citizenry must be healthy. Ill health affects productivity, and therefore, reduces incomes and also tends to wipe away savings and diminish ability to invest, because healthy nation are likely to attract larger amount of foreign direct investment, since investors avoid environment where labour force are likely to be weakened by heavy disease burden and where access to health care is limited. (Alsan et al 2004, 2006).

however, the context of health is rapidly changing. In advanced countries, health care systems are deemed financially unstable, while in emerging economies they are still being shaped. These systemic changes result from the government pressure to contain the cost of health care delivery. These costs have increased due to the growing number of ageing population and sophisticated technological advancement in medicine (in developed countries) and high unemployment rate, population explosion and poor accountability in third world countries. Concerns for affordability of health care are rife and there is a need to operate the health system in a more efficient manner. Nigeria is faced with the challenge of ineffective use of past opportunities to develop a vibrant and sustainable health care delivery; so the future of health care seems uncertain even in the current regime.

Nigeria has made significant improvements in its health sector in recent years, but still faces sizable challenges. For instance, the total fertility rate is 5.7 children per woman, the mortality rate of children under 5 years old is estimated at 157 per 1,000 live births, and the total contraceptive use (any method, among married women) is at 14.6 percent while modern contraceptive methods have a 9.7-percent prevalence rate, adult HIV prevalence is estimated at 5 percent, and immunization rates are low, with only 23 percent of children receiving all of their recommended vaccinations (National Population Commission and ICF Macro, 2008).

Nigeria's economic and geographic health discrepancies are pronounced, with poorer households receiving far less medical care than the relatively wealthy, and Northern regions lagging far behind Southern states with respect to many health indicators. For example, while total contraceptive use in the Southwest region is above 25 percent, in the Northwest region this figure falls to 2.8 percent. Likewise, while the highest and middle wealth quintiles of the Nigerian population fully vaccinate their children at rates of 53 percent and 20 percent, respectively, the proportion of fully-vaccinated children falls to 4.8 percent among the poorest Nigerian households (National Population Commission and ICF Macro, 2008).

According to the most recent available World Health Organization (WHO) National Health Account analysis from 2005-2014, consumers pay a high share of health expenditures 67 percent of health expenditures are out of pocket versus 26 percent from the government and 7 percent from the private sector (private insurance and employers) (Soyibo et al, 2014). Data also show that use of private providers for healthcare is high in Nigeria. For example, according to the 2008 Nigeria Demographic and Health Survey 60.4 percent of women using modern contraception obtained their method of contraception most recently from a private provider. (National Population Commission and ICF Macro, 2008).

Health care development aid in Nigeria is linked directly to addressing health issues in the country. According to WHO (2000), Nigeria has 10% of global disease burden due to high disease burdens and its relative large population on the African continent (National Strategic Health Development Plan NSHDP, 2010). The health indicators in Nigeria have remained below country targets and internationally set benchmarks (National Strategic Health Development Plan NSHDP, 2010). The Federal Ministry of Health in recognition of the health developmental challenges has made efforts to improve access to health care in Nigeria.

The Federal Ministry of Health launched the Health Sector Reform Programme (HSRP) in 2004 to improve access to quality health care services, reduce the burden of disease, and to promote effective partnership, collaboration, and coordination (NSHDP, 2010). The HSRP was implemented from 2002 to 2007. Although the HSRP recorded some success, the large majority of the problems it was designed to address still persist (NSHDP, 2010).

Furthermore, the National Health Insurance Scheme (NHIS) was established to ensure access of every Nigerian to quality health care services and to ensure efficiency in the health care services. As of February, 2009, the NHIS covered only 3% of the Nigerian population (3% of about 171 million); still a majority of the poor pay out-of-pocket for their health care services and this payout limits access to health care for the vast majority who need it most (Kujenya, 2009; WHO, 2004).

In addition to the NHIS, donors and development partners, such as United Nations Children Fund (UNICEF), United Kingdom's Department for International Development (DFID), World Health

Organization (WHO), United States Agency for International Development (USAID), Global Funds, Gavi Alliance, Canadian International Development Agency (CIDA), and Partnership for Transforming Health System in Nigeria (PATH 2), all made efforts to improve access to quality of primary and secondary health care services in Nigeria.

According to the National Planning Commission (2010), Nigeria received a little above $6.00 billion of development assistance from 1999 to 2007. Of this amount, grants and credits constituted about $3.2 billion and $2.8 billion respectively, with the rest of the aid from international nongovernmental organizations (NGOs) (National Planning Commission, 2010). The health sector received about 54%, while education, poverty alleviation, governance, women empowerment and agriculture sectors received 12%, 18%,

5%, 4%, and 1% respectively. This study focused on how donor agencies help towards the improvement of health care delivery in Nigeria.

Almost all the donors and development partners in Nigeria are present in the health sector. These include WHO, United Nations, European Union, CIDA, UNICEF, DFID, WHO, and BILL AND MELINDA GATES. UNICEF represented 45.2% of the total contribution ($1.2billion) to the health sector, and BILL AND MELINDA GATES, CIDA, DFID, European Union, WHO, and United Nations Development Programme (UNDP) represented 0.07%, 10.13%, 6.6%, 6.56%, 5.5%, and 0.09% respectively (National Planning Commission, 2010).

Tracking resource flow from donor and development partners is challenging. Several organizations have provided conflicting reports on donors and development partners in Nigeria (Federal Ministry of Health, 2004); however, information available from the WHO Nigeria Country Cooperation Strategy (2013) showed the type of partnership, principal areas of invention, and location in which each developmental partner in Nigeria health sector was involved. This information showed several donors and development partners in the health sector working in diverse area intervention across the states in Nigeria; however, some developmental partners have the same principle area of invention in the same states.

1.2 Statement of the Research Problem

The general problem that donors and development partners encounter is alignment and coordination of foreign aids in recipient countries. At the global level, there are over 100 major donor organizations active in the health sector (Schleber et al., 2007). Despite the large number of foreign health aid, scholars (e.g., Genhard, Kitterman, Mitchell, Nielson, & Wilson, 2008; Schleber et al., 2007) argued that health aid in developing countries does not improve access to health care in these countries. Lack of coordination mechanisms makes it difficult for the global communities to achieve aid effectiveness in the recipient countries (Genhard et al., 2008; Schleber et al., 2007).

The Nigerian health care system is characterized by fragmented health care delivery, low quality information and data, and poor coordination among key players (National Strategic Development Plan, 2010). Abernethy, Chua, Grafton, and Mahama, (2007) pointed out that it is important that communication channels between all stakeholders in health sector are open to encourage a shared opinion with the aim of reaching some level of agreement over the priorities to be pursued.

The specific problem in this study was that there are large numbers of donors and development partners in the Nigerian health care system and sharing information between them on activities across the health sector is inadequate (Daniels et al., 2011, National Planning Commission, 2010).

This limited flow of information results in inadequate coordination between donors and other donors, program implementers, and other developmental partners in the Nigerian health care sector. Nigeria's health indicators have either stagnated or worsened during the past decade despite the efforts made by the governments to improve healthcare delivery. Life expectancy at 52 years is below the African average, while the numbers on child mortality are astounding partly because of the country's size. Annually, one million Nigerian children die before the age of five due mostly to neonatal causes followed by malaria and pneumonia.

Maternal mortality is 630 per 100,000 live births which is comparable to low-income countries such as Lesotho and Cameroon. An estimated 3.3 million Nigerians are infected with HIV and access to prevention, care and treatment is minimal. Nigeria also continues to combat the double burden of both communicable and non-communicable diseases (NCD).

Nigeria has a federally funded National Health Insurance Scheme (NHIS), designed to facilitate fair financing of health care costs through risk pooling and cost-sharing arrangements for individuals. Since its launch in 2005 the scheme claims to have issued 5 million identity cards, covering about 3 percent of the population. Under the National Health Insurance Act 2008, the national health insurance started a rural community-based social health insurance program (RCSHIP) in 2010. The majority of the enrollees, however, are individuals working in the formal sector and the community scheme still leaves large gaps among the poor and informally employed.

Several proposals are currently in the works to expand the reach of NHIS. One such proposal is to make registration mandatory for federal government employees. Earlier this year, the creation of a "health fund" collecting an earmarked "health tax" of 2 percent on the value of luxury goods was proposed. This fund would be used for the health insurance of specified groups of Nigerian citizens, including: children under five, physically challenged or disabled individuals, senior citizens above 65, prison inmates, pregnant women requiring maternity care, and indigent persons. At a broader level, the National Health Bill which was first proposed in 2006 to improve its poor health sector by allocating at least 2 percent of the federal government's revenue to the health sector is still not signed into law. The public health sector in Nigeria has been in tight corner for its inability to meet the health demands of the masses in spite the enormous investment and donations by generous bodies like the BILL AND MELINDA GATES. In its specific terms, BILL AND MELINDA GATES have been seen in virtually all segments of the Nigerian public health sector

in Gombe state with donations both in kind and cash. In spite of these involvements, the public healthcare delivery in Nigeria still cries for attention both from local and foreign donors. This study is set to assess the role donor agencies play on the improvement of Health service delivery in the country.

1.3 Research Questions

It is in the light of the above that the study seeks answers to the following research questions;

i. What is the current state of the Nigerian health sector in the face of the various donor agencies?
ii. How has the Nigeria health sector been able to manage its challenges?
iii. To what extent has BILL AND MELINDA GATES contributed to Nigeria's health sector development?
iv. How can BILL AND MELINDA GATES and other donor agencies be encouraged to contribute more to the Nigerian health sector development?

1.4 Objectives of the Study

In spite of the above research problems, this study intends to achieve the following objectives:

i. To examine the current state of the Nigerian health sector in the face of donor agencies
ii. To identify the various challenges facing the health sector in Nigeria
iii. To examine the contributions of donor agencies to the Nigerian health sector
iv. To bring to the fore ways through which BILL AND MELINDA GATES as a donor agency can be encouraged to improve the health sector in Nigeria.

1.5 Scope and Limitations of the Study

The scope of this study centered on donor agencies and the Nigerian public health sector from 2007 to 2017. This study covered BILL AND MELINDA GATES in Gombe state as a donor and/or development partner for the public health sector of Nigeria in general. The first factor that may have limited this study was the internal validity of using case study qualitative method because the researcher does not have control over the events.

Therefore, findings from this study are only applicable to this study; however, to reduce internal validity issue, the sampling was done purposefully, and member checking was applied at the end of data interpretation. Coordination may not have been relevant if it was only one donor or two development partners funding a health program. The second factor that might have posed a limitation to this study was the participants' response. The participants might not have been willing to share information on their level of coordination and on the effectiveness of aid they provided. To address this limitation, the study communicated the significance of the study to BILL AND MELINDA GATES and health ministry, how the outcome of the study might help to improve aid effectiveness, and how it could reduce the cost implication of fragmentation of efforts.

1.6 Significance of the Study

This study has evaluated the level of impacts donor agencies have had in the health sector of Nigeria, and the impact of this coordination to the health aid effectiveness towards improving access to primary health care in Nigeria. The case study is the BILL AND MELINDA GATES. This study may increase awareness of the gaps in health intervention programs as a result of inadequate coordination.

It may also provide information for policymakers on the need to create policies or standards to ensure coordination among all the donor agencies and other stakeholders in the health sector of Nigeria. In addition, coordination among all the stakeholders would improve adequate data capturing. Availability of data is essential for policymaking, as well as policy reform. Information on health services deliveries and health aids provided by foreign aid organizations can help donor organizations and other development partners to increase their effectiveness, efficiency, and responsiveness. Furthermore, the result of this research provides information for the health stakeholders on the effectiveness of the existing coordination mechanisms.

Finally, the finding from this study may also influence positive change through using collaborative engagement between donor organizations and other stakeholders in the health sector development. Using insight from this study, the stakeholders may improve the commitment to coordinate efforts. As a result, the aim of health aid, health sector development will be achieved. With a sound health care system in a country, the population will be healthy, and this will improve the economic status of the country.

1.8 Organization of the Study

This study is organized into five chapters. Chapter one; titled Introduction contains the background to the study, statement of the research problem, research questions, objectives of the study, research propositions, scope and limitations of the study,

significance of the study as well as organization of the study. In chapter two, a review of relevant literatures and theoretical framework are captured. Chapter three has the research methodology, chapter four contains data presentation, interpretation and analysis. Chapter five has the summary, conclusion and recommendations of the study.

CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK
2.0 INTRODUCTION

Health care delivery has in recent times received extensive research and policy attention in both developed and developing countries. One of the foremost issues is how to raise sufficient resources to finance health care needs for all citizens (WHO, 2000). Health care provision in Nigeria is a concurrent responsibility of the three tiers of government namely Local, State and Federal governments. Nigeria operates a mixed economy therefore private providers of health care have role to play in health care service delivery. The federal government role is mostly limited to coordinating the affairs of the University Teaching Hospitals (Tertiary health care system) and federal medical centers while the state governments manage the various general hospitals (secondary health care system) and the local government focuses on dispensaries and health centers (Primary health care system) which are regulated by the federal government (Rais, 1991).

It can be difficult to say exactly what a health care system is, what it consists of, and where it begins and ends. However, it can be considered to include all the activities whose primary purpose is to promote, restore or maintain health. Formal health services, including the professional delivery of personal medical attention are clearly within these boundaries. So are actions by traditional healers, and all use of medications, whether prescribed by a provider or not. So is home care of the sick, traditional public health activities such as health promotion, disease prevention and other health enhancing interventions like road and environmental safety improvement are also part of the system (Hsiao, 1992; Mossialos et al., 2002).

Beyond the boundaries of this definition are those activities whose primary purpose is something other than health. Health systems have a responsibility not just to improve people's health but to protect them against the financial costs of illness and to treat them with self-respect. Health systems thus have three main objectives, these are: improving the health of the population they serve, responding to people's expectations and providing financial protection against the costs of ill- health (Murray and Frenk 2000; WHO, 2000). The Nigerian health care system is not indigenous to Africa. It is comparable to what is obtainable in other parts of Africa in which donor agencies have played active role towards its improvement in terms of financial provisions and other related facilities both at state and grass root level.

There is dearth of information on Nigerian health care delivery system coupled with agitations by well-meaning Nigerians for health care system reforms (FMOH, 2004).

This project therefore, sets out to critically review the Nigerian health care delivery system by looking at the role played by donor agencies as well as how it can improved in order to help facilitate productivity.

2.1 Nigerian Health Care Situation

Nigeria is the most populated country in Africa with the population of about 172 million (as extrapolated from the last census conducted by the Census Board in 2006). Despite the high crude reserve, there is still high incidence of poverty (WHO, 2009), there has not been an improvement in the economic growth and welfare of some citizens. With the population of 172 million (2% of the world population), it accounts for about 10% of the world's infant, child and maternal deaths (United States International Development Agency, 2014). Sixteen percent of Nigerian children die of preventable diseases at under 5 years old (DFID, 2013; United States International Development Agency, 2014); however, Nigerian Government recognizes the importance of healthy population to socio-economic development. The Government in collaboration with donors and developmental partners is making efforts to increase the quality of health care to the populace, as well as reduce the morbidity and mortality (NSHDP, 2010).

The goal of the National Health Policy developed by the Government, through the Federal Ministry of Health is to establish a comprehensive health care system, based on primary health care that is preventive, promotive, and rehabilitative to citizens at all levels within the available resources. Also, the government along with donors and development partners initiated programs like: Integrated Management of Childhood Illness, and Integrated Maternal Neonatal and Child Health to improve maternal and child health (WHO, 2009). Also, integrated disease surveillance and response intensified to notify health workers about disease outbreak for treatment and follow-up; however, low population coverage, timeliness, and quality of service still remain challenges (WHO, 2009; United States International Development Agency, 2014).

2.2 Nigerian Health Care System

Nigeria's population is served by three tiers of health care system; the primary, secondary and the tertiary health care systems. The primary health care is the first level of care for the three tiers of health care system. The secondary health care is consultative. It is for the purpose of receiving referral from the primary health care level. The tertiary health care system is for patients with health condition that could not be maintained at secondary health care level. The three tiers of health care system should be a linked with a good referral system (Akande, 2004).

i. The Nigeria primary health care system.

The Nigerian primary health care system is based on Alma Ata declaration of primary health care system. It is focused on achieving equitable health care delivery at grass root level (WHOUNICEF, 1978). The WHO principle for primary health care system includes words like, essential, practical, first level of continuing health care process, first level contact, universal, affordable, and acceptable (Starfield, 1994). The strategy is meant to address the health need of people at the community level (Olise, 2007). In line with the general objectives of primary health care system, the primary health care system is aim to deliver health care services close to where people live. It is the first element of continuing health care system that interacts with households and communities (Bangdiwala, et al., 2010 & Alenoghena et al., 2014).

The primary health care system in Nigeria has not achieved its goal of establishment. Scholars pointed that the shortcoming of the system is that the populace at the rural area are underserved (Abduraheem, et al., 2012, & Alenoghena et al., 2014). Also, research showed that public resources meant to enhance the primary health care service delivery in Nigeria do not appear to be reaching its intended destination (Gupta, et al., 2003 & Abduraheem, et al., 2012).

ii. Nigeria secondary health care system

Nigerian secondary health care system provides specialized services to patients referred from primary health care level, through out-patient and in-patient services of hospitals. Secondary health care hospitals provide supportive services like laboratory diagnostic, blood bank, rehabilitation, and physiotherapy. Available at district, divisional, and zonal levels, secondary health care, serves as administrative headquarters supervising health care activities of the peripheral units (Revised National Health Policy; Federal Ministry of Health, 2004).

iii. Nigeria tertiary health care system

The tertiary health care system consists of highly specialized services by teaching hospitals and other special hospitals providing care for specific disease conditions, specific group of patients.

Uneven distribution of the tertiary health care system is a challenge.

2.3 Management of Nigeria's Health Sector

In principle, the management Nigeria's health care system is decentralized into three; the federal, state, and local government level. The Federal government, through the Federal Ministry of Health ensures the comprehensiveness of the multi-sectorial inputs, community involvements at the local, state and federal level; ensuring that health care services are appropriately supported by an efficient referral system. In addition, the host Government ensures that support provided by donor organizations are in consonance with the overall national health policy (Health Policy; Federal Ministry of Health, 2004); moreover, the Ministries of Health ensures coordination of actions between development partners and other sectors towards achieving health development goals. During the Busan Partnership for Effectiveness Development Co-operation, it was agreed that developing countries would lead coordination efforts to manage proliferation of aid at country level (OECD, 2011).

The Federal Ministry of Health develops modalities and institutionalizes appropriate processes (Country Coordination Mechanism) for effective coordination of international agencies and NGOs operating in health sector. Also, the Federal Ministry of Health collaborates with United Nations agencies, multilateral and bilateral donor organizations to harness and align their assistance in the health sector. Furthermore, the Federal Ministry of Health collaborates with the National Planning Commission for proper coordination of the activities of the donor organizations in the health sector (Health Policy; Federal Ministry of Health, 2004).

The state ministries of health ensure efficiency in the activities in the secondary hospitals and regulating technical support for the primary health care services. While at the local government level, they are responsible for the activities in the primary health care centers and ensuring that the structure is implemented at the community level, which seems to be the most important of all level, because it forms the support structure for the implementation of primary health care (WHO Report, 2000).

Other health care agencies in Nigeria have the mandate to ensure access to quality health care delivery and coordination of stakeholders. The National Primary Health Care Development Agency provides strategic support for the development and delivery of primary health care and enforces compliance with guidelines. In addition, the National Agency for the Control of AIDS (NACA),

established 2000 coordinates all HIV/AIDS actions in Nigeria. In its coordination responsibility, NACA, establishes and sustains relationship with diverse state and non-state actor in five domains; NACA-SACA (State Agency for the Control of AIDS), NACA-CSOs (Civil Society Organizations, NACA Private Sector, NACA-Public Sector, and NACA-Development Partners (National Agency for the Control of AIDS, 2009). On the other hand, the State Primary Health Care Management Board is responsible for the coordination of planning, budgeting, provision and monitoring of all primary health care services that affect residents of the state (NSHDP, 2010). Currently, all these levels provide health services, stewardship, and health financing.

Donors and development partners use country health system as a framework; ensuring deepened, integrated, and accelerated implementation of health aid programs. Donors and development partners support the government of the recipient country to enable them to own the development process for program sustainability and explaining the need of commitment toward achieving the outcome of the health development program. Also, they encourage the civil society organization to participate in implementing health development projects. In addition, the donor organizations and other development partners are responsible for ensuring the reduction of fragmentation of aid.

Further, the developmental partners support government efforts to promote financial management system in line with Paris Declaration on Aid Effectiveness (NSHDP, 2010). Although, the management of Nigeria's health care system seems to be coordinated; in practice, the system is often a duplication and confusion of roles and responsibilities among different levels, as well as agencies (WHO, 2002). The implication is weakness in coordination and tracking of activities at different levels, and between other stakeholders in health sector. Currently, the federal, state, and local government, as well as other government agencies and donors are involved, to various degrees; contribute to the management of health system functions, service provision, and financing.

2.4 Nigeria's Health Care Financing

The two principal sources of health care financing in Nigeria are the public and private. The public source of health care financing includes federal, state, and local government, and the private source health care financing includes household, firms, and donor funding. Health Department, health insurance, and NGOs are other private purchasers of health care services. Of all these sources of health care financing, households contribute the main source of health financing (Olaniyan & Lawanson, 2009).

The state and local governments have statutory contribution for the funding of the primary health care facilities, which include: provision and maintenance of facility equipment, purchase of essential drug, and payment of salaries for personnel at the primary health care level. Contributing less than one-quarter of total health expenditure, the government has not been participating strongly in the funding of health care system in Nigeria (Olaniyan and Lawason, 2010). On the other hand, according to the National Health Account (2009), the Government Health Expenditure was 18.69%, 26.40%, and 26.02% of the Total Health Expenditure from 2003 to 2005.

The Total Health Expenditure in Nigeria increased from N661.662 billion to N976.69 billion from 2003 to 2005 (National Health Account 2009). The Government Health Expenditure as a proportion of the Total Health Expenditure, increased from 18.69% to 26.02% from 2003 to 2005, while the House Hold Health Expenditure decreased from 74.02% to 65.13% from 2003 to 2004, and then increased to 67.22% in 2005 (National Health Account, 2009). The contribution of donor agencies and development partners was increased from 4.0% to 5.6% of the Total Health Expenditure from 2003 to 2005, while the contribution of other firms remained at 3% through the period (National Health Account (2009).

Absence of data on health care spending makes it difficult to capture information on spending of stakeholders (Lawanson, 2014). Also, the poor health system in Nigeria is as result of inadequate resource allocation and expenditure patterns across the different tiers of government (Olaniyan & Lawason, 2010). Appropriate health financing with adequate institutional management and funding allocation result in access to quality health services, efficiency in service delivery that will improve health status of the populace (Hsiao, 2003).

2.5 Foreign Aid

The Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) sees foreign aid as financial flows, technical assistance and commodities that are: designed to promote economic development and welfare as their main objective thus excluding aid for military or other non-development purposes, and are provided as either grants or subsidized loans. Aid is used to cover all financial transactions made or guaranteed by one government to another. Indeed, foreign aid has become a focus and locus in the Third World. It has assumed the status of foreign policy instrument by developed democracies to strengthen their relationship with and consequently spread their influence on, the Third World.

Aid according to Ajayi (2000) is a form of assistance by a government or financial institutions to other needy countries, which could be in cash or kind. The establishment of an aid system was one of the principles of the Breton Woods system in 1944. The system

believes that there should be a free capital market, which allows an unrestricted inflow of foreign aid. Based on this principle, a Marshall Aid Assistance of about $17.5 billion was granted to Western Europe to resuscitate her ruined economy due to the World War II. Since then, the aid system has remained a durable phenomenon of the international economic system Todaro, (1977), as cited in Aluko and Arowolo (2010).

Foreign aid can be in form of investment in the economy of the needy country; loans; infrastructural development; military assistance such as supply of military hardware at subsidized rates, military agreements, bilateral or multilateral, loose or solid or in a defence pact, supply of military technical assistance such as military, presence to a country in crisis or conflict with another country, supply of military technical assistance and advice, direct participation as in the case of military allies to other countries, military subversions, coups, assassinations, etc.

In addition, grants and subsidized loans are referred to as concessional financing, while loans that carry market or near market terms (and therefore not considered as foreign aid) are nonconcessional financing. From the point of view of the DAC, a loan counts as aid if it has a grant element of 25 percent or more suggesting that the present value of the loan must be at least 25 percent below the present value of a comparable loan at market rates (usually by the DAC, though rather arbitrarily to be a 10 percent with no grace period). DAC classified aid into three broad categories, namely: official development assistance (ODA), official assistance (OA), and private voluntary assistance (PVA). ODA is made up of aid provided by donor governments to developing countries. Official Assistance is aid provided by governments to richer countries with per capita income higher than approximately $9,000 and to countries that were formerly part of the Soviet Union or its satellites. PVA covers grants from nongovernment organizations, religious groups, charities, foundations, and private companies. Both monetary and fiscal policies are used to regulate the economy by central banks. The instruments of fiscal policy are government borrowing (debt), government spending and taxes. Paramount among the instruments of fiscal policy is debt especially in financing deficit budgets. Borrowing is sometimes a way of spending the economy out of recession. When borrowing becomes a necessity, the government through the central bank can source the funds from internal and/or external sources (Ohale, 2006).

Basically, what matter in borrowing is the ability of government to judiciously engage these funds in productive activities that are capable of generating returns greater than the initial capital (principal). One popular backdrop of government borrowing is the crowding out effect of debt. Significant government borrowing from domestic residents and banks will increase aggregate demand for loans and raise interest rates and therefore crowd out private investment spending. In other words, government borrowing tends to reduce the total spending by the private sector which now finds it more costly and perhaps more difficult to borrow. It is for this reason that the monetarists argue that the net effect of fiscal measure aimed at expanding demand in the economy may be insignificant because the financing of the budget deficit will have adverse effects on private spending. Also they argue that government deficits in money supply have repercussions on the price level (inflationary pressure). Growth over a long period implies an increase in the capacity of a country to produce" (Cooper, 1996).

2.5.1 BILL AND MELINDA GATES FOUNDATION

One the key project this foundation has gained ground on was the Maternal and Neonatal Health project. The Maternal and Neonatal Health (MNCH) Project 2012 – 2016 provides effective and efficient approaches to improve maternal and newborn health practices in the home, as well as facilitate enhanced facility-based Maternal Neonatal and Child Health (MNCH) services in North East Nigeria. This project hopes to reduce the rate / incidence of maternal and child mortality in Northeast Nigeria.

INNOVATIONS

Emergency Transport Scheme: as a response to the second delay caused by lack of transportation, bad roads and poor terrains; the project runs a successfully tested transport scheme in hard-toreach parts of Gombe State. The Volunteer Drivers receive training on danger signs in pregnancy and basic safe motherhood; the model ensures that training and recruitment of new volunteer drivers occurs as often as necessary. Volunteer drivers also enjoy community recognition and recently began to receive a stipend for their activities in the communities.

Community Volunteers & Frontline Workers: This project works through the Federation of Muslim Women's Association Volunteers (FOMWAN) and Traditional Birth Attendants to facilitate appropriate referral to higher level of care as well as conduct pre and post-delivery checks on a mother and her newborn within the communities. These community volunteers are highly respected within their communities and thus have a big role to play in ensuring that unsafe practices in pregnancy, delivery and post-partum care are eliminated.

Family Health Call Centre: the project runs an MNH Call Centre that provides a linkage between pregnant women and community volunteers or frontline workers as well as Emergency Transport Scheme (ETS) volunteers. The Call Centre is also an information hub for all health issues pertaining to pregnancy, nutrition, post-partum care and recently family planning.

Performance Based Financing For Frontline Volunteers: the project rewards frontline workers per referral to facilities to increase the number of women who receive appropriate care in a facility – from antenatal services to delivery and the baby's immunizations. Frontline workers, community volunteers and Call Centre Staff are usually trained retired midwives who are part of the community and can speak the language. They are trained and effectively monitored to make sure that the right data is collected throughout the project. The MNH project in Gombe also continues to enjoy the support of community and traditional leaders.

ACHIEVEMENTS OF THE PROJECT

- Increased health facility delivery from 18% (NDHS 2008) to 28% (NDHS 2013)
- Increased ANC attendance from 48% (NDHS 2008) to 58% (NDHS 2013)
- 1,450 community based volunteers trained to deliver home based care during early/late pregnancy, postnatal stages and make referrals for skilled care
- Training on Essential Newborn Care (ENC), administration of Misoprostol and Active management of third stage of labour (AMTSL) for 117 health facilities across the 10 local governments of Gombe state.
- Mass distribution of resuscitation kits containing Ambu bag and suction bulbs
- Selection and training of Ward Development Committees for programme sustainability

Maternal and Child Health (MCH) Project NORTHEAST NIGERIA (LEARNING GRANT) 2009 – 2011

The goal of the learning grant in Gombe state was "to demonstrate effective, scalable approaches to improving critical maternal and neonatal health (MNH) practices in the home and position successful approaches for scale up". The project explored models for improving critical MNH practices in the home and increasing recognition of danger signs, provision of essential clean delivery kits and micro nutrient supplements, establishment of a functional Call Centre, referrals and transport to facility-based care when needed. The project employed three models in delivery of services: traditional birth attendants (TBAs), the Federation of Muslim Women's Associations in Nigeria (FOMWAN) volunteers and a 'Combined' Model which consisted of TBAs and FOMWAN volunteers.

Population Services International (PSI) and Transaid partnered with SFH in this project which was funded by the Maternal and Neonatal Health Project (MNH). The project initiated a substantial increase in use of proper health care methods via the intervention of TBA and FOMWAN volunteers, provision of subsidized products as well as the use of the Emergency Transport Scheme.

2.6 Theoretical Framework

As a scientific adventure, this study can be better explained with the use of the Neoliberal theory. Neoliberalism was the hegemonic ideology from the early 1980s to the early 2000s. It was the ideology adopted and promoted by American governments since Ronald Reagan. After the turn of the century, however, its intrinsic irrationality, its failure to encourage economic growth in developing countries, its efficacy in concentrating income for the richest 2% of every rich or developing society that adopted its ideas, and the increased macroeconomic instability (as shown by the successive financial crises of the 1990`s became clear indications of the exhaustion of Neoliberalism (Pereira, 2009).

Neoliberalism is everywhere, but at the same time, nowhere. It is held to be the dominant and pervasive economic policy agenda of our times, a powerful and expansive political agenda of class domination and exploitation, the manifestation of "capital resurgent", an overarching dystopian zeitgeist of late-capitalist excess. Perry Anderson describes it as the most successful ideology in world history. The foundations of modern economics, and of the ideology of neoliberalism, go back to Adam Smith and his great work, The Wealth of Nations. Over the past two centuries Smith's arguments have been formalized and developed with greater analytical rigor, but the fundamental assumptions underpinning neoliberalism remain those proposed by Adam Smith. The liberal doctrines propounded by Adam Smith came under attack from two directions.

On the one hand, Smith's ideal society was one of isolated individuals, each pursuing his own selfinterest. The subject of this article is the concept of "neoliberalism" and its history. The concept has, during the past twenty years or so, become somewhat of an exhortation in many political and academic debates. Neoliberalism is both a body of economic theory and a policy stance. Neoliberal theory claims that a largely unregulated capitalist system not only embodies the ideal of free individual choice but also achieves optimum economic performance with respect to efficiency, economic growth, technical progress, and distributional

justice. The policy recommendations of neoliberalism are concerned mainly with dismantling what remains of the regulationist welfare state. These recommendations include deregulation of business; privatization of public activities and assets; elimination of, or cutbacks in, social welfare programs; and reduction of taxes on businesses and the investing class.

Before 1980, neoliberalism was an esoteric term, used scarcely, and then, only by economists. Since then, it has become one of the most widely used terms across many social science disciplines except in economics where it has disappeared. During this period, there has been a steady trend to rediscover neoliberalism as more complex than previously considered, and to re-theories it as a more subtle, latent, ubiquitous, or expansive phenomenon. As a result, it has been drawn far beyond its conceptual crib in economic policy, political economy, and the states versus markets debate, towards issues of power and ideology, reflecting a shift in theoretical inspiration from Keynes towards Marx, Gramsci, and Foucault (Venugopal, 2015).

Neoliberalism appears to be problematic as a dominant theory for contemporary capitalism. The stability and survival of the capitalist system depends on its ability to bring vigorous capital accumulation, where the latter process is understood to include not just economic expansion but also technological progress. Vigorous capital accumulation permits rising profits to coexist with rising living standards for a substantial part of the population over the long-run. However, it does not appear that neoliberalism promotes vigorous capital accumulation in contemporary capitalism (Kotz; 2000).

Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. The state has to guarantee, for example, the quality and integrity of money. It must also set up those military, defense, police, and legal structures and functions required to secure private property rights and to guarantee, by force if need be, the proper functioning of markets.

Furthermore, if markets do not exist (in areas such as land, water, education, health care, social security, or environmental pollution) then they must be created, by state action if necessary. But beyond these tasks the state should not venture. State interventions in markets (once created) must be kept to a bare minimum because, according to the theory, the state cannot possibly possess enough information to second-guess market signals (prices) and because powerful interest groups will inevitably distort and bias state interventions (particularly in democracies) for their own benefit (Harvey, 2005).

The concept suggests its own definition: “Neo-liberalism” is a revival of “liberalism”. This definition suggests that liberalism, as a political ideology, has been absent from political discussions and policy-making for a period of time, only to emerge in more recent times in a reincarnated form. It suggests, in other words, that liberalism has undergone a process of initial growth, intermediary decline, and finally a recent rejuvenation. Alternatively, neo-liberalism might be perceived of as a distinct ideology, descending from, but not identical to liberalism “proper”. Under this interpretation, neo-liberalism would share some historical roots and some of the basic vocabulary with liberalism in general.

This interpretation places neoliberalism in the same category as American “neo-conservatism”, which is an ideology or “political persuasion” somewhat similar to and yet markedly different from much conventional conservative thought, and often hardly recognizable as a genuinely conservative ideology (Thorsen and Lie, 2006). The explicit conceptual elaboration of critical theories of Neoliberalism and Neo liberalization has been pioneered by human geographers and spatially-sensitive sociologists. Neoliberalism is understood as an ideology that is shaped in a few centres, which then diffuses outwards, and a political project that aims to re-order the territorial framing of capital accumulation. The resulting process of Neo-liberalization is understood to be geographically uneven relationships existing between states.

Donor agencies are not controlled by people without their own peculiar challenges. However, having surpassed the minor health issues such as malaria, polio, HIV/AIDS, measles, cholera, tuberculosis, etc the donor have found it liberal to help the less developed countries of Asia, Africa and Latin America combat these health malaises. It is a bid to liberate (free) the Nigerian state from her peculiar public health challenges that has propelled the big donors like the BILL AND MELINDA GATES to get-involved in the ways and manners it has. Global health entails the ability of the majority of global citizens to enjoy average healthy living. In view of this, the developed societies with their great successes in health management have taken up the liberation crusade of ensuring sound health for all to help develop the public health sector of countries around the worth so as to ensure the sustainability of the development in the global health care systems.

The BILL AND MELINDA GATES FOUNDATION has been involved in the development of Nigeria’s public health sector through its various donations, supports as well as consultancy services in Gombe as well as other parts of Nigeria most especially in the North-eastern region where full attention is been needed due to the recent political ups and downs. On the facial value of its generosity, there is virtually nothing available for BILL AND MELINDA GATES to gain in the course of assisting and aiding Nigeria to manage her

health challenges. It is a mere act of fatherly moral obligation to improving the lifestyle of his son. America's donation to the Nigeria's health sector is obligatory and humanitarian.

One of the major criticisms of the neoliberal theory comes from the Marxists. In the view of the Marxists, nothing moral about the aids and donations coming from the capitalist countries neither could any benevolence act comes from them. The sole aim of their relationships and interactions with the third world is to further entrench the established exploitation. Aids, grants, loans and donations are not meant to develop the third world but to perpetually subject these vulnerable countries of the world to dependency and underdevelopment. Neoliberalism has been accused of signifying neocolonialism by the industrial hegemons like the United States through her various tools and mercenaries like the BILL AND MELINDA GATES etc. Donors are tools of domination and country of medically vulnerable countries like Nigeria by the giant pharmaceutical companies domiciled in the country or the medical experts graduated by the imperial universities in America.

2.7 Definitions of Terms

Aid effectiveness: Aid effectiveness is about ensuring impact of development aid

Alignment: Alignment entails efforts to bring the policies, procedures, systems and cycles of the multilateral and bilateral actors into line with that of the country being supported.

Bilateral donor organization: An organization that operates directly between two well-defined parties.

Development partners: Organizations working towards achieving development in health sector, by providing financial and/or technical support for health development projects.

Donor coordination: A process to harmonize donors' efforts to avoid duplications and improve efficiencies of aid in recipient country.

Donors: Organizations that contribute towards the development of developing countries.

Federal Ministry of Health: The Ministry supervising the health activities in Nigeria at federal, state, and local government levels. The Ministry develops and ensures the implementation of policy that strengthens the health system of the country.

Implementing partners: Federal, state, and local governments, ministries, agencies, civil society organizations, and private organization that implement programs in the health sector.

Multilateral donor organization: An organization that works in consensus with multiple nations towards economic development of developing countries.

National Health Strategic Development Plan: A document that "reflects shared aspiration to strengthen the national health system and to vastly improve the health status of Nigerians.

Recipient country: The country that receives ODA from the donors and development partners' community.

Stakeholders: The group of individuals, individual, or organization that share the same objective to achieve common goals.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology used to determine the impact of donor agencies on the

Nigerian health care delivery system with special reference to the BILL AND MELINDA GATES. In this study, the nature and character of donors as well as their donations in the Nigerian public health sector are unraveled. Also, in this chapter, the research design, methodology, participant selection criteria, data instrumentation, data analysis plan, are discussed.

3.2 Design of Study

This study is designed to examine the impact of donor agencies on the Nigerian health care delivery system with special reference to the BILL AND MELINDA GATES. Both primary and secondary sources of data collection were relied upon in getting the relevant data for this study. While the secondary data were analyzed based on the contents of the materials, the primary data were analyzed using statistical tool.

3.3 Area of Study

The area of study of this research is the entire public health sector of the Nigerian health system vis-à-vis the activities of donors. Since the list of donors in the Nigerian public health sector is large, the reference donor for this study is the BILL AND MELINDA GATES between 2007 and 2017.

3.4 Population of the Study

The population covered was the entire Gombe state population at about 6 million (NPC, 2006 census report). Since the public health sector is theoretically designed to accommodate the entire Gombe populace, it therefore forms the population of study for this research.

3.5 Sampling Techniques

A purposive sampling was used for the study. This is because the population was made up of relevant stakeholders in the Nigerian public health sector and the BILL AND MELINDA GATES. Since the research is a case study in nature, the questionnaires were issued to the relevant sections of the population that are in custody of the information relevant to the study.

3.6 Sample Size

In the course of this research, a total of two hundred and ten (100) people were sampled in across the spectrum of the studied population both within the Nigerian public health sector as well as the donor agency under study i.e. BILL AND MELINDA GATES.

3.6 Research Instrument

For the purpose of this research, a set of structured questionnaires containing bio-data as well as critical questions were designed for the purpose of getting answers to the research questions so as to achieve the objectives of the study. A total of 100 questionnaires went out to respondents in this format; 50 to BILL AND MELINDA GATES, 25 to the ministry of health and 25 distributed at the General Hospital in Gombe state.

3.7 Method of Data Analysis

The analysis of data and process were handled using a statistical software known as SPSS. Simple descriptive statistics in line with the pre-determined format provided by the researcher were applied to analyze data from the survey. Thus, the collected data were presented using tables and analyzed using simple percentage to give in clear terms the reliability and coherence nature of the answers from the respondents.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter is devoted to data presentation, analysis and interpretation. The raw data, which were elicited from field survey, oral interview and observation, were renewed to meaningful form, for empirical understanding of the result of the findings. A total of two hundred and ten (210) questionnaires was administered to the respondents, out of which only one hundred and fifty-five (155) was returned and deemed fit for analysis. Therefore, the analysis is based on the correctly answered questionnaires.

4.2 Socio-demographic characteristics of respondents

Table 4.2.1 Sex Distribution

Sex	Frequency	Percentages (%)
Male	40	26
Female	115	74
Total	**155**	**100**

Source: Survey, January 2018

The table shows the sex distribution of the respondents as follows: Male 40 representing (26%), while female 115 representing (74%). This affirms that at hand there were more females than males who participated in the study.

Table 4.2.2 Age Distribution

Age	Frequency	Percentages (%)
18-24	49	31.6
25-32	63	40.6
33-40	29	18.7
41 above	14	9
Total	**155**	**100**

Source: Survey, January 2018

The above table shows the age distribution of the respondents in the following ways: 18-24 years are 49 representing (31.6%), 25-32 years are 63 (40.6%), 33-40 years are 29 (18.7%), and 41 years above are 14 (9%). From the distribution majority of the respondents were between the ages of 2532 years.

Table 4.2.3 Religious Affiliation

Religion	Frequency	Percentages (%)
Christianity	31	20
Islam	121	78.1
Others	3	1.9
Total	**155**	**100**

Source: Survey, January 2018

The table above reveals the religion affiliation of the respondents in this ways, Christianity represents 31 (20%), and Islam represents 121 (78.1%), while those in the other religion were 3 respondents representing 1.9%. The implication is that Muslims participated more in the study owning to the fact that Gombe state is a Muslim populated state.

Table 4.2.4 Showing Marital Status of Respondents

Marital Status	Frequency	Percentages (%)
Single	15	10
Married	131	85
Divorced	5	3
Widowed	4	2
Total	**155**	**100**

Source: Survey, January 2018

The table above indicates that 15 respondents constituting about 10% are single, 131 respondents making up 85% are married, 5 respondents (3%) are divorced while 4 respondents forming 2% are widowed. This shows that married respondents participated more in the study.

Table 4.2.5 Educational Backgrounds of Respondents

Variables	Frequency	Percentages (%)
Primary	13	8.4
Secondary	27	17.4
Post-Secondary	110	71
Others	5	3.2
Total	**155**	**100**

Source: Survey, January 2018

From the table above, the educational backgrounds of the respondents are clearly shown in order to give credence to the opinion expressed by them in terms of its relevance. Those with primary school leaving certificate were 13 respondents constituting 84%, Secondary School holders were 27 of the respondents amounting to 17.4% and the Post-Secondary holders were the highest with 110 respondents covering 71% while 5 respondents; that is 3.2% were holders of other formal and informal educational certificates. The import of this is that the sampled population had the relevant knowledge to provide the needed responses for this study since the bulk of the respondents are literate enough to understand the subject of discourse.

Table 4.2.6 showing the Occupational status of respondents

Occupation	Frequency	Percentages (%)
Civil Servant	87	56

Farmers	59	38
Others	9	6
Total	**155**	**100**

Source: Survey, January 2018

This table shows that 87 (56%) are Civil Servant, 59 (38%) are Farmers, while 9 (6%) constitute respondents with other occupations. It can be deduce from the above table that most of the respondents are mainly Civil servants. In this basic understanding, these groups are very important to national development. Their health signifies the vitality of the nation.

Presentation of the Opinions of Respondents

Question 1: Which health provider do you prefer?

Table 4.3.1 Showing Preference for health care providers

Variables	**Frequency**	**Percentages (%)**
Traditional	75	48
Orthodox	50	32
Traditional and orthodox	25	17
Undecided	5	3
Total	**155**	**100**

Source: Survey, January 2018

From table 4.3.1 above the preferences of respondents on health care providers in Nigeria are captured. Those that rely on traditional healthcare providers were 75 respondents constituting 48%, 50 respondents (32%) makeup of the orthodox medicine, 25 respondents constituting 17% combine both the traditional and orthodox, While 5 (3%) were undecided on the question. The various societies that make up the Nigerian State have for long relied on the indigenous health system which was developed as a response to their environment and it involves the use of locally available resources to prevent and cure diseases.

It is a natural health care system which many generations of Nigerians have used. The practice transcends the maintenance of good health of the people as it also protects them from the menace of wild animals, evil spirits, accidents, provide bountiful harvest, good luck and other human activities (Roan, 1999, Osborn, 2007). Nigerians therefore, have a deep belief and reliance on traditional medicine, hence about 80 percent of the population uses it almost exclusively while about 95 per cent use it concurrently with western medicine.

This is because, to the Nigerian, traditional medicine treats the entire individual rather than one aspect of him or just his disease. According to the World Health Organization (2008), traditional medicine is:

"The total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing".

At the center of this practice are health professionals variously called *Babalawo* (Yoruba), *Dibia* (Igbo), *Boka* (Hausa), and among whom different expertise in healing has emerged. These include herbalists, bone-setters, traditional birth attendants, and psychiatrists among several others. They usually rely on vegetables, mineral substances, animal parts and certain other methods such as prayers, divinations, and incantations (Mbiti 1976, Owumi and Jerome, 2008).Traditional medicine exists in four major categories viz: Nature healing (bone setting, hydrotherapy, use of air, fire and hypnotism etc.), Natural healing (telepathy prayers, incantations, hypnotism etc.),Herbal healing (use of leaves, branches, fruits, stem back, roots, whole plants); Spiritual healing (involving spirits such as demons, witchcraft, water mermaid etc.) (Nigerian Tribune, 2010).

The practitioners acquire herbal knowledge either through inheritance or apprenticeship or as a call and the training period is usually long and expensive, even starting the preliminary preparations at the age of five in some cases. Part of the training involves some apprenticeship where candidates acquire knowledge pertaining to medicinal value, quality and use of different herbs, the causes, cure and prevention of diseases, among others. Overtime, they have created lasting impressions on the minds of the people and are given due recognition as competent health care providers (Erinoso, and Ayomide, 1985).

The typical medicine-man devotes much time and personal attention to the patient and this enables him to penetrate deep into the psychological state of the patient.

Western/Orthodox medicine was introduced to the Africa continent in the wake of colonialism through missionaries of the Christian faith (Mbiti, 1976). This new medicine prepared people psychologically to become more receptive to western culture and education. This led to the relegation of traditional medicine to the background and the practitioners were derided and tagged 'witch-doctors'. In Nigeria, traditional medical practice suffered a decline during the era of British colonization which virtually out-law it. This is coupled with the rise of Christian ideology especially of the Pentecostal genre which considered most aspects of the practice as un-Christian and therefore 'evil' (Nigerian Tribune, 2010).

The rejection and derision of the indigenous healing practice has continued till present time, leading to government's unwillingness to recognize and harmonize it with the global system of health care delivery. This policy declaration by the Nigerian government is a follow-up to the launch of the 2000-2010 Decade for African Traditional Medicine (ATM) by the Summit of the Organization of African Unity (OAU), [now African Union(AU)], in July, 2000, in Lusaka, Zambia. This is in realisation of the fact that in some communities, traditional medicine is all the health care services available, affordable and accessible to majority of the people on the African continent to whom traditional medicine is certainly, not an alternative. The main objective of the Plan of Action of ATM is the recognition, acceptance, development and integration of Traditional Medicine by all Member States into the public care system on the continent by 2010 (AU, 2009). Additionally the AU in collaboration with partners declared 31st of August of each year as the day to commemorate ATM. During the 2008 commemoration of ATM (31 August 2008) in Yaoundé Cameroon, Ministers of Health deliberated on the Mid-Term Review of the Decade of ATM. Among other recommendations, the Ministers emphasized that member States should strengthen their political will and infrastructural commitments for institutionalization of ATM into national health systems at all levels. Furthermore, a national mechanism should be established whose objective is to promote a dialogue between traditional and conventional practitioners of medicine (AU, 2009).From the fore-going and given the state of infrastructural development in the health sector it is apparent that one particular health type cannot claim self-sufficiency and adequately meet the health needs of the country alone. All that government needs to do to promote traditional medicine in the country according to the AU are the: establishment of the efficacy of native therapies/medicines;

i. Systematic organisation and codification of the knowledge base of the medicines;
ii. Standard dosage of medicines;
iii. Establishment of the framework for the control of the practice of healers; and
iv. Protection of the public from the harmful practices of quacks.

It is worthy of note that traditional medical practitioners in Nigeria are now trying to 'modernise' their methods and practices. This is more apparent in the areas of recruitment, education and training (for instance, many qualified pharmacists are now involved in the practice), specialisation, use of modern equipment for diagnosis, packaging and marketing. This is in addition to routine evaluation and monitoring by the regulatory agency, the National Agency for Food and Drug Administration and Control (NAFDAC). Also many of them now own medicinal/botanical gardens where herbs are grown and thereafter collected for use thereby, reducing the threat to the forests through over-harvesting of medicinal plants and thus contributing towards the conservation of natural resources.

Question 2: How would you describe the current health care service delivery in Gombe state?

Table 4.3.2 Showing the health care service delivery in Gombe state.

Variables	Frequency	Percentages (%)
Efficient	43	27.7
Not efficient	73	47.1
No response	39	25.2
Total	155	100

Source: Survey, January 2018

Table 4.3.2 above reflects the perception of respondents on the health care service delivery in Gombe state. The respondents that claimed the health care delivery is efficient were 43 (27.7%), not efficient respondents were 73 (47.1%), while the undecided respondents were 39 (25.2%). The dominant opinion of respondent is that the health care has not been well delivered to meet the task of quality health care delivery in the country. Detailed information was available for the Federal Government spending on the Federal Ministry of Health only. There was no data for spending at the state or local government level. The total spent was $1,037 million, approximately $6.70 per capita. The World Bank records that $18.70 per person was spent from public sources on health. Decentralized spending at state and local level probably explains the $12 difference between these figures.

In 2005 (the most recent year for which a budget breakdown is available) the WHO National Health Accounts document for Nigeria show that federal government funded 13% of all healthcare spending, and state and local governments funded a further 13%. If this pattern held in 2009, that would account for some of the discrepancy between the budget document figures and the World Bank report.

Nigeria Budget Office for the Federation does not release any quantitative information about donor support for health, so it was not possible to assess donor funding in Nigeria or to compare patterns of foreign and domestic funding allocations.

Question 3: Is the health sector strategic to national development?

Table 4.3.3 The Gombe state Health Sector and national development

Variables	Frequency	Percentages (%)
Agreed	58	37.4
Strongly Agreed	37	23.9
Disagreed	23	14.8
Strongly Disagreed	19	12.2
Undecided	18	11.6
Total	155	100

Source: Survey, January 2018

The table 4.3.3 above indicates the opinion of the respondents on the role of the Nigerian health sector in national development. Majority of the respondents; 58 (37.4%) and 37 (23.9%) agreed and strongly agreed respectively while 23 (14.8%) and 19 (12.2%) disagreed but 18 (11.6%) were undecided. The description of the current status of the health situation in the country leaves one with the choice from the opinions expressed above.

Gombe state's health sector is characterized by poor quality and inefficiencies in the provision of public sector health services resulting in poor health outcomes, lack of appropriate targeting strategies for reaching poor and under-served populations; large disparities in health status between the poor and non-poor, inadequate quality of government health services, which stems from, inter-alia, lack of drugs, limited human resources and managerial capabilities; lack of an enabling environment to allow private sector providers to build partnerships with the public sector; low levels of public funding combined with shortcomings in the way resources are allocated, spent and managed; and poor delineation of roles and responsibilities within the three tiers of government with regard to the provision and financing of health care. During the past two decades of military regimes health outcomes have generally stagnated or deteriorated. Basic health indicators are poor.

The resurgence in malaria combined with the HIV/AIDS/TB co-epidemic now runs the risk of further deterioration in health outcomes. Life expectancy at birth is 54 years while the infant mortality rate is 77 per 1000 live births. High infant and child mortality and morbidity rates; poor nutritional status and high fertility rates are the indicators of the adverse effects of poor sanitation, low incomes and other determinants of the pervasive poverty in Gombe.

The major causes of mortality and morbidity in children under five are diarrhea, respiratory infections, malnutrition, vaccine-preventable diseases, and malaria. Children under five appear to be particularly hard hit by malaria, with 75 percent of malaria deaths occurring in this age group. Child mortality and malnutrition, which are good proxies for social welfare, are consistent with the increasing trend in poverty.

Less than 30% of children under five years of age are fully immunized against vaccine preventable diseases (VPD). Thus, pertussis (whooping cough), cerebrospinal meningitis, neonatal tetanus and measles, account for over 90 percent of morbidity and 80 percent of mortality in children. Diarrheal diseases are the second and third main causes of infant and under-five mortality respectively. A 2013 Multiple Indicator Cluster Survey (MICS) reported that 15.3percent of children under five had experienced diarrhea in the two weeks preceding the survey and less than 50 percent of these children visited a health facility in Gombe state. Maternal mortality, one of the main indicators of the state of reproductive health, is unacceptably high (54 per 1000 live births). Approximately 15% of all maternal deaths in Nigeria. The excessively high maternal mortality levels are a reflection of the inadequate access to obstetric care, poorly functioning referral systems, socio-cultural barriers to health care, and general systemic problems concerning the health care delivery system.

Gombe state and Nigeria at large appears to have experienced a moderate decline in fertility, but continues to lag considerably behind most African countries. Although, recent data indicates that the Total Fertility Rate (TFR) and population growth rate dropped from 6.9 to 5.3 and 3.2 to 2.6 percent respectively. Patterns of fertility suggest large urban rural and intra-regional

differentials, with the Northeast and Northwest regions recording the highest fertility rates. The number of births are higher among rural women and those with fewer years of schooling. It is probable that most of the decline is attributable to a shift towards a late pattern of childbearing rather than to improvements in access to family planning services. The recent Demographic Household Survey (DHS) found that the Contraceptive Prevalence Rate was only 15 percent (all methods) and less than one-quarter of currently married non-users intended to use family planning in the future. Approximately, 42% of women compared to 77% of males are aware of family planning methods. More aggressive family planning efforts among women could help reduce the high maternal mortality rate.

With a prevalence rate of over 20%, malaria is endemic in Gombe state and Nigeria at large. It accounts for approximately half of all outpatient visits, 20% of all hospital admissions, and 35% of deaths in children less than 5 years of age. Acknowledging the serious threat that malaria poses to the health and economic development of Nigeria, the Government convened the African Summit on Roll Back Malaria in Abuja on April 25, 2000.

The summit, which was attended by 25 heads of state and high-level delegates from all other countries with endemic malaria in sub-Saharan Africa, resulted in the Abuja Declaration. The declaration committed countries in the region to meet three specific targets which include provision of prompt access to correct, affordable and appropriate treatment with 24 hours of the onset of symptoms by at least 60% of those suffering from malaria at least 60% of those at risk of malaria, particularly pregnant women and children less than 5 years of age, benefit from the most suitable combination of personal and community protection measures, such as insecticide-treated nets (ITNs) and other interventions which are accessible and affordable to prevent infection and suffering; and at least 60% of pregnant women who are at risk of malaria, especially those in their first pregnancy, have access to chemo prophylaxis or intermittent presumptive treatment. No doubt that the labour force as supported by the quality of healthcare in the country is very strategic to national development.

Question 4: Would you say donor agencies have improved Nigerian health sector?

Table 4.3.4 Have donor agencies helped improve the health sector in Nigeria?

Variables	Frequency	Percentages (%)
Yes	72	46.4
No	53	34.2
Undecided	30	19.4
Total	**155**	**100**

Source: Survey, January 2018

Table 4.3.4 above shows the opinions of respondents on the impacts of donor agencies on the Nigerian health sector improvement; 72 respondents making up 46.4% said yes, 53 respondents (34.2%) said No while 30 (19.4%) were undecided.

Donors and development partners provide financial support for the Nigeria's public healthcare system strengthening. Besides funding, these donors and development partners provide technical support by mobilizing and training of health care professionals and health care workers in order to achieve their objectives in Nigeria.

The majority of the funding for Maternal and Newborn Health comes from development partners.

These development partners are (the President's Emergency Plan for AIDS Relief (PEPFAR), Global Fund, UNICEF, WHO, DFID, JICA, BILL AND MELINDA GATES, and World Bank. The World Bank loaned US$140.3 million to Nigeria to support a 5-year Maternal and Newborn health Programme Development Project I (2002-2007) (World Bank, 2009). World Bank also went on to contribute US$225 million towards a Polio Programme Development Project II (2009-2013) (World Bank, 2012). To achieve an increase in gender sensitivity, prevention, interventions, and to increase access to antiretroviral treatment, funding are on decentralizing on prevention and support programs, making it available at the primary health care facilities, and at community levels.

President's Malaria Initiative, a part of the Global Health Initiative focused on helping Nigeria to reduce mortality caused by malaria by 2015, as compared with 2009-2010 baseline levels (Nigeria Malaria Operational Plan, 2014). This goal is expected to be achieved by reaching 85% coverage of the most vulnerable groups. These groups are: pregnant women and children under 5 years of age.

Nigeria was also one of nine countries to pilot the Affordable Medicines Facility malaria (AMFm). The AMFm was focused on making the ACTs affordable as other cheap antimalarial monotherapies. The World Bank Malaria Booster Program provide $280 million in the first and second phase of the program to support a broad set of malaria intervention programs in seven states (World Bank, 2013). Although the World Bank Booster Program ended in June 2013, the country requested an extension of theproject to June 2014, at no cost. The DFID launched a 5-year £50 million malaria programme in 2008 (DFID, 2012). Nigeria received $600 million

of Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) Round 8 in 2008; $ 375 million for the Phase I and Phase II of this grant from August 2012 to October 2014 was released (Nigeria Malaria Operational Plan, 2014).

Donors' assistance is spread to ensure its benefits in many states. The National Malaria Control Program (NMCP) works with donors to ensure that the malaria programmes are not clustered in one geopolitical zone; however, the decentralized system of Nigerian health care and its large population is the challenge that donors face in providing assistance (Nigeria Malaria Operational Plan, 2014).

The majority of the funding for HIV and AIDS program in Nigeria comes from development partners. These development partners are (the President's Emergency Plan for AIDS Relief (PEPFAR), Global Fund, UNICEF, WHO, DFID, JICA, BILL AND MELINDA GATES, and

World Bank. The World Bank loaned US$140.3 million to Nigeria to support a 5-year HIV/AIDS Programme Development Project I (2002-2007) (World Bank, 2009). World Bank also went on to contribute US$225 million towards an HIV/AIDS Programme Development Project II (20092013) (World Bank, 2012). Through PEPFAR, the United States allocated a large amount of money to Nigeria. In financial year 2011, PEPFAR provided approximately US$488.6 million to Nigeria for HIV/AIDS prevention, treatment and care (PEPFAR, 2012). By August 2012, the Global Fund approved US$360,454,493, and disbursed US$275,586,635 in funds for Nigeria to expand HIV/AIDS treatment, prevention, and care programmes (Global Fund, 2004). To achieve an increase in gender sensitivity, prevention, interventions, and to increase access to antiretroviral treatment, funding are on decentralizing HIV prevention and support programs, making it available at the primary health care facilities, and at community levels.

Also, malnutrition is a critical problem in Nigeria, especially the Northern part of the country. The rates of stunting, underweight, and wasting among children in Nigeria are58%, 41%, and 16% respectively (Akinyele, 2009). These levels are high when compared with the WHO's standard. According to the Vitamin and Mineral Damage Assessment Report (2004), 25% of the Nigerian children that have lower immunity results from vitamin A deficiency. This leads to frequent ill health and poor growth in children.

Donors and development partners are involved in improving nutrition in Nigeria which includes

BILL AND MELINDA GATES, DFID, UNICEF, WHO, World Bank, UNFPA, EU. Currently,

UNICEF Nigeria supports Nutrition projects in two major areas, sustainable elimination of vitamin

A deficiency and iodine deficiency disorders (IDD), as well as reduction of Iron Deficiency Anaemia (IDA) and zinc deficiency (UNICEF,2009). In partnership with other partners and stakeholders, UNICEF is contributing to promote early childcare practices beyond its focus LGAs. The DFID funded the Working to Improve Nutrition in Northern Nigeria (WINNN) program. WINNN is working to improve the nutritional status of 6.2 million children under 5 years of age in five states of northern Nigeria (Nutrition Commitment Audit for Nigeria, 2013).

The World Bank is supporting Nigeria's efforts to improve nutrition problems through health and agricultural sector projects, these include, a US$450million of the Third National FADAMA Development Project which has a goal to reduce food insecurity of FADAMA users, a US$90 million extension of the Second Health Systems Development Project to target maternal and child health, and a US$150 million Commercial Agriculture Development Project which strengthens market access by small and medium farmers and agricultural production. A sector study to fill in the knowledge gap in nutrition is being done through a landscape analysis of existing experiences in community health and nutrition programs (World Bank, 2011).

Question 5: Would you support the call for health sector reform in Gombe state?

Table 4.3.5 The Need for Health Sector Reform in Gombe state

Variables	Frequency	Percentages (%)
Yes	120	77.4
No	25	16.1
Undecided	10	6.5
Total	155	100

Source: Survey, January 2018

Table 4.3.5 above explains the opinions of respondents on the need for health sector reform in Nigeria in which 120 (77.4%) respondents said yes, 25 (16.1%) said no while 10 (6.5%) were undecided. To this end, the majority of the respondents called for reforms in the health sector of Nigeria. The reason that we have needed health systems reforms all along is because the systems we had prior to that time were not working or producing the optimal health status possible and deserved by the people of Gombe state. The 2000 World Health Report ranked Nigeria as the187th of the 191 member nations for its health systems performance.

That speaks a whole lot about the fact that Nigerian health care system in general is not working which strongly calls for health sector reform in Gombe state.

Question 6: Are you aware of the BILL AND MELINDA GATES's supports to the Gombe state health sector?

Table 4.3.6 Awareness of BILL AND MELINDA GATES's Support to the Health Sector in Gombe state

Variables	Frequency	Percentages (%)
Yes	120	77.4
No	25	16.1
Undecided	10	6.5
Total	155	100

Source: Survey, January 2018

From the table above, the opinions of respondents as regards their awareness of the interventions of the BILL AND MELINDA GATES in Gombe state and the health sector specifically. The number of the respondents that said yes to the question was 120 constituting 77.4% of the total respondents, those that said no were 25 respondents (16.1%) while 10 respondents making up 6.5% of the population sampled were undecided.

The opinion expressed by Mr. Aminu Waziri; the Director of Information of Growth and Employment in States (GEMS) in Gombe state substantiate the above data. In his analysis, BILL AND MELINDA GATES implemented $83.3 million of activities to execute development programs throughout Gombe state. Most of BILL AND MELINDA GATES development activities are implemented through contracts and grants to a variety of non-governmental organizations, corporations, and academic institutions. Contracts are used by BILL AND MELINDA GATES to generally hire institutions and organizations to provide specific goods and services that the Mission has identified as necessary to accomplish its development objectives.

Grants are used to enter into a partnership with institutions or organizations to support activities, either in whole or in part, that are consistent with the Mission's objectives in Gombe state.

In many cases, these organizations conduct their work in partnership and collaboration with Gombe state organizations. All organizations receiving contract or grant awards must meet minimum financial and management accountability standards established by the United States. Currently, BILL AND MELINDA GATES works with about 36 implementing partners. The majority of work is awarded through full and open competition and a small percentage through grants.

Question 8: Do you think there is a collaboration between BILL AND MELINDA GATES and other donor in the health agencies in Gombe state?

Table 4.3.8 Collaboration among Donors in Health Sector in Gombe state

Variables	Frequency	Percentages (%)
Yes	133	85.9
No	14	9
Undecided	8	5.1
Total	**155**	**100**

Source: Survey, January 2018

The table 4.3.8 above depicts the responses of the respondents on the need to harmonize the interventions of donors in the health sector in Gombe state for its effectiveness. Those who believe in this synergy were the majority with 133 respondents constituting 85.9% of the population, 14 (9%) said no while 8 (5.1%) could not decide. This is not to scare agencies like BILL AND MELINDA GATES away from its invaluable interventions in the sector but to enhance the effectiveness of the agencies' supports in the sector. The above opinion justifies the content of one of the official documents extracted from the elibrary of the United States of America. The coordination of health aid to developing countries for effective outcome is a growing concern to the donors, developmental partners, and other stakeholders in the health sector. The Nigerian health sector is among the sectors in developing countries that experience a challenge in international development assistance coordination (WHO, 2013). According to the WHO (2009), the challenges facing aid in Nigerian health sector are getting all partners to be committed to the process of harmonization and alignment and fragmentation of service delivery from donors and development partners. Donors and development partners concentrate more on one health program, neglecting other health concerns. For example, there is no balance between aid for

polio eradication and aid for other health intervention programs (WHO, 2009). Almost all the donors and development partners provide aid for polio eradication, while there are few, perhaps no donors and development partners that provide aid for other health intervention programs to address other disease burden in Nigeria. This challenge is an inadequate flow of information among donors, developmental partners, and the government (WHO, 2009). The Gombe state health care system is a little more complex with many international organizations and other developmental partners after several insurgency attacks. The flow of information between all stakeholders in the health sector for health development is limited (Daniels et al., 2013).There is insufficient flow of information and relevant data, which makes transparency and mutual accountability between the government and donor organization difficult (Gombe state Planning Commission, 2014). Health development aid coordination involves coherence in activities and communication from all the donors and development partners and other relevant stakeholders in the health sector.

Question 9: What would you say is the major intervention area of BILL AND MELINDA GATES as a donor agency to the Gombe state health sector?

Table 4.3.9 BILL AND MELINDA GATES health intervention areas in Gombe state

Variables	Frequency	Percentages (%)
MNH	109	70
HIV/AIDS	16	10
Polio	17	11
Tuberculosis	10	6
Others	3	3
Total	**155**	**100**

Source: Survey, January 2018

The table above reflects the opinions of respondents on the areas of intervention by the BILL AND MELINDA GATES. Those who believe that Maternal and newborn health has been the major area of intervention constitute 70% (109 respondents), 17 respondents (11%) said Polio, 16 respondent (10%) said HIV/AIDS, tuberculosis was the claim of 10 respondents which constituted 6% while 3 respondents, that is, 3% indicated other health challenges like, advocacy against female circumcision, personnel training.

The Millennium Development Goals to reduce maternal and child mortality in Africa cannot be achieved without major improvements in the health status of Nigeria's women and children. Strengthening the health sector and improving the overall health status of the population are among the most important development issues facing Nigeria.

In general, Nigeria is making much slower progress on maternal and child health indicators than most other African countries. The maternal mortality rate is among the highest in the world and completed fertility remains over seven in the Northern states where child-bearing starts very early and births are closely spaced. About one million children die each year before their fifth birthday, infant and child mortality rates are extremely high, and contraceptive prevalence is low.

In conjunction with high maternal and child mortality rates, Gombe state suffers from an HIV/AIDS prevalence rate of 3.1 percent with an estimated 2.6 percent of the population living with HIV and AIDS.

Risky behaviors continue and are targets for BILL AND MELINDA GATES key prevention interventions. Gombe state government has been slow to recognize the gravity of the epidemic and to mobilize the required commitment and resources for a sustainable state response. While progress has been made in policy development and strategic planning at the Federal level, provision of care, treatment, and prevention services remains inadequate and the level of unmet need continues to increase.

To meet these challenges, BILL AND MELINDA GATES Health activities emphasize a stronger coordination of activities, greater focus in geographic and technical implementation, and strategic integration of key programme areas and resources, including family planning and reproductive health; maternal, neonatal, and child health, including routine immunization; and prevention and treatment of malaria and HIV.

This approach improves health services by increasing the number and quality of health providers, expanding access to and use of essential life-saving commodities, and strengthening health facilities to adhere to international standards of practice. Integration across sectors, particularly at the community level and with education and civil society activities, is also a priority and key to accomplishing sustainable improvements in health. Engaging civil society, the media, and the private sector in the policy and advocacy process will increasingly strengthen political and budgetary support for health.

Question 10: Do you think the ministry of health has been effective in the management of the Gombe state health sector?

Table 4.3.10 The Ministry of Health and Health sector management in Gombe state

Variables	Frequency	Percentages (%)
Yes	34	21.9
No	111	71.6
Undecided	10	6.5
Total	155	100

Source: Survey, January 2018

Table 4.3.10 above conveys the opinions of respondents on whether the ministry of health has been up to the task of managing the health situations, 34 respondents representing 21.9% said yes, 111 respondents, that is, 71.6% all accused the federal ministry of health of not being up to the task of managing the state's health sector while 10 respondents (6.5%) could not decide. In principle, the management of Nigeria's health care system is decentralized into three; the federal, state, and local government level. The Federal government, through the Federal Ministry of Health ensures the comprehensiveness of the multi-sectorial inputs, community involvements at the local, state and federal level; ensuring that health care services are appropriately supported by an efficient referral system.

In addition, the host Government ensures that support provided by donor organizations are in consonance with the overall national health policy (Health Policy; Federal Ministry of Health, 2004); moreover, the Ministries of Health ensures coordination of actions between development partners and other sectors towards achieving health development goals.

During the Busan Partnership for Effectiveness Development Co-operation, it was agreed that developing countries would lead coordination efforts to manage proliferation of aid at country level (OECD, 2011). The Federal Ministry of Health develops modalities and institutionalizes appropriate processes (Country Coordination Mechanism) for effective coordination of international agencies and NGOs operating in health sector. Also, the Federal Ministry of Health collaborates with United Nations agencies, multilateral and bilateral donor organizations to harness and align their assistance in the health sector.

Furthermore, the Federal Ministry of Health collaborates with the National Planning Commission for proper coordination of the activities of the donor organizations in the health sector (Health Policy; Federal Ministry of Health, 2004).

The Gombe state commission of health ensure efficiency in the activities in the secondary hospitals and regulating technical support for the primary health care services. While at the local government level, they are responsible for the activities in the primary healthcare centers and ensuring that the structure is implemented at the community level, which seems to be the most important of all level, because it forms the support structure for the implementation of primary health care (WHO Report, 2000).

Donors and development partners support the government of the recipient country to enable them to own the development process for program sustainability and explaining the need of commitment toward achieving the outcome of the health development program. Also, they encourage the civil society organization to participate in implementing health development projects. In addition, the donor organizations and other development partners are responsible for ensuring the reduction of fragmentation of aid.

Further, the developmental partners support government efforts to promote financial management system in line with Paris Declaration on Aid Effectiveness (NSHDP, 2010). Although, the management of Nigeria's health care system seems to be coordinated; in practice, the system is often a duplication and confusion of roles and responsibilities among different levels, as well as agencies (WHO, 2002). The implication is weakness in coordination and tracking of activities at different levels, and between other stakeholders in health sector. Currently, the federal, state, and local government, as well as other government agencies and donors are involved, to various degrees; contribute to the management of health system functions, service provision, and financing.

Question 11: Are the activities of BILL AND MELINDA GATES being felt outside the State Health Structure?

Table 4.3.11 BILL AND MELINDA GATES health interventions in the State

Variables	Frequency	Percentages (%)
Yes	135	87.1
No	15	9.7
Undecided	5	3.2

Total	155	100

Source: Source: Survey, January 2018

Table 4.3.11 above is a reflection of the opinions of respondents on whether the activities of BILL AND MELINDA GATES in Gombe state health sector have been felt outside the state health structure, 135 (87.1%) believes its intervention are captured in other sectors other than health structure, 15 respondents (9.7%) accused the agency of over concentrating its aid at the federal level, 5 respondents (3.2%) were undecided. This is tentative for the agency to note on how to tackle this issue such that its activities would be felt multiplicitly and not just within the hemisphere of the health structure of Gombe state.

Table 4.3.12 Has the current insurgency affected the rate at which BILL AND MELINDA GATES intervene in the Gombe state health sector?

Variables	**Frequency**	**Percentages (%)**
Agreed	48	31
Strongly Agreed	17	11
Disagreed	20	13
Strongly Disagreed	70	45
Undecided	0	0
Total	155	100

Source: Source: Survey, January 2018

The table above reflects the opinions of respondents on the whether the current insurgency has affected the rate at which BILL AND MELINDA GATES intervene in the Gombe state health sector. Those who agree and strongly agreed that insurgency has affected its intervention constitute 31% (48 respondents) and 11% (17 respondents) respectively, while 20 respondents (13%) disagreed, 45% (70 respondents) strongly disagreed, to this end majority of the respondents are correct. Following the 2015 insurgency attack which led to the loss of two BILL AND MELINDA GATES personnel the agency had to be on halt for about two which lead to the slowdown of some of its proposed programmes and some of its resource persons had to leave the state due to the tension then, this intuitively means that insurgency has to some extent affected the rate at which BILL AND MELINDA GATES intervene in the Gombe state health sector.

Question 13: Would you say BILL AND MELINDA GATES has also been assisting private health sector in Gombe state?

Table 4.3.13 BILL AND MELINDA GATES and Private Health Sector Development in Gombe state

Variables	**Frequency**	**Percentage (%)**
Agreed	83	53.6
Disagreed	51	32.9
Undecided	21	13.5
Total	**155**	**100**

Source: Survey, January 2018

Table 4.3.13 above reflects the opinions of respondents on the intervention of the (BILL AND MELINDA GATES) in the Gombe state private health sector, 83 respondents making up 53.6% agreed, 51 (32.9%) disagreed while 21 (13.5%) were undecided. In a speech made available by the director of Information and Research Centre (ICR) of the United States Embassy in one of the conference organized by the agency, "the BILL AND MELINDA GATES has been of great assistance to the private health sector development in Gombe state. In December 2010, BILL AND MELINDA GATES commissioned the Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct a private sector assessment in Gombe state to identify ways in which BILL AND MELINDA GATES and other donors/stakeholders could engage the private sector effectively to achieve Gombe's reproductive health (RH) and family planning (FP) goals.

The private sector is an important entry point for addressing Nigeria's unmet need for contraception. The 2008 NDHS revealed that the private medical sector was the most frequently reported source of contraceptive supplies, providing contraception to

approximately 2.5 times as many women as the public health sector. Among the private sector facilities, private pharmacies and patent medicine vendors are the most common suppliers. According to the latest national health accounts report for Nigeria (Soyibo, 2009), private health facilities (including private hospitals, clinics, pharmacists, and patent medicine vendors) are the most patronized type of health facilities in Nigeria. Thus, there is no doubt that strengthening the private health sector is an important step in expanding high-quality reproductive health/family planning (RH/FP) counseling and services in Nigeria.

In 2010, the establishment of a BILL AND MELINDA GATES Development Credit Authority (DCA) guarantee was an encouraging step, as it should motivate financial institutions and microfinance lenders to lend to a sector that they view as especially risky, thereby helping existing private providers expand and attract new entrants. The assessment identified multiple plans and policies developed by the government in partnership with relevant stakeholders that acknowledge the private sector as a vital partner in the supply of FP commodities. Key among them is the Reproductive Health Supplies Coalition (RHSC) Strategic Plan 2003–2007, which covers the procurement of contraceptives. In spite of these policies, there is limited coordination between the sectors, except for the RHSC stakeholder committee, which serves as the key mechanism for coordinating stakeholder activity related to facilitating commodity security.

However, this committee only exists at the national level and is yet to be replicated at the state level. Even though some states coordinate between the Ministry, nongovernmental organizations, and international partners, no formal committees exist. BILL AND MELINDA GATES has been championing RH/FP and MNCH issues in Gombe through its health projects such as ACCESS/Maternal and Child Health Integrated Program; Access, Quality and Use in

Reproductive Health; Improved Reproductive Health in Gombe state; Private Sector partnerships One, and the SHOPS project. Any new program working in the private sector needs to coordinate closely with these projects as well as with the recently awarded Expanded Social Market Project in Nigeria, whose mandate is to build demand for modern Family Planning methods throughout the country, including in private health clinics.

4.4 DISCUSSIONS OF FINDINGS

The health sector is one primary sector that is needed to enhance the development of the individuals, state and by extension, the nation at large. It no doubt supports the development of the labour force (productivity) in the society. The growing concern in the donor community about the relatively unproductive cost of aid as a result of inadequate harmonization of donors and development partners' actions spurred efforts towards improving development aid effectiveness (OECD's Development Assistance Committee, 2003). Based on the findings of this study, it has been discovered that the Gombe state health sector has received considerable interventions from both local and foreign donors in order to help it meet the herculean demands and enough to improve its health care delivery system.

As a result of these peculiarities, there should be a coordination mechanism for donor interventions in the health sector with the national health strategic policies. In addition to developing and strengthening coordination mechanism areas of interest to agencies like the BILL AND MELINDA GATES, interventions should be designed to integrate activities at the national, state, and local government levels, to ensure coordination at all levels.

The findings also confine the fact that BILL AND MELINDA GATES as a donor agency has also impacted immensely in the Gombe state health sector virtually in a lot of aspects concerning Health care delivery, reform and sustainability justifying the verdict that the Bill and Melinda Gates has a strong positive significant impact on the health care delivery system in Gombe state.

The Gombe state government should strengthen the health sector and ensure that all development partners funding and supporting health programs in the state must key into the priorities of the government. According to the OECD (2005), donor organizations should not impose their system on recipient countries or states; rather, they should adopt the systems of the recipient country. Finally, governments should own the process of health development for sustainability, and harmonization efforts should be cascaded to the state level to ensure adequate and quality implementation of health intervention programs.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study has been an attempt to measure the impact of donor agencies on the improvement of health care delivery service in Gombe state and also to relate the activities of donor agencies in the Gombe state health sector with emphasis on the BILL AND MELINDA GATES. The first chapter set the pace with a background to the study, and where the research problem was earlier stated showing the significance as to why the research has to be carried out, research question which were to be answered before the end of the research were raised, coupled with objectives of the research, and finally organization of the study.

Chapter two stabled around literature review where articles, journals, books surrounding this research were reviewed in order to glance at the view of past works research. In this segment the Nigerian health care system as well as its management were been evaluated, sub themes such as health care financing, foreign aid etc. as were emphasized as well as introduction of the BILL AND MELINDA GATES program.

Chapter three concentrated on the methodology as to how the research would be carried out in terms of research design, study area, population of the study as well sample size and technique. Chapter presumes discussion using the research questionnaire designed and made analysis using the simple percentage method where findings were drawn and discussed.

Chapter five sums up the research by drawing relevant conclusions and recommendations.

5.2 Conclusion

From the result of the analysis, it was concluded that donor agencies have been of tremendous help in the improvement of health care delivery in Gombe state. The sector should however be developed for all health intervention programmes to provide guideline of harmonizing the activities of the development partners in line with priorities of the state's health sector. Respondents stressed that the government of the state should own the coordination process and strengthen the already existing coordination mechanism and ensure that all development partners funding and supporting health programmes must key into the priorities as in the coordination mechanism.

The positive social change of these findings could be experienced at organizational, societal, and at policy making levels. This study identified gaps and challenges of harmonizing donor agencies' activities with the state health policy. This information may increase awareness of the gaps in health intervention programmes as a result of inadequate coordination of donors and their activities. It may also inform stakeholders on during health policy review. The identified gap in the flow of information may inform the government on the need to provide adequate channels of information among all key players in the health development.

The Nigerian health sector is among the sectors in developing countries that has experienced a challenge in both local and international development assistance coordination.

In order to identify the impacts of BILL AND MELINDA GATES as a donor agency in the Gombe state health sector vis-à-vis the development of the sector, several questions were asked on the nature, composition, character and contents of its donations, the impact of the existing intervention efforts, and the challenges of aligning and harmonizing its activities with the sectorial development.

Respondents' responses to these questions revealed the partial coordination efforts in the health sector development. Harmonization effort should be at both national and state levels to ensure adequate implementation of the health programmes. Most respondents opined that there was a need for the government of the state to strengthen its commitment, as well as the agents to adhere to the guidelines of the intervention platforms. Findings also revealed a need for the government to own the intervention mechanism in the state and ensure that donors like BILL AND MELINDA GATES key into the state health priorities. To mitigate this intervention challenges and to achieve sustainable effectiveness of health aid in Gombe state, all stakeholders in the health sector should commit to transparency and encourage adequate flow of information. In addition to government chairing the intervention process, donor agencies should key into the state's health priorities as they provide aid for health care development in line with social demands.

5.3 Recommendations

Having examined the donor agencies' impact in the state health sector, and with all the challenges identified above, the following recommendations would help improve the Gombe state health system and health partnership:

1. If there is adequate coordination and alignment of efforts between donors, developmental partners, the Gombe state government, and other stakeholders, it would improve the outcome of the official development aid to the state.
2. It is now obvious that exclusive reliance on one particular health practice cannot assuage the health needs of the populace. There is no doubt that traditional medicine remains in the forefront in meeting the health needs of the people especially in the rural areas of the state in spite of the expansion of orthodox medicine.
3. In furtherance from the point above, donor agencies should look beyond the usual interventions but assist in the development of the nation's traditional health system.
4. For a long time, donors and governments have opposed private sector involvement fueled by concerns over profit motives, issues with regulation, and fears of inequity. But increasingly it is recognized that, given the challenges faced in developing countries, health systems cannot do without the private sector. This shift is partly motivated by the expectation of decreasing aid budgets due to the global economic turmoil, but also by recognition of the dual realities of the weakness of public systems and the potentially significant contribution of private resources to health care delivery.

5. Massive national and community mobilization/participation, and the adaptation of Chinese model would help in ensuring that health care gets to the grassroots. The core of Chinese 20092011 reform programme includes: establishment of the basic medical insurance coverage; establishment of national essential drug system at all local levels; upgrading the primary healthcare services at the grass-roots level; expanding the coverage of basic public health services; and facilitating pilot reform programs in public hospitals. This model will help enhance basic health delivery in Gombe state if adopted.
6. The government of Gombe state should massively increase investment and public spending on health. The health system currently rely on mixture of government budget, health insurance, external funding and private sources including non-governmental arrangements and out of pocket payments. Despite the variety of financing sources, the level of health spending is relatively low. Gombe state government spends less than 5% of her annual budget on health and per capita health spending is slightly lower per person per year. The ridiculously low per capita health spending in Gombe state indicates a negligent lack of commitment by the State government to health, and the leadership continues to pay lip service to healthcare services. At a minimum, per capita health spending must increase to $60 in order to provide a minimum range of services.
7. The state commission of Health should promote the implementation of integrated model for community-based chronic and communicable disease control in health services delivery. The Gombe state government should develop guidelines for the practice of traditional medicine and facilitate the retraining and registration of traditional medical practitioners to improve their skills and effectiveness and thus, help promote their integration with the primary health care system. Also, the government should strive to promote the development of industries and relevant manpower to enhance local capabilities in the production of drugs, including antiretroviral and laboratory reagents, medical equipment and spare parts to improve supplies and maintenance capabilities so as to reduce cost and improve efficiency.
8. Reform in itself is not an event, but a description of a process that should lead to an improvement in the way a service is delivered. True reform takes time, but even in the realm of public health, where indices takes time to change, seven years is long enough time for measurable change to have occurred.
9. America is a country that is going to witness enthronement of a new leadership personality with an anti-Nigerian plans, an over-reliance on BILL AND MELINDA GATES's intervention in the cause of disease outbreak like Ebola virus may spell doom for the country. There is need to really develop the local healthcare techniques to meet the present challenges and forestall future eventualities.

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