A HISTORY OF BRITISH AID IN HEALTH AND SOCIAL DEVELOPMENT IN BENUE STATE, 1992-2003

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DECLARATION

I, Simeon Gbor, do hereby declare as follows:

(i) That this thesis is a product of my own research as is written by me.

(ii) That to the best of my knowledge no part of this thesis has been presented for the award of any higher degree in any university.

(iii) That all quotations and references have been acknowledged and distinguished by endnotes and quotation marks.

Simeon Gbor
December 2004

CERTIFICATION

This is to certify that the research work for this thesis and the subsequent preparation of this thesis by Simeon Gbor (PGA/UJ/11251/00) were carried out under my supervision.

______________________	______________________
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Supervisor	Department of History)

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This work is dedicated, firstly, to God’s glory, and secondly, to my wife, Rosemary and my two children, Sewuese and Ngunengen.

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ABBREVIATIONS

ADB	-	African Development Bank.
BEN-SHACC	-	Benue State HIV/AIDS Control Committee.
BERWASSA	-	Benue State Rural Water Supply Sanitation Agency.
BGS	-	British Geological Surveys.
BHF	-	Benue Health Fund.
BI	-	Bamako Initiative.
BNARDA	-	Benue Agricultural and Rural Development Authority.
CAP	-	Country Assistance Plan.

CEC - Cooperative Extension Centre.
CIDT - Centre for International Development and Training.
CLO - Community Liaison Officer.
CODESRIA - Council for the Development of Social Science Research in Africa.
CRP - Community Resource Person.
CRUDAN - Christian Rural and Urban Development Association of Nigeria.
D&E - Deferral and Exemption.
DAC - Development Assistance Committee.
DFID - Department for International Development.
DOTS - Directly Observed Treatment Strategy.
DRF - Drug Revolving Fund.
FOS - Federal Office of Statistics.
HEAP - HIV/AIDS Emergency Action Plan.
HMB - Health Management Board.
HMC - Health Management Committee.
IEC - Information, Education and Communication.
IFPREB - Improved Farmers Participation in Research and Extension in Benue.
ITN - Insecticide Treated Net.
LACA - Local Action Committee on AIDS.
LATH - Liverpool Associates in Tropical Health.
LDC - Least Developed Country.
LEEDS - Local Economic Empowerment and Development Strategy
M&E - Monitoring and Evaluation.
ManCom - Management Committee.
MCH - Maternal and Child Health.
MEH - Micro-Enterprise for Health.
MOU - Memorandum of Understanding.
NACA - National Action Committee On AIDS.
NAPEP - National Poverty Eradication Programme.
NEEDS - National Economic Empowerment and Development Strategy.
NKST - *Nongu u Kristu u Ken Sudan hen Tiv*.
NPEC - National Primary Education Commission.

NPHCDA	-	National Primary Health Care Development Agency.
ODA	-	Overseas Development Administration.
ODI	-	Overseas Development Institute.
ODM	-	Overseas Development Ministry.
OECD	-	Organization of Economic Cooperation and Development.
OI	-	Opportunistic Infection.
OIC	-	Officer in Charge.
OPR	-	Output-to-Purpose Review.
PABA	-	People Affected by AIDS
PAC	-	Project Advisory Committee.
PATHS	-	Partnership for Transforming Health Systems.
PHC	-	Primary Health Care.
PHCMC	-	Primary Health Care Management Committee.
PI	-	Pathfinder International.
PLWHA	-	People Living With HIV/AIDS.
PM	-	Project Manager.
PM&E	-	Participatory Monitoring and Evaluation.
PPFN	-	Planned Parenthood Federation of Nigeria.
PRA	-	Participatory Rural Appraisal.
QoC	-	Quality of Care.
RUSAFIYA	-	*Ruwa Tsafta Lafiya.*
SACA	-	State Action Committee on AIDS
SLGP	-	State and Local Government Programme
SDP	-	Service Delivery Point.
SEEDS	-	State Economic Empowerment and Development Strategy.
SHC	-	Secondary Health Care.
SHPP	-	Strategic Health Planning Process.
SHT	-	School of Health Technology.
SJRHCO	-	St. Joseph's Rural Health Center Ogobia.
SSI	-	Semi-Structured Interview.
SVHA	-	St. Vincent's Hospital Aliade.
SWAAN	-	Society for Women and AIDS in Africa Nigeria Chapter.
TCT	-	Technical Cooperation Training.
UBE	-	Universal Basic Education.
UNAIDS	-	United Nations Programme on HIV/AIDS.

UNCED	-	United Nations Conference on Environment and Development.
UNDP	-	United Nations Development Programme.
UNESCO	-	United Nations Educational and Scientific Organization.
UNFPA	-	United Nation Fund for Population Activities.
UNICEF	-	United Nations International Children Emergency Fund.
UNRRA	-	United Nation Relief and Rehabilitation Administration.
USAID	-	United State Agency for International Development.
VCT	-	Voluntary Counseling and Testing.
VDC	-	Village Development Committee.
WA	-	WaterAid.
WAS	-	Water and Sanitation.
WASCOM	-	Water and Sanitation Committee.
WASMC	-	Water and Sanitation Management Committee.
WASU	-	Water and Sanitation Unit.
WES	-	Water and Environmental Sanitation.

ABSTRACT

Since 1992 the British Government, through its aid agency, the Overseas Development Administration (ODA), later known as the Department for International Development (DFID), began to provide development assistance to Benue State mainly, but not exclusively, in the area of health and social development. This assistance was (and still is) in line with Britain's bilateral policy to implement key principles of internationally accepted sustainable development. With the acceptance of Benue State as one of its foci for health and social development aid in Nigeria, the British Government funded the Family

Planning Situation Analysis Study in 1992; the Oju and Obi Water and Sanitation Project from 1996 to 2002; the Benue Health Fund Project from 1997 to 2002; and the STD/HIV Management Project from 1997 to 2003.

The main objectives of this research were to determine the volume of British assistance to Benue State, bringing out the impact of the projects on Benue's rural poor. The research also sought to know the sustainability status of the projects. It also tried to discover possible undertones for this assistance to Benue State, and by extension, Nigeria. The research has generated a body of knowledge that will be useful for rural development assistance and has contributed to aid policy for both the donor and the recipient. A rigorous and critical examination of secondary and primary sources, as well as semi-structured interviews, and visits to project sites and to beneficiaries were methods used for achieving these objectives.

This historical study has also brought into focus two crucial issues, among others, that have formed the fulcrum of the research. Firstly, the thesis argues that contrary to radical views held by some scholars that foreign aid in whatever guise be rejected, it was our discovery that if well managed, aid which come as a direct response to international development targets and Millennium Development Goals (MDGs), agreed upon by member nations of the UN, are not only desirable but imperative for poverty alleviation, especially in nations that are experiencing failed governments.

For instance, from the DFID-assisted projects studied, it was discovered that in spite of some observable lapses in projects implementation, the three major projects executed in some selected target communities at the cost of ₦ 1,135,641,376.85 impacted, positively, the lives of the Benue rural poor and vulnerable groups. Thus, the British Government has demonstrated that poverty alleviation in Nigeria is feasible, if only all the tiers of government would muster political will to respond to the cry of the poor for help; and if they would introduce some measure of transparency and accountability in public finance

management. It was also discovered that partnership and community participation strategy, which is central in development project efforts, is equally achievable and could be adopted by our governments. The three major projects studied revealed some health and social development models which, if replicated in other places outside the project areas, could equally produce positive effects.

The second issue in focus in the research was an attempt to answer the question: what does the British Government stand to gain for her aid to Nigeria? It was discovered that apart from the purpose of friendship, prestige, the spirit of globalization and humanitarian concern, British aid to Nigeria serves the former's national interest of strengthening Nigeria's economy and socio-political structures so that "success will spread benefits" to the donor also. It is, therefore, part of our thesis that the four focal states (including Benue) for British assistance were actually 'pilot sites' to test how far the British Government could succeed in her strategy for achieving her development targets in Nigeria.

Finally, our research concludes with summary and recommendations that, if implemented, would inform future policy thrust for both developoment partners and recipients of development assistance in 21st century Nigeria. All the lessons learnt from this research shall be shared, in due course.

CHAPTER ONE
INTRODUCTION

1.1 BACKGROUND

The origin of development assistance (or foreign aid)[1] as an instrument of national policy dates back to the 18th century when Fredrick the Great of Prussia subsidized certain allies in order to ensure their military support[2]. This practice continued intermittently in Europe during the next century. However foreign aid gained ascendancy during the First World War when the United States of America (US) gave substantial loans to its European allies but later, out of sympathy, converted them into "lend-lease" form when the allies could not repay due to the Great Depression of the 1930s. By this arrangement, the U.S. supplied her European allies with essential equipment and supplies while her allies in turn equipped and supplied the needs of U.S. troops stationed abroad.

With the establishment of the United Nations Relief and Rehabilitation Administration (UNRRA), which operated from 1943 to 1946, foreign aid was transformed from the older conception as subsidy to an institutional element of policy. Since he who pays the piper, it is said, dictates the tune, the U.S. which contributed the largest funds to UNRRA began to use aid as an instrument of post-World War II reconstruction. The fears of Soviet expansion into Western Europe dominated the U.S. and her allies' humanitarian and economic motives for promoting large-scale post-war reconstruction.

In the late 1968, the then President of the World Bank appointed Lester B. Pearson to head the Commission on International Development with a mandate to conduct an inquiry into the operations and results of development assistance. The Pearson Commission Report titled "Partners in Development" was submitted in

September 1969 and was going to set the stage for discussions on aid in the 1970s just as the United Nations (UN) report on Measures for the Economic Development of Underdeveloped Countries formed the discussion on development in the 1950s[3]. The publishers of the Pearson Commission Report described it as "the most comprehensive analysis on development aid to date." [4] The report put its full weight behind development assistance. It lamented the widening gap between the developed and developing nations and called for a bridging of this gap by urging developing countries to mobilize their resources for economic growth while the developed countries were called upon to transfer resources, on unprecedented scale, to poorer countries. The report introduced a moral argument for development assistance when it wondered if the governments of rich countries eliminated poverty and backwardness at home and ignored them abroad and still expected to maintain firm moral and social foundations of their own societies. It argued further that this imperative is re-enforced by enlightened self-interest. Rich countries would also benefit if the world's resources were used to the fullest capacity; if international trade expanded and if all were prosperous and secured[4]. There is now a growing awareness of globalization. This concept of the world as a community is itself a major reason for international co-operation for development.

Since the Pearson Commission Report, there have been repeated calls on the developed world to assist in the development of the underdeveloped areas. Only recently the World Bank, while calling on developing nations to harness their own policies to address poverty, urged industrial countries to open their markets more fully to imports from poorer countries, eliminate the OECD tariffs and subsidies, do more to support debt relief for poor countries and increase aid to countries with policy environment that support poverty reduction. [6] A similar call for concerted international action to fight

poverty and disease was made, jointly, by the International Monetary Fund (IMF), OECD, the UN and the World Bank Group in a document titled 2000: A Better World for All: Progress Towards the International Development Goals.[7]

With the end of the Cold War, however, the developed countries, led by the U.S. sought to build linkages with developing countries that could be of mutual benefits, politically and economically. Thus today, the Organization for Economic Co-operation and Development (OECD) comprising the U.S., Canada, Japan, Australia and the former non-communist nations of Europe have formed a vanguard for development assistance to the developing nations.

Nigeria, with a high poverty profile became a development target for several international organizations and industrialized countries.[8] For a long time Nigeria has enjoyed one multilateral development assistance or the other from the World Bank, United Nations agencies such as the United Nations Development Programme (UNDP), United Nations International Emergency Children Fund (UNICEF), World Health Organization (WHO), United Nations Fund for Population Activities (UNFPA), etc. Bilateral assistance also came from development agencies of developed countries such as the United States Agency for International Development (USAID) and the United Kingdom's Department for International Development (DFID), formerly Overseas Development Administration (ODA), to mention only a few.

1.1.1 An Overview of British Aid in Nigeria

A brief overview of British aid in Nigeria is necessary at this juncture, because this will serve as a launch pad from where we hope to launch our discussion on British aid in Benue State.

One year after Nigeria became independent one of the countries that gave aid to her was Great Britain. Others included Australia, Canada, West Germany, Japan, Israel, the Netherlands, Pakistan and the US. [9] This showed, from the onset, that Balewa was going to adopt policies, in terms of economic relations, in favour of the West. For instance Nigeria's trade with the European Economic Community (EEC), which Britain is a member, increased considerably as imports to EEC countries rose from 18.9% in 1962 to 21.2% in 1963 while exports rose from 34.9% to 37% during the same period. [10] As long as Balewa was in power there seemed to be no Soviet block investment in Nigeria. In fact the Soviet Union's interest-free loan offered to Nigeria at independence was rejected by the Balewa Government[11]. Explaining this scenario, Osoba says:

> The concrete political measures taken by the British administration in Nigeria during the period of decolonization were designed to ensure that Nigerian society after independence would not be exposed to certain forms of external relations which might generate pressures on the Nigerian political decision-makers to terminate or drastically reduce the especially close and intimate relationship that the British would want to subsist between them and their former colony . . . [12]

According to Osoba, Britain believed that her policy of containing 'atheistic communism' in Africa generally, and Nigeria in particular was imperative in view of her (Britain's) strategic economic and political interests in Africa.[13] Thus, it is the view of Osoba that, all bilateral contractual agreement between Britain and Nigeria were designed to reinforce Britain's domination of the Nigerian economy and cheat her of her economic independence. The aim of Britain was to guarantee extremely profitable conditions that will ensure British monopoly of Nigerian economy and ensure Nigeria's dependence on Britain, economically, for a long time.[14]

It is the opinion of Adeniran that Nigeria's cordial relationship with Britain (and by extension) the West could be traced to the foundation laid during the colonial years.

He maintains that during the first two years of Nigeria's independence Britain alone provided 75% of Nigeria's aid while most of the private foreign investment in the country was by British interest.[15] In 1960 Britain gave Nigeria a Commonwealth Assistance Loan of £2.84 million; the Nigeria Railway Corporation Loan of £1.5 million; Exchequer Loan of £3 million; Apapa Industrial Development Loan of £1.25 million and Niger Dam Loan of £5 million. Also, in terms of investment up to 1966, British's total foreign investment in Nigeria stood between 65% and 70%[16].

In view of the fact that relations between Britain and Nigeria were at a low ebb from 1967 to 1970, during the civil war years, aid flows from Britain to Nigeria were equally low or non-existent. In Aluko's estimation the relations between Lagos and London during this period were of mutual suspicion, acrimony, down-right hostility and name-calling. The situation repeated itself in the late 1970s especially over the alleged involvement of Britain in the assassination of General Murtala Muhammed in the 1976 coup d'etat[17].

Since aid flows for domestic needs to Nigeria from Britain were insignificant, coupled with the fact that Nigeria experienced growing prosperity from the oil boom during the 1970s, the federal government did not need to seek for capital aid from Britain. Instead, the government placed emphasis on technical assistance, co-operation in the fields of education, medicine, agriculture, geology, etc[18]. Between 1974 and 1977 the cost of this technical assistance was estimated at an annual average of £2million. [19] For instance, A. Y. Eke, the then Federal Commissioner for Education revealed in 1974 that there were about 350 British contract teachers in Nigeria and that Britain had agreed to send four experts every year to train English and science teachers. Also, in 1974 Britain donated £20,000 to the Benue-Plateau State Library for the purchase of library books. In

1975 a Technical Cooperation Agreement (TCA) was signed, and was renewed in 1983. Known as Key Educators Supplementary Scheme in Nigeria (KESSIN), the agreement which now provided for joint funding was put at the cost of £4 million for 1982 and 1983[20].

From 1980, as the country began to experience economic hardship caused by the global oil glut of that period this form of aid was reversed [21]. From this period onwards both capital flows and technical assistance were valued equally and were received by the federal government. For instance in 1984 Britain donated one million rinderpest vaccines to Nigeria. Later, pesticides and spraying equipment worth £3.5 million were donated to assist Nigeria control grasshoppers in the northern parts of the country. A medium term line of credit of £20 million by the British Export Credit Guarantee Department followed this donation, in 1987.

Information and materials on British aid flows to Nigeria during the military regimes of Generals Ibrahim Babangida and Sani Abacha remain very scanty. The reason for this may not be unconnected with the fact that military regimes were becoming increasingly unpopular especially towards the end of the 20th century and donor nations were beginning to tie development assistance to democratization. Other reasons could be attributed to aid fatigue and also the end of the Cold War. But in spite of this, Britain continued to send skeletal assistance to Nigeria, even during the notorious Abacha era[22]. It was during the Abacha regime that the U.K. Department for International Development (DFID) opened a Country Office in Abuja.

With the inauguration of a new democratic government in Nigeria on May 29, 1999, Britain responded to this new dawn in Nigeria with a visit to Nigeria in March 2000 by the British Secretary of State for International Development, Clare Short. During

the visit she held discussions with Nigerian officials on a range of economic and development issues and pledged to assist Nigeria in her poverty alleviation programmes[23]. The UK also committed huge resources for the fight against HIV/AIDS in Nigeria with the pilot project on AIDS in Shagamu, Ogun State and Otukpo in Benue State [24]. British High Commissioner to Nigeria, Sir, Graham Burton, while commending the efforts of President Olusegun Obasanjo on the fight against AIDS pledged ₦25 billion for the fight[25]. Whether or not all these monies were received by the Federal Government of Nigeria remains uncertain.

In November 2000, The Daily Champion reported that ₦82.5 million was already allocated to Nigeria in grants over the next three years by the British government for the purpose of supporting civil society initiatives promoting good governance, political empowerment, anti-corruption initiatives and the promotion and protection of human rights. According to the report, another sum of ₦15 billion was pledged by Britain to support Nigeria's economic reforms. The envoy also promised to add a fourth state from the South-East, to the three already supported by DFID[26]. This was done in 2001 with Enugu State becoming the fourth focal state for DFID assistance.

Another ₦35 million aid was announced in April 2001 by the new British High Commissioner to Nigeria, Mr. Phillip Thomas. According to Thomas, this package was to develop key sectors of the economy, especially the health sector.[27] In May of the same year Britain committed N1.3 billion to Nigeria's privatization programme. According to Phillip Thomas this package was designed to ensure the success of the programme. He said the assistance could come in the form of conferences, workshops and seminars on privatization.[28] Also in September 2001 it was reported that Britain signed a military assistance agreement with Nigeria at the Defence Headquarters, Abuja. Mr. Phillip

Thomas said Britain would provide training materials to the National War College and other military institutions as part of the package. He also announced that Colonel Craig Coker was seconded to the Nigerian Armed Forces as head of the British Defence Advisory Team to co-ordinate the provisions of the military assistance. [29]

In the area of education Britain has continued to aid Nigeria. Apart from the Commonwealth Scholarship Fund into which Britain has, probably, been the highest contributor, which has provided scholarships to Nigerian students, the British Chevening Scholarship Scheme has also provided opportunities for young Nigerians to study in British Universities and Colleges. In March, 2002 The Guardian reported that 670 Nigerians benefited from the scholarship scheme since 1984. According to Phillip Thomas, about N113 million is spent yearly by the British government to train 40 Nigerians in the scheme.[30] Also, Daily Times reported in May, 2002 that Book Aid International (BAI), the largest and best known book aid charity in the U.K. donated 700,000 books worth ₦6.7 billion to 250 schools, public libraries, universities, research institutions and non-profit organizations in Nigeria.[31]

It is evident from the above that the tempo of aid flow to Nigeria from Britain increased with Nigeria's democratization.

1.1.2 British Aid in Benue State

If Nigeria's poverty profile is as high as to warrant foreign aid, then Benue State of Nigeria is one of the states that has contributed the highest quota to this poverty level. This will be discussed in detail in chapter three. It is therefore no wonder that the state has become one of the foci of many development agencies working for the development

of the state, especially in the areas of health and social welfare. The socio-economic backwardness of Benue State is manifested in several ways. A more comprehensive analysis of Benue's socio-economic backwardness is attempted in chapter three. Even though we do not want to risk repetition, it will be necessary to mention here that this backwardness is manifested in ways such as malnutrition, lack of social amenities, cases of communal conflicts, seasonal hunger periods, labour migrations, mutual jealousies, etc.[32]

Poverty and ill health form a vicious circle[33]. Undoubtedly, a people's poor health situation has a direct link with their poverty and underdevelopment. Professor Adetokunbo O. Lucas, in a WHO 2000 Report on Nigeria, indicted Nigeria's leadership for neglecting its health sector when he said:

> The Nigerian health system is sick, very sick, and is in urgent need of intensive care. It is blind, lacking vision of its goals and strategies; it is deaf, failing to respond to the cries of the sick and dying; and it is impotent, seemingly incapable of doing things that neighboring states have mastered. Every organ is affected and ailing …[34]

If the picture painted by Professor Lucas describes the Nigerian situation, the picture in Benue State cannot be different. In fact, the picture in the State may be grimmer. This is in view of the high poverty level in the society. Poverty breeds ill health and ill health breeds poverty. Therefore, it is logical to say Benue State is poor because it is sick and sick because it is poor. The logic is corroborated by the DFID in a document cited earlier when it said:

> The poor are most vulnerable to ill health and have the least means to combat it… Ill health is not simply a consequence of poverty, it is an aspect of it. Better health contributes directly to diminishing poverty by improving quality of life, expanding opportunities and safeguarding livelihoods.[35]

In spite of the bogus National Health Policy Declaration of the Federal Republic of Nigeria[36], good health care has continued to elude the majority of her citizens. It is against this background that we approach the history of British intervention in the area of health and social development in Benue State for the past ten years. But before we do this may we emphasize, for the avoidance of doubt, that we are writing this dissertation neither as agents nor advocates of the British government. It is hoped that the evidence at our disposal will speak for the research. We are, however, careful, as counseled by Marc Bloch not to swallow any historical evidence without first synthesizing it[37]. That, we must do. Therefore, as we embark upon this venture may we bear in mind the view of Walsh when he said:

> Whatever it is, genuine history is thought by historians to be distinguishable from propaganda, and would be said to have objective validity just because of that.[38]

One of the major landmarks in the history of development in Benue State at the beginning of the last decade was the noticeable presence of the British government and the accompanying projects that were initiated, mainly (but not exclusively), in the health and social development sector. This presence was manifested through the U.K. Department for International Development (DFID), formerly ODA, which has championed the cause of health development in the State. It may be pertinent to say a word or two on ODA/DFID before concluding our discussion on the background to this study.

The British government's aid agency, the ODA which metamorphosed into DFID outlined the purpose of the British aid programme as enshrined in the Overseas Development and Co-operation Act 1980 as:

> Promoting the development or maintaining the economy of a country or territory outside the United Kingdom, or the welfare of

> its people. Accordingly ODA's main aim is to help people in countries poorer than our own to improve their lives.[39]

To achieve this, ODA supported economic reforms, enhanced productive capacity, helped to achieve good governance, financed activities directly benefiting poor people, promoted human development, including better education and health, and children by choice, promoted the status of women and helped in tackling environmental problems. It also responded with emergency aid to natural and man-made catastrophes in poorer nations.[40]

The ODA was the aid wing of the Foreign and Commonwealth Office. It managed Britain's aid to about 150 developing countries as well as the states of Central and Eastern Europe and the former Soviet Union. It worked in partnership with governments of developing countries, with international organizations including the European Union (EU) and the UN. The ODA also handled Britain's contribution to the international efforts geared towards tackling global environmental problems, assisting those affected by disasters and above all, working to reduce poverty. Poverty reduction was to be accomplished through sustainable development projects, finance for materials and equipment, technical advice and training and support for research.

In May 1997, the government of Mr. Tony Blair changed ODA's nomenclature to DFID and increased its commitment to development by strengthening the department and increasing its budget. The policy of the new regime was set out in the White Paper on International Development published in November 1997. The summary of the policy is a commitment to the internationally agreed target to reduce the proportion of people living in abject poverty by half, by the year 2015. It also plans to provide health care and universal access to primary education by the same date.[41] Today, the British government,

in a show of its commitment to development efforts in Nigeria, has opened a DFID office in Abuja and one of the state coordinating offices in Makurdi, Benue State, which, as we pointed out earlier, is one of the foci of British interest in development assistance. Other co-ordinating offices are located in Enugu, Jigawa and Ekiti States.

The DFID initiated and executed four major projects in Benue State during our period, namely, Water and Sanitation Project, the Benue Health Fund (BHF) Project, Improved Farmers Participation in Research and Extension in Benue (IFPREB) Project, and the STD/HIV Management Project. The SLGP is on-going. All the projects, except IFPREB and the SLGP, targeted the development of the health and social sector in Benue State. IFPREB worked, in conjunction with the Co-operative Extension Centre (CEC) of the Federal University of Agriculture Makurdi to assist the Benue Agricultural and Rural Development Authority (BNARDA) to improve the effectiveness of agricultural research, training and development agencies in meeting the information and skills need of poor farmers, especially women, through greater participation of beneficiaries. The SLGP, a programme that is still in progress, is aimed at enhancing the capacity and effectiveness of state and local governments to formulate policy, manage resources and support service delivery in the interest of poor people. The health and social development projects form the fulcrum of our research and will be given full coverage subsequently.

Apart from the major projects mentioned above, in 1992, which marks the beginning of a definite and pragmatic approach by the British government (and in fact by any bilateral development agency for that matter) to intervene in the health situation in Benue State, the ODA funded the Benue State Family Planning Situation Analysis Study. Although this assistance does not constitute a chapter of its own in this research it will be examined, among other issues, in chapter three. Briefly stated, this research is out to

enquire into the activities of the British government in Benue State in health and social development.

1.2 OBJECTIVES

Health, they say, is wealth. It is no wonder then that the eradication of disease and improvements in the health of the poor and vulnerable groups in our societies have become very critical among the issues that have dominated international discussions on development. Today, it seems there can be no meaningful academic discourse or scholarship if such are not tailored towards world development, generally, and the development of our immediate communities specifically. A few examples to buttress international concern for the health of the world may be worthwhile at this point.

In 1978 the world gathered at Alma-Ata in former USSR and proposed that primary health care (PHC) constitute an integral part of each country's social and economic development and called for the adoption of a more inclusive approach to health development which will in turn integrate other sectors and bring about an enabling environment for social and economic growth[42]. The WHO which has continued to play its role as the "world's health officer" has continued to draw the attention of multilateral and bilateral organizations to the health needs of the international community. Even recently the WHO, in conjunction with the World Bank, sponsored the publication of "Global Burden of Disease and Injury Series"[43] to sensitize the international community on the health situation in developing countries and made projections up to the year 2020. The WHO also supported, tremendously, the African Initiative for Malaria Control in the 21st Century. This new initiative was being developed to control malaria in order to

enhance a more equitable development, globally, and to control malaria in Africa, to enhance its overall health and socio-economic development.[44]

In response to this clarion call for international action for the world's health development, the British government mapped out strategies for achieving the international development target as stated in the DFID publication Better Health for Poor People.[45] Before 1994, the ODA provided financial support to malaria control efforts in eight African countries, namely, Ghana, Kenya, Malawi, Namibia, Tanzania, Uganda, Zambia, and Zimbabwe.[46]

In Benue State the British intervened definitely in both the primary and secondary aspects of the people's health needs. But we must admit that primary health care received greater attention, in line with the Alma-Ata Declaration. A brief look at primary health care as a concept may be worthwhile, before dwelling fully on the objectives for this research. This is necessary because in the course of the study reference will be made to primary health care from time to time.

According to the Alma-Ata declaration, primary health care (PHC) is:

> Essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[47]

In line with the WHO posture on PHC, Nigeria's 1979 constitution put it on the Fourth Schedule.[48]

By enshrining within the Constitution the statutory responsibilities of Local Government Areas (LGAs) for the promotion and operation of PHC schemes, the LGAs automatically became the nodes and cells for comprehensive national health care mobilization. The LGAs have liberty to plan and to execute health projects considered essential for the enhancement of the well being of their people. It was for the purpose of coordinating and ensuring sustainability of PHC nationwide that the National Primary Health Care Development Agency (NPHCDA) was set up in 1992. [49] There are other functions of the NPHCDA that exists which are not necessary for our consideration.

Apart from the constitutional backing that PHC enjoys, the Federal Government provided for the establishment of a school of health technology in each state of the federation. These schools are engaged in the training of community health workers. The aim of the scheme is to provide the human resources required for driving and sustaining PHC.

To finance PHC, the Federal Government annually budgets funds for it. State governments are also required to provide supplementary funding for the scheme. Originally, PHC delivery was expected to be free but due to under-funding caused by inadequate supply of budgeted funds or shortages caused by several factors, including reckless mismanagement of resources, PHC suffered poor implementation, especially in the rural areas, giving rise to introduction of user fees at PHC facilities.

One of the strongest pillars of PHC is ownership of the process by the countries and the civil societies they served. It is no wonder then that the UN Systems-Wide

Special Initiative on Africa (UNSIA) advocated inter-sectoral collaboration in the provision of water and sanitation, roads and rural infrastructure, development and access to micro credit/enterprise for development. The WHO also supports this new approach to health development. [50] In fact the Bamako Initiative (BI), an African movement formed (after the WHO Regional Committee held in Bamako, Mali, in September, 1987) [51] to focus and strengthen PHC with emphasis on maternal and child health care became a reference point for many grassroots health projects in Africa, including those executed by DFID in Benue. In a nutshell, the BI placed responsibility for health care management at the grassroots level with the grassroots people. This involved community action in the management and financing of peripheral health services for the well being of the grassroots population. The aim of the BI was to improve service quality and ensure long-term sustainability. The basis for the programme was to provide mother and child health care interventions such as immunization, prevention and control of common diseases and pre-and post-natal care. The BI was to also assist in providing accelerated action on HIV/AIDS. [52]

Since 1992 the DFID intervention in health and social development in Benue State was carried out under three major projects, viz, the Water and Sanitation Project, the Benue Health Fund and the STD/HIV Management Projects. The first assistance in health was in 1992 but cannot be possibly considered a project. It was a family planning survey which ODA sponsored. The exercise was brief, and actually a brain child of Nigeria's National Policy on Population for Development, Unity, Progress and Self-Reliance" approved on February 4, 1988 with the following goals:

> To improve the standard of living and the quality of life of the people of this nation, to promote their health and welfare, especially through preventing premature death and illness among

> high risk groups of mothers and children; to achieve lower population growth rates through reduction of birth rates by voluntary fertility regulation methods that are compatible with the attainment of economic and social goals of the nation, to achieve a more even distribution of population between urban and rural areas.[53]

To achieve this goal, the Federal Government of Nigeria in collaboration with UNFPA, USAID and ODA sponsored a National Family Planning Situation Analysis Study. The study in Benue State was funded by the ODA. As will be seen, when this assistance is discussed in chapter three, it was not very substantial, but it was nonetheless important. The main kernel of this research will be on the three major projects already highlighted.

We have focused much attention on the objectives of the British aid in health and social development to enable the reader grasp the general importance of health and primary health care, specifically, to the general socio-economic development of a people. As we now re-focus attention on the objectives of this study, the fact that the projects in question were mainly grassroots projects should be borne in mind.

The first thing we desire to achieve in this study is a critical examination of the projects in health and social development executed by DFID with particular reference to the physical infrastructures bequeathed to the people. We shall also find out the cost for the projects. Secondly, some of the projects developed models for replication for the purpose of improving health services. We shall find out whether or not these models were replicated by other communities within Benue State and outside. For instance, the BHF developed these models in only seven LGAs in Benue State which has 23 LGAs. So, for these models to be useful to the entire state, the remaining 16 LGAs will need to adopt them also. The same goes for the water and sanitation models developed only in two LGAs. Twenty-one LGAs will need to adopt these models for their communities.

Furthermore, the intention and policy of the British Government in development assistance is that the projects are owned and sustained by the people, long after the aid was ended. Therefore, another aim for embarking on this study is to find out if these projects have been sustained in the various communities where they were cited.

Moreover, the matter of the impact of the projects on the communities in which they were executed, and on the Benue society generally is very central to this enquiry. If this aspect of our objectives is missing, a vacuum will inevitably be created in the whole research effort.

Another intention of the research is to leave behind, when completed, a thesis that will become a reference material for donor agencies, health managers and stakeholders who may, in future, desire to embark on similar development projects and may wish to borrow an idea or two from the British example in Benue State, or might learn from their mistakes. Thus, we would have succeeded in contributing our quota to the growing literature in this area of study.

One other objective for this research is to find out whether or not the British development efforts in Benue State had diplomatic undertones. This will be done through reading in-between lines as we study the various British policies pertaining to the projects. As we read through the various literatures on development assistance it was discovered that many schools of thought believe that aid, in whatever guise, should be taken with a pinch of salt. This will be investigated.

Finally, it is our modest aim and desire to develop, not only the diplomatic aspect of history, but also make incursions into areas hitherto reserved only for health scholars, sociologists and political scientists. Thus, this work, when completed, may be one of the

authoritative works on foreign aid in health and social development by a historian in this part of the country or even in the nation as a whole. The desirability of this ambition will be discussed more fully, shortly, as we bring forth the justification for this research.

1.3 JUSTIFICATION

As we attempt an enquiry into the British development efforts in the health and social sector of Benue State, we are conscious of the fact that the history we are writing is very recent. This fact brings us headlong with two needs that we must do our best to meet in the course of the study. Firstly, we must not disappoint the ‘new philosophers’ of history calling on us to engage more aggressively in development studies, by producing a thesis in this area that will stand the test of time. The second need is to satisfy the so-called ‘conservative’ historians by abiding by the rules (for want of a better word) of history writing so that we don’t end up with a sociology or political science thesis.

The relevance of this research lies in the fact that more than ever before, historical studies are shifting from the stereotyped approach of the past centuries to a new and more dynamic and pragmatic approach that is emphasizing development relevance. Historians all over the world, especially in Africa, are being urged to embark on researches that provide immediate solutions to the developmental needs of their societies. Thus, studies in community development and other areas of development, which seemed to be the exclusive preserve of social scientists in times past are becoming more and more open to historians.

Our study is fascinating for the fact that though historical, it has a sociological element because it is community development oriented, with a foreign policy touch since we cannot discuss foreign aid in isolation of its policy. It also has in it some spices of

developmental economics in a globalized world and, obviously, by virtue of the main kernel of the topic 'compelled' us to come face to face with health issues and jargons. In justifying this research effort it is imperative to dwell, in more details, on the issue of developmental relevance of history which has become an important issue in historical scholarship today.[54]

Some critics have accused historians of continuing in the study of dead empires, kingdoms and cultures while the modern African societies are sinking under deep crises of development.[55] This does not mean, however, that the study of ancient kingdoms, empires and cultures are irrelevant, but it was because the scholars who conducted researches in these areas before failed to bring out the lessons of development necessary for the development of their own societies. It is this growing concern that has led veteran African historians to call on their colleagues to make historical studies more relevant to the needs of the society, so that the present could more concretely and practically learn from the past.[56] In spite of this call it has been observed that only a few scholars have taken heed. No wonder, the accusations against Nigerian historians have continued to mount, especially from people outside the discipline who are saying Nigerian historians seems to be talking only to themselves at the expense of the larger society to which they are responsible. For instance, a critic's general observation on the work of historians has this to say, in part:

> Historians focus upon issues too far removed from actual social concerns to be useful… their choice of topics is guided by criteria remote from actual problems; secondly that the way in which historians organize their research and present their conclusions is limited to specific cases that wider comparative insights are lost…[57]

It is an open secret that the African continent, generally, and Nigeria specifically has been grappling with the problem of underdevelopment. Several approaches in the past were adopted to address these difficulties. One of the approaches recommended by the Economic Commission for Africa (ECA) is that African nations should redesign their educational programmes and tailor them towards tackling these problems. [58] The World Bank also suggested changes in the structure of education and training to ensure greater relevance for the need of African economies. [59] Since the language the whole world is speaking now is the language of development, historians must join in speaking it now or stand the risk of loosing out sooner or later. If any discipline must pay attention to development studies it is history because the discipline is interested in virtually every aspect of the human past. This is why we have social history, political history, economic history, military history, history of science and technology, etc. Moreover, development studies, according to Apthorpe [60] should be interdisciplinary in focus. He stated categorically that development studies are not an exclusive reserve of any particular discipline. History is relevant in development both in content and method. In spite of this, it seems we are lagging behind social science because we have not yet fully accepted the challenge of development studies. It is no wonder, then, that research organizations do not patronize historians as much as they do social scientists. Some of these agencies, except the United Nations Educational and Scientific Cooperation (UNESCO), don’t even send historians invitations to their meetings. Currently the Ford Foundation-supported “Reflections on Development” which is being implemented by the Council for the Development of Social Science Research in Africa (CODESRIA) has no single historian as a fellow.[61] Moreover, only a few postgraduate students of history have ever won CODESRIA’s small grants for thesis writing. True, history methodology is different

from social science. While social scientists are more hypothetical and theoretical, historians deal with real life situations; and while social science research bodies prefer short-term interventions, historians are more detail in reporting findings. However, it has been suggested that due to the current challenge of development in Nigeria, historians too must condescend to find a seating position between the social science methods and the scientific history.[62]

This suggestion is endorsed by Schimitt when he said:

> History has a future, if we exert ourselves to that end. But we shall have to adjust ourselves to changing times and needs and not to be bound by customary conventional approaches.[63]

To further give credence to this suggestion the report of a methodological seminar sponsored by UNESCO and CODESRIA in collaboration with the Chadian National Commission in 1989 stated that:

> It is necessary for historians to develop a sharper sense of social commitment so as to contribute actively, to the clarification of historical issues the society needs to grasp before it can accurately assess the problems facing it… The social commitment of historians must become an integral aspect of the daily exercise of their skill…[64]

At this seminar, participants recommended that the topics the African historian needs to research in, among others, include: rural and urban development, the challenge and implication of economic development, social, religious and peasant movements, etc.

Adejo[65] rose in strong support of this new approach in historical scholarship by criticizing the rigid approach in the study of the subject. It is his strong opinion that in contemporary times the diversification of historical scholarship is a reflection of the diversity of historians' interest and the materials or evidence available to him. It is this

diversification that has kept other disciplines alive and has sustained the commitment and interest of their practitioners. Presently, Nigerian historians have picked greater interest in the field of international relations which was, for long, abandoned to political scientists by our historians of yesteryears. This interest is extending to all fields of endeavor, including development studies. It is our suggestion, therefore, that we evolve a field of history to be known as development history, if there is no such area already in existence.

All we have said so far points to why this research is not only justifiable but timely. We must put our searchlight on areas of development especially in the areas of health and social welfare of our people. Since the British began to aid Benue State to develop its health and social sector we do not know of any comprehensive work by either historians or social scientists that have researched into these activities. This research will attempt, for the first time, presumably, to do this.

Quite obviously, the objectives of this study justify it. It was highlighted in the objectives that health is very critical in the development of a people especially economically. Sick people don't generate meaningful revenue, if they ever generate any at all. Therefore any study that centers on the health and social development of any people ought to be applauded. Again, with reference to the objectives of the study, some of the issues the research has enquired into have not really been researched. For instance, not many have bothered to find out what our donors stand to gain by the material and financial support being pumped into development efforts in our societies. This study will attempt to find this out.

Although British aid in Benue State covered other areas such as agriculture and governance, we deliberately choose to study aid in health and social development to underscore the importance of health in the development of any community. Thus, the

final justification for this study is based on the fact that since the constraints facing health services delivery in Benue State include poor planning, financial mismanagement, lack of co-ordination of efforts between the two tiers of government (state and local), lack of drugs and equipment, absence of a maintenance culture, etc., the research will bring out the example of what the DFID has done, to inform the government for possible adoption. If this is done the yearnings and aspirations of the Benue society for good health and social development will be met.

1.4 SCOPE

The scope of this work is determined by two major factors, viz, geography and the duration covered by the study. Geographically, our Benue State of 1992 neatly excludes the Igala-speaking areas that were excised from the 'old' Benue State and merged with present day Kogi State in 1991. A study on Benue State before 1992 will inevitably require one to extend his research to the Igala-speaking areas of Kogi State.

The Benue State of our study, by Odey's [66] estimation, lies roughly between longitudes 7° and 10° East and latitudes 6° and 8° North of the equator. It has a population of 2.78 million people, which places it as the 13th most populous state in Nigeria, by the 1991 census. The area of the state roughly covers about 6,574 hectares of land, which is about 69,740 square kilometers.

The State has 23 LGAs namely, Ado, Apa, Agatu, Ohimini, Otukpo, Okpokwu, Ogbadibo, Oju, Obi, Gwer, Gwer-West, Konshisha, Kwande, Vandeikya, Katsina-Ala, Ukum, Logo, Gboko, Tarka, Buruku, Makurdi, Guma and Ushongo. Out of these LGAs the British executed projects and developed models in health and social development in

10 LGAs, namely, Gboko, Tarka, Katsina-Ala, Logo, Ohimini, Otukpo, Vandeikya, Obi, Oju, and Gwer. As shown on Figure 1 Page 26.

It is our candid opinion that the geographical scope of this study is sufficient because, coincidentally, it was from 1992 that the British government began what one may refer to as noticeable interventions in the health and social development of the people. Therefore, there was no project located in the Igala-speaking area that will warrant our extension of the geographical scope to cover those areas.

In terms of the duration of our study 1992 is a watershed because two events stood out prominently in that year. First, the British government sent an ODA mission to Nigeria and Benue State in 1991and 1992 to explore and set out the basis and conditions for ODA support.[67] It was shortly after that mission that the ODA funded the Benue State Family Planning Analysis Study. Four years later, the first DFID-assisted project, the Water and Sanitation Project, commenced. Secondly, and probably by coincidence, it was in 1992 that the European Commission promised a significant boost to the developing countries in respect to aid flows. [68]

The study ends in March 2003, with the coming to a close of the STD/HIV Management Project. Thus, we would have studied British aid in health and social development in Benue State for slightly over ten years.

Figure 1: Map of Benue State Showing DFID focal LGAs.

Source: Bureau for Lands and Surveys, Makurdi

1.5 LIMITATIONS

A curious observer may want to raise three issues concerning this study. First, one may want to know why our study of British aid is limited to Benue State and excludes other states, knowing fully well that the British government extended similar assistance to a few other states of the federation. Secondly, one may want to know why British aid, and not other donors, attracted our attention. Finally, he/she may want to know why our inquiry into British aid in Benue is limited to health and social development and not in other areas such as agriculture or governance. If we were able to tackle these issues raised we would have succeeded in bringing out the limitations of this work.

Firstly, we must admit that a research work at this level ought to be specific, both in scope and content, addressing a definite research need. That is all the more reason we have decided to limit our scope to Benue State, emphasizing only the British efforts in health and social development. It is hoped that future researchers will examine British aid in agriculture, good governance and other areas, in Benue State. It is also hoped that this research effort will stimulate scholars of development to carry out similar researches focusing on other states of the federation.

Secondly, this study could not be extended beyond the boundaries of Benue State in view of the fact that huge financial resources would be needed to expand our geographical scope. Extensive travelling will be required if we are to do this. Unfortunately, the financial resources at our disposal are terribly limited. Moreover, this research work has to be carried out within a specified time frame. Therefore it is imperative to work within the scope defined in order to beat time.

Furthermore, for the avoidance of doubt, health and social development, in this research, is studied as a single unit. In other words the British projects in health had

imbedded in them social development components. This clarification is necessary in view of the fact that social development could mean different things to different people.

Finally, our scope is limited because of the availability of sources. To carry out a research of this nature, at this level, one would first be sure of the sources, especially primary, at his disposal. Thus, we have limited our scope to what it is now because we hope to have source materials to cover it. Out of all the renowned bilateral donor agencies working in Nigeria it is only DFID that has a coordinating office in Benue State. We requested for permission, and it was granted us, to study DFID projects in the state. The implication of this is that all information and documents pertaining to these projects were at our disposal for consultation and scrutiny.

1.6 FOREIGN AID: A CONCEPTUAL FRAMEWORK

Although the approach to this research is multidisciplinary, the conceptual framework upon which it is anchored is foreign aid. Many scholars have agreed, generally, on the definition of foreign aid with slight differences here and there which, to us, are only semantic.[69] They see it as the international transfer of capital, goods and services for the development of other nations. Foreign aid come through capital transfer, in cash or kind. It also comes in form of military and technical assistance and training, usually as grants in form of human resources and technical equipment. These resources are also for poverty alleviation, relief from war and natural disasters. They are also for the long-term development of the poorer countries so that they would be able to support their populations to attain high and acceptable standard of living. The OECD definition does not include military assistance probably for the fact that military assistance does not come for the purpose of uplifting the standard of living of poor countries.[70]

Foreign aid comes in two forms, viz, multilateral and bilateral. Multilateral aid comes from international agencies such as the World Bank, WHO, UNDP, UNICEF, UNESCO, EU, EEC, ECA, African Development Bank (ADB), etc. While bilateral aid comes from governments especially, but not exclusively, from the industrialized nations of the world to developing ones. Aid could come from a developed to another developed country, or developing to a developing one. Foreign aid is given as loans under concessional terms or as direct grants or technical assistance. [71] All these could be in form of funds, materials or personnel. It is assumed that when the country benefiting from foreign aid reaches a stage of sustained economic growth, aid would no longer be necessary.

Foreign aid is expected to be for development. That is why some scholars prefer to call it development assistance. Akinrinade and Barling[72] believe that the issue of development assistance gained prominence with the emergence of a "Third World" which was a product of the acquisition of independent status by several African and Asian countries. Politically, these third world nations gained international equality and were at par with the industrialized nations of the world, but it soon became evident that economic inequality would persist except something drastic was done to bridge the wide economic divide that existed, otherwise the relationship between the "North" and "South" would manifest in the form of neo-colonialism. In an attempt to avoid this situation, the 1950s witnessed discussions and consultations on the future of development cooperation.

It is the view of these scholars that since many aid programmes to Africa in the 1960s resulted from the de-colonization process, the aid programmes of France, the United Kingom and Belgium were, in many respects, a direct continuation of the

development efforts initiated in the colonies during the 1950s. [73] According to them, the United States of America which did not create spheres of influence in Africa and Asia during the era of colonization channeled its aid to areas of key strategic interests, including Africa, with a desire to consolidate zones of influence, during the Cold War era. Soon, other developed countries of Europe and North America joined France, the U.K., Belgium and the U.S. in the aid efforts. For instance, by 1960 the Federal Republic of Germany established capital and technical assistance programmes to Africa. The Scandinavian countries, the Eastern European countries and Canada soon joined the bandwagon of aid givers to Africa. From the Asian continent China and Japan also established aid programmes to Africa in the 1960s. Apart from bilateral aid programmes directed towards developing African and Asian countries in the 1960s, multilateral aid also flowed from the World Bank and the UN agencies to these countries.

The developments in the donor countries, with regards to development assistance, led to the establishment of aid ministries or administrations. There were also efforts among donor agencies to establish "normative standards in the operationalization of the aid process".[74] The product of these efforts was the establishment of the Development Assistance Committee (DAC) of the Organization for Economic Co-operation and Development (OECD), in 1961.

At the beginning of the 1970s the developing countries of Africa, Asia and Latin America were receiving over seven billion dollars a year in technical and financial assistance. Of this aid 95 per cent came from the members of the OECD. From the 1970s onward, every passing decade witnessed increased aid to developing countries in Africa (especially Sub-Saharan Africa), Asia, and Latin America.

However, today, aid programmes, especially in Africa, are threatened by two teething problems. Firstly, in spite of increased flow of development assistance to developing areas, it has not stimulated rapid economic development in poor countries. This has brought about considerable skepticism in the parliaments and the conscious public of the donor nations as to the economic merit of foreign aid. The second problem arises from the backdrop of the fact that developing nations with colonial heritage are naturally suspicious of motives of industrial nations and are concerned about demonstrating their independence. Developing nations receiving aid attempt to pursue what they think is their national interests, and this may conflict with the interests of their donors. This is especially so if the aid is tied to certain conditionalities. Donor nations sometimes cite humanitarian motives as necessitating development assistance to poorer countries. But most times governments are also motivated by national self-interests.

These interests are reflected in commercial, political and strategic reasons. Often, when the interests of the donors clash with those of the recipient it is the poor citizens that suffer.

These problems notwithstanding, foreign aid has come to stay; and international cooperation for development has become an issue that cannot be ignored, in a world on the fast lane towards globalization.

1.7 METHODS OF DATA COLLECTION

As stated earlier, a preponderance of primary sources is required for conducting a credible research at this level. This does not imply, however, that secondary sources are irrelevant in the scheme of things. As a matter of fact they constitute the necessary background and reference point for such studies. Often times, it is from secondary

sources that one acquires inspiration for further research into different areas of inquiry. Therefore, the collection of both primary and secondary materials and a rigorous and analytical scrutiny of these constituted the methodological framework of this research.

1.7.1 Primary Sources:

Primary sources of this work included oral interviews, DFID projects documents, Benue State and Federal Government Official Documents and publications/reports of multilateral and bilateral donor agencies.

Oral Interviews. The DFID projects in Benue State under our examination were located in different communities in the State. To be able to objectively assess their impact on the benefiting communities there was the need to visit some of the project sites and interview a cross-section of the benefiting population to ascertain the level of the usefulness of these projects. We used the semi-structured interviews (SSIs) system for this purpose.

There was also the need to interview some of the key DFID officials in the state with a view to ascertaining the machinery put in place for the sustainability of the projects they helped to put in place. We also interviewed key State Ministry of Health officials, policy makers, stakeholders and service providers at the state level. The information elicited from this last category of people interviewed include the extent of the involvement of the state government in these projects and the modalities for sustaining them.

DFID Project Documents. The documents for all the projects, although predominantly unpublished, abound. In fairness to the DFID almost everything done in respect to the projects in health and social development was documented. These documents were

mainly meticulous reports on the activities of the various projects. They were thoroughly examined.

Government Official Documents. The Benue State Governments documents on health and social development relating to our research were examined.

Publications, Reports of Multilateral and Bilateral Agencies. Official reports of multilateral and bilateral donor agencies were quite useful to our study. Other publications of these agencies such as journals, bulletins, books, newsletters, etc., constituted useful sources for our study.

1.7.2 Secondary Sources.

Secondary sources for this research included individual published works in books, journals, magazines, newspapers, etc. They also included unpublished articles presented at seminars/conferences as well as unpublished findings of dissertations and research reports. These were painstakingly examined and used.

We must state categorically, at this juncture, that no historical source is flawless, whether it is primary or secondary. Thus, in using these sources we first thoroughly synthesized them.

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CHAPTER TWO

LITERATURE REVIEW

The area of our research is relatively novel. We are yet to have published literature that addressed, directly or indirectly, the issue of British aid, or any aid at all for that matter, in Benue State. Fortunately, the research is multidisciplinary so the review of materials from the different disciplines has helped to build up the literature framework to this research.

Our approach to the review of related literature shall be as systematic as possible. We shall first review published and unpublished literature on foreign aid, generally. Literature on British aid; and then the literature on aid in health and social development closely follow this.

Robert Chambers' Whose Reality Counts?: Putting The First Last[1] is a very recent and fascinating publication. It brings out very current insight into international development efforts. It is the argument of Chambers that central issues in development have been overlooked. It is his belief that in many countries recipients of aid (both rural and urban) have shown an astonishing ability to express and analyze their local, complex and diverse realities that often conflicts with the realities imposed by professionals. He suggests in this work that professional and institutional change is essential if the realities of the poor and vulnerable are to receive greater recognition. The book presents a radical challenge to all concerned with development, whether they are practitioners, researchers or policy makers, in all organizations and disciplines, and all levels from fieldworkers to the head of agencies. This work is, as it were, a 'how-to' manual and very necessary for donor agencies. However, the work has neatly avoided the debate on the desirability or otherwise of development assistance as a solution to the socio-economic problems of

underdeveloped countries. The author writes more like a development professional than as an academician. As a proponent of development assistance, Chambers provides, in this work, recommendations for personal, professional and institutional changes, and has called for changes in concepts, values, methods and behaviours of development practitioners and donors for greater participation and empowerment of the poor and vulnerable in the society.

Another work, which we feel should be examined along with Chambers' Whose Reality Counts? is Who Changes? Institutionalizing Participation in Development, edited by James Blackburn and Jeremy Holland[2]This book is another 'how-to' book for donors and policy makers in development. It draws together, for the first time, lessons and experiences from key development agencies around the world on the institutional change needed to make participation a reality. The work is on participatory rural appraisal (PRA) and is a valuable asset to all development professionals concerned with PRA approaches. This work and Chambers' are valuable to our research in the sense that they throw light on several issues of poverty, development, community participation in development, etc. That notwithstanding, we must not lose sight of some of the shortcomings of this publication. Firstly, the book examines several cases of participatory rural appraisal (PRA) in countries such as Ethiopia, Vietnam, Bolivia, Zimbabwe, India, etc, without a word about Nigeria. Secondly, the views expressed therein are biased in favour of development assistance. Just like Chambers, (he wrote the foreword to this publication) the editors of this work together with the contributors to it wrote more as professional development workers than academicians. Thus, the work lacks the rigorous analysis and critique, which characterizes works by academicians.

Five World Bank publications ought to be mentioned in this review. Two are in the "Voices of the poor series". The first of the two is titled Crying Out for Change[3] while the second is titled Can Anyone Hear Us?[4], both authored by Narayan. These two publications are dependable commentaries on the poor and needy. They x-rayed the condition of poverty in the world and provide basis for international action. These works are relevant to our study in the sense that poverty as an issue features prominently in this study. We need not over flog the fact that these publications are pro-development assistance. The World Bank is pro-development assistance. The World Bank has become a 'voice in the wilderness' calling for international co-operation for development assistance to under-developed countries. Since he who pays the piper calls for the tune, authors writing for the World Bank are most likely to express views that are not at variance with the Bank's policies. It is therefore no wonder then that Narayan and his colleagues presents in these two publications the concerns of the World Bank for the poor of the world. The voices of the poor publications used participatory and qualitative research methods to present very directly, through the voices of the poor themselves, the realities of their conditions, thus justifying foreign aid. The bits and pieces from these publications have added up to build some aspects of the research, in a little way, especially for chapter three.

The third publication by the World Bank is titled World Bank Policy and Research Bulletin.[5]A write-up in this publication attracts our attention for the same reason as stated above: a clear x-ray of the poverty conditions of vulnerable groups. The title of the article is: "Attacking Poverty with a Three-Pronged Strategy." This article provides a graphic picture of poverty as seen by the World Bank today and highlights earlier approaches aimed at reducing poverty. It dwells extensively on the bank's new

strategy for attacking poverty. This new strategy includes promoting opportunity, facilitating empowerment and enhancing security.

The fourth publication is titled Nurturing Development: Aid and Cooperation in Today's World.[6] In this book the author, Ismail Serageldin, puts his full weight behind foreign aid as a viable tool for the development of the Third World. In it he rebutted all the four arguments put forward by anti-aid elements. Such arguments like: aid promotes dependency, aid is often misused, aid has failed and that trade is better than aid in promoting economic growth. Serageldin is also one of those 'World Bank authors' who seems not to have seen the other side of aid. His work is, needless to say much, a 'newsletter' of the World Bank. But it is nonetheless useful in the sense that it provides a viewpoint in the current debate on foreign aid. In the final analysis this publication has brought into the limelight, vis-a-vis the other publications which expressed alternative views, the desirability of development assistance.

The last of these World Bank publications in these series is the organization's document titled Assistance Strategies to Reduce Poverty.[7] As the title indicates, this work presents the World Bank's strategy for the reduction of poverty, globally. The key elements of this strategy as presented by the publication include the analysis of countries' socio-economic policies on poverty reduction, designing of assistance strategies for these countries, the development of an information base and the implementation of poverty reduction policies for these countries. This document, just like the other World Bank publications, provides useful bits of information, which will help us in our discussions on poverty, in chapter three. These does not rule out the fact we have been trying to stress that the views in these publications are one-sided and must be taken with a pinch of salt.

The 1986 Report of the Development Assistance Committee (DAC).[8] of the Organization for Economic Co-operation for Development (OECD) compiled by Joseph C. Wheeler, though too general, provides us insight into what the OECD has been doing in development assistance. It would actually be strange to carry out a study on foreign aid without keeping in touch with OECD publications. Just like Wheeler's report, other OECD publications that provide such necessary information into what OECD is doing include: "Donor Assistance to Capacity Development in Environment"[9] "Co-operation for Sustainable Development"[10]"Assisting developing countries with the formulation and implementation of National Strategies for Sustainable Development: The need to clarify DAC targets and strategies,"[11]"Principles for Evaluation of Development Assistance"[12] and Goran Ohlin's Foreign Policies Reconsidered.[13]

Ohlin's book, which is, as it were, a report of a study conducted for OECD has a very fundamental and important theme among others: the multilateralization of bilateral aid. In other words, the OECD which is an umbrella body for the co-ordination of bilateral aid is moving towards harmonizing aid policies of the donor nations so that aid policies are no longer different or divergent but uniform. Writing from the perspective of a historian, Ohlin traces the origin of foreign aid as an inescapable instrument of foreign policy, as initially conceived by governments. He suggests that it is becoming increasingly a tool for the guarantee of international peace and security so that the spread of disorder will be stemmed. Now he believes it is used more as a moral obligation. The impression one gets from Ohlin's conclusion is that foreign aid has gone through a process and now has reached a point where it is seen mainly as a moral obligation. It is the fact that the three stages highlighted by Ohlin are, in our estimation, still issues in

bilateral aid policies today. The authors' standpoint is not surprising to us because he wrote for an organization that is synonymous with aid.

In the same category with the World Bank and OECD literature is a book jointly published by the IMF, UN, OECD and the World Bank titled A Better World for All.[14] This publication cannot be wished away because it is put together by institutions that matter in multilateral aid administration. It provides a general picture of how the world is thinking about the matter of overseas development assistance. The book paints a grave picture of the poverty level among the poor and vulnerable and urges international action against deprivation. It emphasizes the urgency of this action. The document goes further to enumerate obstacles to international development. These include weak governance, bad polices, human right abuses, the spread of HIV/AIDS, which has become an issue of international concern today, etc. This publication is one of the literatures that merely provided a general knowledge on foreign aid and has served as a nice reference material for one who wishes to know more about it.

In Economic Development in Africa: International Efforts, Issues and Prospects edited by Akinrinade and Barling,[15] general issues on foreign aid and international development are brought into focus. The book discusses the contribution of the international community to the development process in Africa. It considers efforts conceived within bilateral, multilateral and regional frameworks. It is a collection of articles by scholars, most of who are working in the field of international relations with special interest on Africa. For instance Barling's article, "Aid and African Development", Steven's "The EC and Development Efforts in Africa", and Akinrinade's "The Commonwealth and Development Efforts in Africa" are quite informative and relevant to our study. The work provides a good framework for this present study. As a matter of

fact, this is a very scholarly and purely academic discourse on foreign aid and economic development. It stands shoulder high above several of the literature hitherto reviewed. It presents a balanced view of issues of development in Africa. For instance, the book traced the origin of Africa's economic difficulties to colonization, the global economic recessions of the early and late 1970s and poor economic performance. The authors see a solution to these difficulties through African regional economic co-operation, self-help, self discipline of African leaders in policy formulation and implementation, and international assistance under the terms of the UN programme.[16] It is, however, only a resource material since it does not address the core matter of this current research.

Similarly, Oyewole's[17] article titled "Western Economic Aid in Black African Development", Tinubu's[18] "Multilateral Corporations and their impact on developing countries" and Ogunpola and Ojo's[19]"The Role of Multinational Corporations in the Development of African Countries", all published in Nigerian Journal of International Studies provides us with the kind of information and insight which Akinrinade and Barling's work provided. For instance, these articles express Africa's aid needs, objectives of aid donors, the unique features of developing countries, the impact of multinational corporations on developing countries, etc. Even though these articles are valuable source materials, they do not treat in specific terms the issues raised in our current research so shall be treated the same way Akinrinade and Barling's work were treated.

Ordinarily, Akinbobola's[20] "Foreign Assistance as an Instrument of Nigeria's Foreign Policy: A Critique and Policy Options" ought not to have attracted our attention for the fact that while our study is centered on aid from a developed nation to a developing one, his write-up centres on aid from a developing nation to another

developing one. But the interesting aspect of this article is its emphasis on foreign aid as an instrument of foreign policy.

Another article to note with particular interest is Eyinla's[21] "The European Union and the Application of Political Conditionality in Sub-Saharan African." Like the work just reviewed, Eyinla's work provides one of the motives for the flow of resources from multilateral and bilateral organizations to Sub-Saharan Africa. According to the author, the EU's aid policy during the Cold War changed from an instrument of resource security to becoming a powerful instrument of blandishment for promoting political change in Sub-Saharan Africa. The EU and individual European nations began to demand a promotion of democracy and good governance, including respect for human rights, as necessary pre-condition for aid. This work too only assists us discover the interplay of resource flows from donors and the conditionalities attached to them.

The central theme of <u>Foreign Aid: Selected Readings</u> edited by Bhagwati and Eckaus[22] attracts our attention. The book argues that the optimistic expectations that foreign aid would bring development to least developed countries (LDCs) have given way to skeptical evaluation of what has been achieved. But the argument does not end there. The book turns another side of the coin by submitting that the gains of foreign aid cannot be expected unless both its ends and means are more fully appreciated. While some of the contributors to this debate believe that the growth performance of the LDCs has been too poor to deserve additional scarce resources, which are often needed for the domestic programs of the donor nations, others feel otherwise. For instance, some argue that the LDCs have not performed badly when compared either to the developed countries, or to their pre-aid programme growth rates. This school of thought also argues that while there are indeed horror stories of aid wastages, there are also success stories.

And that actually, certain extraneous factors could be responsible for aid wastages. The case of severe droughts in India from 1965 to 1967 is cited to strengthen this argument.[23]

As a matter of fact, this work presents a classical example of a balanced discourse on this debate. Even though it does not contribute substantially to the main subject of our research, it presents to us an insight into the general issue of foreign aid.

Another critical issue of foreign aid as an instrument of national policy is addressed in three separate publications authored and edited by some American scholars. In Why Foreign Aid? edited by Robert Goldwin,[24] and Herbert Feis' Foreign Aid and Foreign Policy[25] the contributors and author respectively, wonder why the United States has persisted in her aid programme long after the Marshall Plan, knowing fully well that communism was no longer a serious threat to her security. In other words, if foreign aid was to serve America's national interests, in what ways did economic assistance to the development of LDCs contribute to America's interests? And if these interests are being served at all, are the results commensurate with the huge expenditures? It is the conclusion of these scholars that America needs to go back to the drawing board and re-examine her aid policies to the LDCs; that there is at present a lack of understanding of what should guide American policy on development assistance to LDCs.

Edward S. Mason, while contributing to the issue at stake brings out an interesting argument in his work titled Foreign Aid and Foreign Policy.[26] According to him the United States, and indeed all aid-giving countries, design their aid programs with their (donors') interests in mind. And that 'interests' cover a wide spectrum of concerns. He agues further that it does not always follow that because the interests of the donors are served, those of the recipients are thereby denied. He alludes to the fact that part of the interests of the donors, such as the Scandinavian countries and Holland, are the

maintenance of international peace and security. Other donors' interests are commercial, e.g. Japan, while others are political, such as Germany. [27] He submits that foreign aid should be given and should be received as long as both the interests of the donors and recipients are protected.

The publications by these American scholars have only added up to our general background knowledge of aid as instrument of foreign policy. The fundamental issues pertaining to our present research remains unattended to by these authors. Therefore, the publications remain mere source materials.

A publication akin to the ones by the American scholars is John White's The Politics of Foreign Aid. [28] The basic position taken in this work is that it is illegitimate to separate economic from political factors in foreign aid. The book attempts to weld political and economic considerations in the giving and receipt of aid into a single framework. According to him the 'selfish' interests of the donors are often political and economic while the approach to the utilization of aid by the recipients is equally political and economic. He argues further that neither the political nor the economic aspects of the process of aid giving or receiving can be studied exclusively in terms of countries. The crucial political question, according to this author, should be: who uses aid, and for what? The economic question should be: what is the resource that he is using? While we appreciate the quality, in terms of issues raised in this piece of literature, and the dexterity of White's presentation of the facts, we are however uncomfortable with his vehemence in advocating for the continuance of foreign aid. True, White is entitled to his personal views but it would be academic wisdom to express such views moderately and modestly, especially in the midst of several other dissenting voices. For instance, in advocating for aid continuance White says:

> I am sometimes asked why, if I believe that current aid practices have the failings, some of which are analysed in this book, I nevertheless count myself as an advocate of aid and as a supporter of the politicians and administrators who strive for its continuance.[29]

With this kind of conclusion White is saying in essence that aid is aid, whether (badly) tied or not should be given and received.

Another advocate of foreign aid is Theodore A. Sumberg. In his book Foreign Aid as Moral Obligation? [30] he answers his question in the affirmative. We wonder why the title of this book was a question. But now we know it was a mere rhetoric question. For instance, in the first chapter of the book Sumberg pays tribute to foreign aid by quoting Harry Truman's speech in January 20, 1949, calling for a "bold new program" to put an end to man's "ancient enemies – hunger, misery, and despair." [31] Sumberg forgot that behind attacking hunger, misery and despair was the critical political issue of the containment of communism, which dominated the U.S. policy in the post-World War II era.

Actually, there is no serious need to dwell long on Sumberg's rhetorical question since in the final analysis our verdict on his book will be the same as the one passed on White's. However, the publications are still relevant to us in a little way because they provide the authors' personal viewpoints to the divergent views on this subject matter.

J.M. Healey's[32] The Economics of Aid is a work we cannot dismiss with a wave of the hand. Although writing from an economist's point of view the content of the book is useful and relevant, especially as our study is multidisciplinary in its approach. The book draws the attention of the undergraduate and postgraduate economics student to the analytical approach to aid and aid policy. It examines some of the main aspects of foreign assistance to developing countries in terms of economic principles. In other words, this

work, which is on developmental economics and international economics, suggests that foreign economic aid ought to be examined basically from the economist's viewpoint and not necessarily to satisfy the politicians who use it to achieve foreign policy goals. Healey explains in some detail the motives for economic aid. He summarizes them under commercial, political and strategic motives. But if Healey thinks that aid should be looked at from a purely economic point of view he may be making a mistake. This is because humanitarian considerations are also becoming a major factor in development assistance. Healey may therefore need to update his views in this direction.

Bureaucracy, the Marshall Plan and the National Interest[33] is a work on foreign aid that presents an important view to the theory of national interest. This book by Hadley Arkes presents the interplay of foreign aid and the pursuit of national interests. For instance Arkes believes that when, in 1947, during an address at Harvard, George Marshall, the then U.S. Secretary of State declared that the Marshall Plan was not directed against any country but against hunger, poverty, desperation and chaos the policy was actually anti-communism. One other important lesson we learn from this publication is that not all aid motives are written in black and white. Some are concealed or kept at the recesses of the mind and spoken about only in low tones. Arkes believes that if we must get at such motives we must search for them beyond the pages of newspapers. A curious reader may want to know why a piece of literature, which has no direct bearing on our work, should attract our attention. The answer to this question is not far-fetched. Arkes' work opens our eyes to the fact that when we seek to examine the diplomatic undertones in British aid in Benue State we may have to look beyond the newspapers or other published materials.

Among the scholars of the Marxist persuasion there is a strong bias against foreign aid. Their works seems to be crying out against foreign aid. It is their view that foreign aid cannot solve the problems of underdevelopment in Africa, Asia and Latin America. According to them foreign aid is a bait, which when swallowed keeps the recipients perpetually in bondage to the donors. They also elaborated on the crippling effects of aid on the economies of developing nations. Some of the publications in this category that attracted our attention are Teresa Hayter's Aid as Imperialism,[34] Taresa Hayer and Catherine Watson's Aid: Rhetoric and Reality [35,] Harry Magdoff's Imperialism: From the Colonial Age to the Present,[36,] Tibor Mende's From Aid to Re-Colonization: Lessons of a Failure[37] and Patricia Adams and Lawrence Solomon's In the Name of Progress: The Underside of Foreign Aid. [38] All these publications' counsel to developing nations is one: take foreign aid with a pinch of salt. It is like saying: while eating with the devil use a long fork!

It is our thinking that the views expressed by the radical Marxists in these literatures could be considered a bit extreme. Just as we did not hesitate to observe lapses in the extreme views of the pro-aid apologists, we owe it a duty to do it in the case of these anti-aid apologists. To conclude that aid, whether bilateral or multilateral, should be avoided is a little bit unacceptable. For instance, Hayter and Watson would want the word 'aid' to be completely abandoned and replaced with descriptions like 'export subsidy', 'debt insurance' (whatever these descriptions mean), 'funds for counter-insurgence', etc.[39] These scholars see nothing good, whatever, with foreign aid, not even aid for relief during disasters or catastrophes. While they think the word 'aid' shoud be replaced with 'funds for counter-insurgence', they are oblivious of the fact that communist countries had equally sent military aid to less developed countries to fight

capitalism and colonialism, e.g. the then Soviet Union gave aid to guerilla fighters in Angola, Mozambique, etc.[40]

We do not have particular axes to grind with Hayter, Watson, Magdoff, Mende, and so on, because they are entitled to their personal opinions. However, we only thought they ought to have introduced some balance in their views. Nevertheless, their works has helped us in our research in the sense that we now have more divergent views in the foreign aid debate to think about and probably work with.

Gunnar Myrdal[41] seems to have taken a middle position between the proponents and opponents of foreign aid. In his book titled The Challenge of World Poverty: A World Anti-Poverty Programme he takes a strong position for foreign aid but warns that mere flow of capital and resources to developing nations will not, possibly, bring about development except the recipients of aid brace up to their responsibilities which include, according to him, good governance, education, population control, etc.

Benjamin J. Cohen also seems to have taken a middle position on foreign aid. In his book titled The Question of Imperialism: The Political Economy of Dominance and Dependence,[42] he admits taking a middle position when he said: "my position... will be partially in accord with Marxist and radical discussions, and partially agnostic". His position on the issue of aid is, therefore, that external conditions might have truely influenced the economies of the LDCs, the fact still remains that in the family of nations all participants are dependent on one another to a greater or lesser extent. Our interpretation of this is that even though colonialism and capitalism had adversely affected the economies of most of the LDCs, this does not preclude the LDCs from accepting bilateral or multilateral development assistance. Put differently, Cohen seems to be saying it will be an act of irrationality for LDCs to reject development assistance

just because the developed countries, which are the main donors, were responsible for the conditions that impoverished them in the first place. Myrdal and Cohen's works have introduced the much-needed balance in the on-going debate on aid. No doubt these books are useful to us, to some extent, in this research.

Having considered the literature on foreign aid generally, we will need to now examine the literature on British aid, specifically. Guy Arnold's Aid in Africa[43] provides a window into British aid policy in the 1970s and earlier. According to him, Britain, like all the major donors disbursed assistance through a wide range of mechanisms and made use of methods currently in use. Britain provided bilateral loans, grants and credits to developing nations and other developed nations, as the needs arose. According to Arnold, Britain is a member of regional aid-giving groups, of the various consortia and consultative groups such as EU, EEC, OECD, etc. Britain is also a founding member of various Commonwealth bodies such as the Commonwealth Fund for Technical Cooperation (CFTC), responsible for aid or technical assistance. At one end of the scale Britain gave loans at full business rates of interest through the Commonwealth Development Corporation (CDC), for example. But at the other end Britain was a contributor to disaster relief. Arnold believes that the scope of British aid has expanded with a substantial proportion of British aid giving in the form of educational places for students to study in Britain while much of the overseas efforts are concentrated upon the supply of experts.

In 1964, the U.K. Labour government set up a Ministry for Overseas Development (ODM), charged with the responsibility of administering development assistance to needy areas, among other responsibilities. The functions of this ministry were taken over by the Overseas Development Administration (ODA) established in

1979; and in 1997 ODA was changed to Department for International Development (DFID). These details are overstressed for the simple fact that ODA and DFID have almost become synonymous with international development and cooperation, and all that one would like to know about British policy and activities towards development assistance, especially overseas development assistance, is contained in the publications of these agencies. Arnold's work, though useful, is rather 'outdated', in the sense that it is far behind recent British policies and instruments of foreign aid. For instance, since the bood is not current, it says nothing about the U.K. government's DFID which its activities in Benue State forms the crux of the subject of our research.

Also worthy of review is British Aid and International Trade: Aid Policy Making: 1979-89 by Morrissey, Smith and Horesh.[44] The book, as its main thrust, examines British aid policy during the Margaret Thatcher years. The authors' verdict on the aid policy during this period is that neither developmental nor commercial objectives were achieved during the Thatcher era. To them it was political objectives, more than any other objectives that the aid policy served.

Were it only for the above conclusions there would have been no need for us to put our searchlight on this book. But chapter two of this publication provides us a window into the objectives of British aid and also highlights the intrinsic conflict between the interests of the donor and those of the recipient. Although this work is quite a good source material, it is limited in the sense that whereas our emphasis is more on the practical aspect of aid, it has dwelt more on the policy aspect.

British Aid-4: Technical Assistance (A Factual Survey of Britain's Aid to Overseas Development Through Technical Assistance) is a study report put together for the Overseas Development Institute (ODI) by Peter Williams.[45] It contains detailed facts

and figures on British technical assistance to developing countries, tracing the historical background of this scheme up to 1961. The publication considers, among other things, issues such as: who are the main beneficiaries of this assistance, and on what terms and conditions? What are Britain's priorities in this field? What contributions does Britain make to the UN technical assistance, etc?

On the face value we thought this book would provide sufficient data and general information for us to use in our research generally, and specifically on the historical background to British aid in Nigeria. But after a careful examination it was discovered that the publication has two major shortcomings. Firstly, it discussed issues rather generally without looking at individual countries among the colonies or in the Commonwealth or the LDCs it gave assistance to. This makes it difficult for us to identify the technical assistance given to Nigeria specifically, during the period under examination. Secondly, the book seems to be behind recent trends in British technical assistance. The book lacks recent data on the subject, having been published in 1964 without undergoing any review. Notwithstanding the shortcomings mentioned above, this publication is useful in a little way because it discusses the terms and conditions for British technical assistance.[46]

Apart from these works which give us only a sketch of what British aid was all about, we have ODA and DFID publications at our disposal, which provides additional information on the subject. We must warn from the onset that these publications are not academic works. Their contents are neither analytical nor critical. They are similar to the publications we nicknamed 'newsletters', but in the absence of more critical and analytical literatures we shall be content to rely on them for whatever little information they offer.

An ODA publication titled British Overseas Aid Annual Review[47] outlines the purpose of the British aid programme as enshrined in the Overseas Development and Cooperation act of 1980. To us, this is the first publication that has expressed in very clear terms what British Aid is out to accomplish. It highlights the government's aid agenda on health, education, gender issues, governance, economic reforms, environment, etc. The summary of this policy is the eradication of poverty and the improvement of the standard of lives of people in the areas targeted for development by the British.

This publication cannot replace our present study but will surely guide us as we examine British aid policy and activities in Benue State. Another publication similar to British Overseas Aid… is DFID's Better Health for Poor People.[48] This publication is current and specific on Britain's aid policy on health and social development. It presents strategies for achieving the international development targets in health. This publication is relevant to whoever wants to know what and how the British government is doing about international developments in the health sector in countries of Asia and Sub-Saharan Africa. In the preface to this publication the DFID presents, generally, the agenda of the British government in international development. The policy is an improvement on ODA's British Overseas Aid… it states, in part, that the DFID seeks to:

> Work in partnership with governments that are committed to the international targets, and seek to work with business, civil society and the research community to encourage progress, which will help reduce poverty. We also work with multilateral institutions… The bulk of our assistance is concentrated on the poorest countries in Asia and Sub-Saharan Africa…[49]

This publication too has provided us a guide on some aspects of our research even though it does not address in direct terms the main theme of our research.

Apart from these two important publications reviewed, there are other DFID publications on Nigeria that we cannot afford to overlook. They include Nigeria Country

Strategy Paper,[50] Nigerian Country Strategy Process: Poverty Audit,[51] and Nigeria HIV/AIDS Strategy[52] The first publication provides the UK's general policy framework on development efforts in Nigeria and maps out strategies for meeting these development targets. The last two publications address, specifically, policy frameworks and strategies for combating poverty and the HIV/AIDS scourge in Nigeria, respectively. These publications are good reference materials for our study, no doubt, but they are grossly limited in terms of content and details, if compared to what our research is out to discover. Therefore, they too remain mere source materials.

There is yet another publication by the DFID Health Systems Resource Centre titled Nigeria: Country Health Briefing Paper authored by David Johnson.[53] This document is a briefing paper and so very brief but loaded with useful information pertaining to this study. The paper highlights the poverty situation in Nigeria and emphasized key health indicators, health service structure and provisions as well as key health policies including health sector financing. Thus, this paper provides any researcher in health and social development valuable background information on the health situation and health needs of Nigeria as seen by the British government through its agency, the DFID. This brief document ends by highlighting the involvement of the DFID in the health development of Nigeria. It mentions DFID health projects in Nigeria (including those sited in Benue State) and explains the roles of other development agencies in the health development in Nigeria. This publication is useful but rather too brief to provide all the answers to our present enquiry.

We cannot afford to end this review without examining the literatures on health and social development written by scholars of diverse backgrounds and orientation.

These literatures touch on one aspect of health or the other and are useful as reference materials, as we have continued to emphasize.

In year 2000 Anyebe submitted a Master of Public Health (MPH) thesis titled: "Who is Eligible for Payment Exemption in a Drug Revolving Fund Scheme? An Explanatory Study of a Nigerian Example"[54] to the Nuffield Institute of Health, University of Leeds, in the U.K. The thesis explains how the DFID-assisted Benue Health Fund Project successfully piloted Participatory Community Selection (PCS) tools and techniques to enable community members use their local knowledge of poverty to identify the worst-off among them for the purpose of exempting them (worst-off) from user charges.

The background to Anyebe's study is that in 1988 user charges were introduced in PHC in Nigeria though the Drug Revolving Fund (DRF) schemes in line with the Bamako Initiative of 1987. The BI strategy recommended exemptions as a means of assisting the worst-off in the society who were unable to pay for charges. Unfortunately, after a decade or so studies revealed that the worst-off continued to find health services inaccessible because exemption mechanisms were not in place at all, or there were difficulties identifying genuinely worst-off clients who should benefit. Anyebe's thesis is therefore a report of how the BHF project succeeded in developing the tool and technique for fishing out the worst-off.

Although this work is quite standard and valuable, it cannot replace what we are researching into because it touches only a minute portion of the entire work of the BHF Project, talk less of touching on all that the DFID has done in Benue State.

In Questioning the Solution: The Politics of PHC and Child Survival,[55] David Werner and David Sanders explains why, in spite of bogus and ostentatious promises by

world leaders to provide health care, 13 million children still die yearly from preventable causes, and challenged the strategies of our health managers. According to these authors health planners should be blamed for these lapses because instead of confronting the social and economic inequalities that perpetuate poverty, poor health and child mortality, they prefer to politicize PHC. The authors used the case of the commercialization of the Oral Re-hydration Therapy (ORT), a potentially viable life-saving technology, to prove how the poor are further exploited and impoverished. The duo argues that health is determined more by the equity or inequity of social structures than by conventional health services. They blamed the implementation of the Structural Adjustment Programme (SAP) and the tendency towards the globalization of world economy by the World Bank and IMF for the diminished health and quality of life by vulnerable people especially women and children. This radical publication could not pass quietly because in it we discover two or more reasons why health systems are failing in developing nations especially in Africa, south of the Sahara. The book also provides us insight into why development efforts in health and social development by donors yield little or no dividends in Sub-Saharan Africa. This book is another useful source material for our study. However, its shortcomings are obvious. For instance, although Nigeria's health indicators are said to be very bad, as shown in Figure 3-1, page 75 of the book, the author did not consider it necessary to give enough coverage to Nigeria's situation but gives full coverage to countries like Mozambique, Zimbabwe, Mexico, and so on.

Chapter 12 of Carol Baker's The Health Care Policy Process[56] is titled "Aid and the Health Sector." This chapter reveals that whereas in the 1960s development was seen as a matter of economic growth above all else and the health sector received little aid, today health improvement is regarded as an integral part of development. It is the

author's strong view that aid relationship is a two-way process. This, according to her, means that both the donors and recipients benefit. The benefits to recipients are good health infrastructures while the donors benefit by securing friendships and influence as well as commercial opportunities. Since we also investigated motives for aid, as part of our concern in this research, this book became a useful companion.

Baker also expresses other points that are worth mentioning. Firstly, she opines that aid comes with conditions and demands that things be done in certain ways. Secondly, she says Sub-Saharan Africa, more than any region in the world, benefited from aid flows in health in 1990. Apart from this truths Baker's ideas have helped to facilitate our understanding of the concepts of poverty and development.

An Overseas Development Institute (ODI) Briefing Paper titled "Mainstreaming Participation in Economic Infrastructure Project"[57]deals with the issue of community and public participation in development projects. From this publication we understand that for the past 10 years (from the date of its publication) public participation has become central to the social development sectors of development assistance. These sectors include small-scale agriculture, forestry, health care, education, sanitation, water supply, etc. The rationale is that if people are not involved in sustainable development, i.e. becoming both architects and engineers of the concept, it will not be achieved. The document suggests that the public should be involved in development since public participation seeks to inform and consult with those directly affected by the projects. Incidentally, British aid in Benue State placed great emphasis on public participation in projects. It is this fact that attracted our attention to this publication. Similar works that attracted our attention, and for similar reasons include: The World Health Report 2000 titled Health Systems: Improving Performance,[58] IDS Working Paper No. 86 titled

Household Coping Strategies in Response to the Introduction of User Charges for Social Services: A case Study on Health in Uganda,[59] the PTF-Assisted National BI Programme Report titled Guidelines for the Implementation of the PTF-Assisted Bamako Initiative Programme Nation-Wide,[60] Julio Frenk's[61] "The Public/Private Mix and Human Resources for Health", Stephen W. Jarret and Samuel Ofosu-Amah's "Strengthening Health Services for MCH in Africa: The First Four Years of the 'Bamako Initiative'[62] and the World Bank Discussion Papers No. 294 titled Financing Health Services Through User Fees and Insurance: Case Studies from Sub-Saharan Africa, edited by R. Paul Shaw and Martha Ainsworth.[63] The issue of sustainability of aided projects in health and social development features prominently in this research. One of the questions frequently asked is: why are foreign–aided projects in Sub-Saharan Africa often not sustained? A few literatures on the issue of sustainability will provide us a reference point. Thomas J. Bossert's "Can They Get Along Without Us?: Sustainability of Donor-Supported Health Projects in Central America and Africa"[64] tackles this issue head-on. The author presents a synthesis of five country studies of the sustainability of the US government–assisted health projects in Central America and Africa. His study compared the projects of the same framework executed in the two regions to determine which project activities had continued after the donor funding ceased. From the studies it was discovered that health projects in Africa were less firmly sustained than those in Central America. Bossert's work has helped in one way or the other in throwing some light on this aspect of the research. But we must warn that Bosset's study was on USAID-assisted projects and not DFID. Therefore, the use of this work must be cautious since the policies of the two donor countries may not exactly be the same.

Eric R. De Winter's "Which Way to Sustainability?: External Support for Health Projects in Developing Countries"[65] has a similarity with Bossert's work. Apart from analyzing the process by which donors decide whether or not to support specific primary health care projects, the article discussed extensively the issue of recipients' ability to sustain projects once they are started. He suggests that for aided projects to be sustained, donors should first help the recipient countries develop sufficient institutional capabilities to carry out health services properly before aid is sent.

The USAID Working Paper No. 174 titled A Synthesis Study of the Factors of Sustainability in A.I.D. Health Projects[66] provides a model questionnaire with which sustainability could be assessed. It is a nice instrument for testing sustainability is useful for project evaluation generally.

CEPAL Review No. 59.[67] devoted a section that discussed ways of ensuring sustainability of aided projects. Although this publication looks mainly at social investment funds in Latin America, its author, Siri, expressed views that are of general applicability to all projects, including health projects. He strongly believes that project funds are temporary mechanisms while the works they create are meant to be permanent. Therefore to ensure sustainability he advised both the donors and recipients to consider the building of infrastructures as merely the first phase of a project while its sustainability should be its second phase. Siri concludes that for projects to be sustained, the involvement of the communities is an imperative.

As we come to the end of the review of related literature, we need to emphasise that the DFID-assisted projects in Benue State had a special place for women and children. The place of women and children was clearly enunciated in the various DFID country strategy and briefing papers. Moreover, gender was mainstreamed in all the

DFID projects in the State. Mark W. Rosenberg and Kathleen Wilson's article, "Gender, Poverty and Location: How Much Difference Do They Make in The Geography of Health Inequalities?"[68] The authors set out to investigate the general believe that women live longer than men but suffer more illnesses throughout their lives; and that health and health behavior vary over different geographical scales. These authors tried to find out if there are connections between health, gender, poverty and, especially, location. It was found that gender, poverty and location play relative roles on the geography of health inequalities.

This article is reviewed so that we can have a reference point as we consider the DFID development assistance policies as they affect women vis-à-vis their practical implementation as seen in the projects executed in Benue State. Although, the findings of Rosenberg and Wilson cannot be universally applied, the work is a modest attempt on this issue. We accept it as a useful work that has helped us in our study.

In view of the fact, as we earlier stated, our research is a relatively novel and pioneering effort, especially in this part of the country, it is not surprising, therefore, that majority of the literature reviewed are written by foreign authors. The implication of this is that since their culture, orientation and background are different from ours, these materials ought to be used cautiously, their usefulness notwithstanding.

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CHAPTER THREE

HISTORICAL BACKGROUND, POVERTY PROFILE AND THE BEGINNING OF BRITISH AID IN BENUE STATE

3.1 INTRODUCTION.

This chapter examines three major issues as captured by the chapter title. The first issue is a brief historical background of the Benue State of our research. Although the research is not about the history of Benue State, neither is it about the history of its peoples, this section provides an overview of the history of the State to enable those new to the area follow the issues in the study more closely. This section is closely followed by a presentation of the poverty profile of the State, within the general context of the poverty conditions in the country, to explain the rationale for British aid in health and social development in the State. Thus, logically and naturally, the final section of the chapter leads us to examining the beginning of British intervention in health and social development in the State. As a matter of fact, this section would have constituted a chapter of its own but for the fact that the aid was not substantial, and also because we could conveniently accommodate it in this chapter. It is hoped that the section will, also, naturally link us up with the major DFID-assisted projects, which we shall begin to study as from chapter four.

3.2 THE HISTORY OF BENUE STATE: A PANORAMIC VIEW

The late Murtala Muhammed, the then Head of State of Nigeria created Benue State on 3rd February 1976 along with six other States, when he increased the number of States from 12 to 19. The creation of Benue State was the conclusion of decades of

agitation by the people of the Benue valley to carve for themselves an identity, separate from that of the people of the Plateau.[1]

Benue State, named after the River Benue, the second largest river in Nigeria, is situated almost in the heart of Nigeria. At creation, Benue State covered 69,740 square kilometers and was populated by three major ethnic groups, namely, the Idoma, Igala and Tiv, while the minority groups included the Igede, Bassa-Komo, Bassa–Nge, Etulo and the Jukuns. The then new State comprised of seven Local Government Areas (LGAs) namely: Gboko, Makurdi, Katsina-Ala, Otukpo, Ankpa, Dekina and Idah. Several local government creation exercises increased these to 13 and later to 19.

Following the creation of additional states and LGAs by the administration of General Ibrahim Babangida on 27th August 1991, the Igala and Bassa areas, with a total of six LGAs were excised to form part of what has now became Kogi State.

3.2.1 Geography.

Benue State, before August 1991 was bounded by Plateau State to the north, Gongola State to the east, Anambra and Cross River States to the south and Kwara and Bendel States to the west. The State lied between Longitude 6^0-10^0 East and latitude 6^0 and 8^0 North with an estimated area of 69,740 square kilometers and a population of about 4,076,375 (1984 population projecting). It was the seventh most populous state in the federation. The Benue State of August 1991 shares boundaries with five other states: Nassarawa State to the north, Taraba State to the east, Cross River State to the south, Enugu State to the south west and Kogi State to the west. The State also shares a common boundary with the Republic of Cameroon on the southeast. By the 1991 census Benue State had a population of 2,780,389 and occupies a landmass of 30,955 square

kilometers [2]. Generally, the River Benue with its tributaries deposited alluvial soil in the Benue trough which has constituted the bulk of rich agricultural land that has made the state the “food basket of the nation”[3].

The State has a tropical climate with two seasons: the rainy season which starts from April to October and the dry season, which lasts from November to April. The people are predominantly farmers, although the communities living on the banks of the Rivers Benue and Katsina-Ala also engage in fishing as an important secondary occupation. Apart from the fact that Benue State is blessed with abundant agricultural and well-watered lands and a conducive tropical Savannah climate, nature has also endowed the state with rich mineral resources such as limestone, coal, sandstones, etc.[4].

3.2.2 Early Migrations

Some of the people that inhabited Benue State of 1976 and 1991 migrated to the area with the collapse of the Kwararafa Kingdom. This great empire lasted till about the 17th century when it collapsed following severe military campaigns from the emerging Borno Empire. Its fragmented groups disintegrated from the economic and political cohesion of the Jukun leadership and migrated in different directions. The Idoma, Igala and Etulo, to mention only a few, are a product of this scenario.

The Bassa-Komo and Bassa-Nge, like their kith and kin, the Nupe, may have probably fled from the turbulence caused by the invading Fulani jihadists, crossed the Benue to settle where they live today.

The Tiv, a people of the semi-Bantu stock who are believed to have migrated from the Congo basin to the west of Cameroon between 1750 and 1800 finally arrived in the Benue valley by 1800 [5]. Since the communities that had made up the Apa kingdom

were in a state of turmoil, it was easy for the arriving Tiv to fight their way into the land until they reached the banks of the Benue. [6]

3.2.3 Colonial Rule

By 1800 all the people who inhabited what later became Benue State had settled down and learnt to co-exist with one another. The introduction of indirect rule by the British colonizers during the colonial era was not very successful even though the colonizers coerced the various peoples of the area. The Tiv who were the dominant group in the area proved a hard nut to crack by the colonizers. There were punitive expeditions against 'recalcitrant' peoples of the area and unsatisfactory administrative adjustments of districts, divisional and provincial boundaries [7].

The people reacted negatively to obnoxious laws, policies and misjudgment during the early years of colonial rule. As a result, the British overlords created paramount chiefdoms in 1946, in complete disregard for the traditions of the people. The Och' Idoma and Tor Tiv institutions were created to represent the Idoma and Tiv respectively, in the Northern House of Chiefs. Only the Igalas represented by the Attah Igala, had a truly indigenous and authentic representation.[8]

3.2.4 Post-Independence.

The people of the Benue area began the search for a state of their own very early. This was due to two main reasons. First, it was to enable the people recover fast from the political and economic exploitation by the colonial administration. Secondly and more pressing was the need to break loose from the proselytization threat of the northern ruling elites, coupled with the fact that the people of the area felt they were not adequately

represented in the Northern House of Chiefs. The people also felt discriminated against in the sharing of the regional assets. It looked to the people like the Hausa-Fulani domination of the area was another form of colonialism. It was this feeling, more than any other factor that sparked off the famous Tiv riots from 1960 to 1965. The formation of the United Middle Belt Congress (UMBC) led by the Late J.S. Tarka was an attempt to create a sitting position in Nigeria for the oppressed people of the Middle Belt. This was vehemently resisted by the ruling Northern Peoples' Congress (NPC). Consequently, the Middle Belt peoples generally, and the peoples of the Benue particularly, were alienated and marginalized by the NPC government. Thus the people resorted to more agitations and struggles for recognition and integration into the polity.

In 1967 Benue-Plateau State was created as a fusion of the Benue and Plateau provinces of the defunct Northern Region. Thus the yearnings of the minorities of the middle belt were partially satisfied. The Igalas and the Bassas were, however, merged with the peoples of the defunct Kabba province to form Kwara State. As time progressed the people of the Benue valley began to notice signs of neglect in the distribution of development projects in Benue- Plateau State. Similarly, in the then Kwara State, the Igala and Bassa speaking areas were termed "Kwara overseas". The people also felt marginalized. It was to reverse this trend that Benue State was created in 1976 by the administration headed by the late Murtala Mohammed. By this arrangement the oppressed people of Benue-Plateau and those of Kwara were excised from their former states and put together to form what became Benue State.

The Benue State of 1976 witnessed the regimes of eight military governors and administrators while one civilian governor ruled the state from October 1979-December 1983. During this period the state experienced socio-economic and political vicissitudes

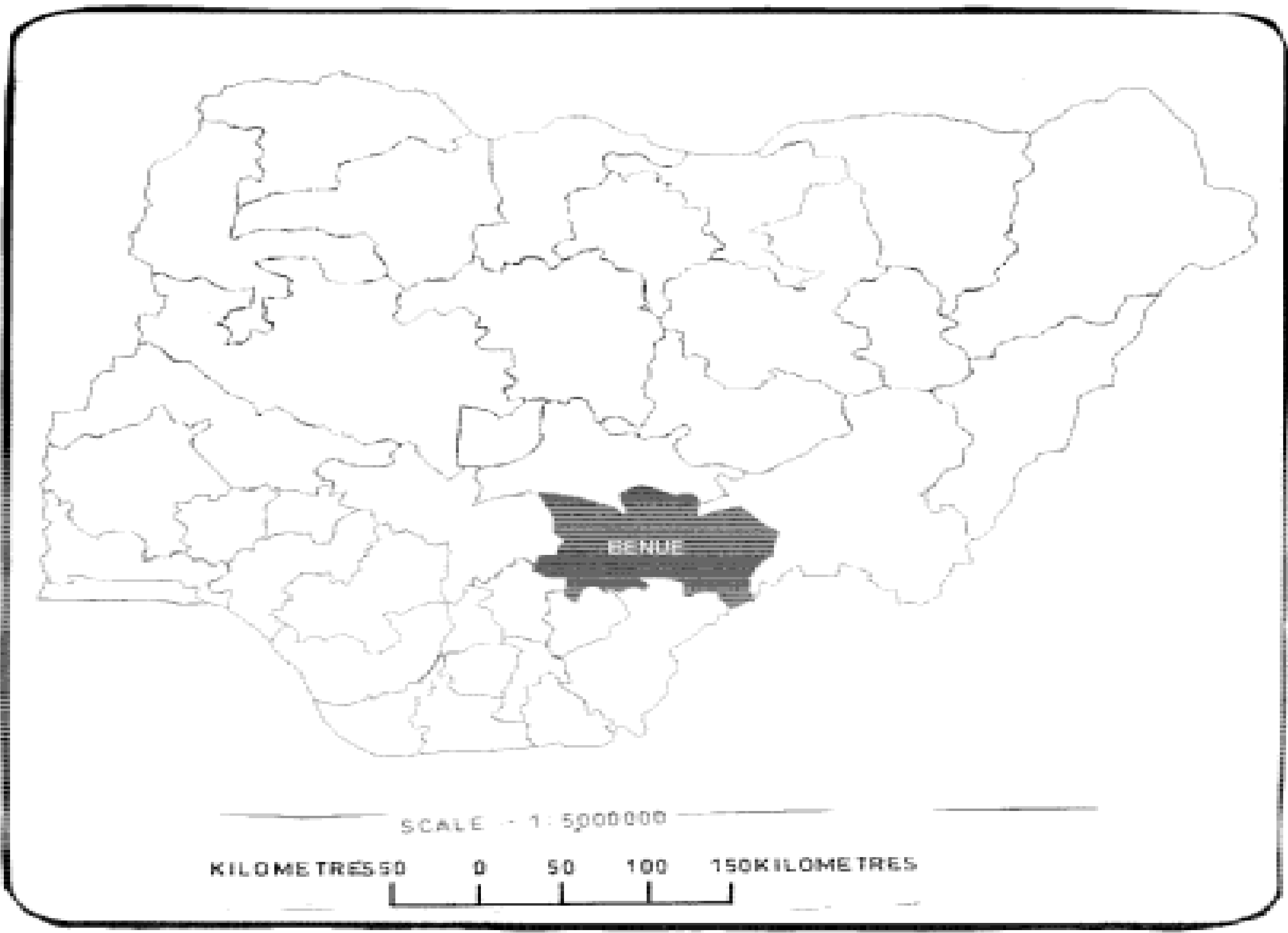
which we have no need to emphasize here. The reason being that if we are to do this we will be required to study the activities of each of the regimes beginning from 1976. The scope and objectives of our study does not cover this.

The creation of additional states in 1976 did not bring to an end the allegations and counter allegations of marginalization. Thus, agitations from allegedly marginalized sections mounted with renewed vigor fuelling more states creation exercises, the last being in August 1991, which saw the Igala and Bassa-speaking areas being excised from Benue to join what used to be the Kabba province, then in Kwara State,[9] to form Kogi State.

With the Igalas and Bassas excised, the Benue State of August 1991 (see Figure 2 on Page 77) is now populated mainly by the Tiv and Idoma with other minority ethnic groups such as the Igede, Etulo, Akweya, Ufia, Jukun and a handful of migrant peoples. The state has a total of 23 Local Government Areas namely, Makurdi, Gboko, Katsina-Ala, Otukpo, Gwer West, Gwer, Oju, Obi, Ado, Ogbadibo, Konshisha, Tarka, Guma, Okpokwu, Ohimini, Apa, Agatu, Logo, Ukum, Kwande, Vandeikya, Ushongo and Buruku, as shown on Figure 3, page 78.

With several decades of colonial and post-colonial exploitation and marginalization of the Benue people, the State has not yet found its feet politically, socially and economically. Extreme poverty, which we shall be discussing shortly, has become a recurring decimal and stigma among the people of the State. Moreover, the philosophy behind the proliferation of LGAs during the several Local Government creation exercises in the country did not find relevance in Benue State. The philosophy

Figure 2: Map of Nigeria showing Benue State.



Source: National Action Committee on AIDS (NACA)

Figure 3: Map of Benue State showing the 23 LGAs.

Source: Bureau for Lands and Surveys, Makurdi

was to bring development closer to the grassroots people. But sadly, the Benue situation has been a bit worrisome. A tour of the 23 LGAs would show that apart from the older LGA headquarters such as Makurdi, Gboko, Otukpo and Katsina-Ala which existed as divisional headquarters in the defunct Benue – Plateau State, the rest are yet to experience development in the modern sense of the word. The grassroots people of the State have continued to face acute water scarcity, poor condition of access roads, near absence or complete absence of electricity supply, poor sanitary conditions, etc. As we get deeper into the study the picture of this situation will become clearer.

3.3 POVERTY, ILL-HEALTH AND UNDERDEVELOPMENT OF BENUE STATE

Just as in laying the foundation for this research we brought out the background to British aid in Benue State within the general context of British aid in Nigeria, it is also necessary to do likewise as we look at the poverty conditions in Benue, by placing it within the context of the general poverty conditions in Nigeria. This is necessary because it will be difficult to comprehend the poverty in Benue State in isolation.

In the Foreward to the World Development Report 1990 the World Bank President reported that for sub-Saharan Africa (Nigeria inclusive), the 1980s was a lost decade for the poor. According to him whereas the developed countries saw favorable developments in growth, trade and investments, the situation in sub-Saharan Africa was the opposite. Real per capita incomes, living standards and investments slipped. According to this report life expectancy for the developed world in 1985 was 76 years while it was about 50 years for sub-Saharan Africa.[10] This Report that had poverty as its theme discussed the poverty situation in the world generally and poverty in Africa specifically. Obviously, Nigeria as a country in Africa cannot go unnoticed when

Africa's poverty is discussed. But before we consider the general poverty situation in Nigeria, it is imperative to first attempt to define it.

3.3.1 Poverty: A Definition

Scores and scores of scholars have defined poverty. Any attempt to incorporate all these definitions in this chapter may likely lead us to writing volumes, only defining poverty. Be that as it may, we shall review some generally accepted definitions of this concept before dwelling in details on specific aspects of the poverty in Benue State.

Poverty is a condition that relates to the absence or scarcity of requisite substance or element. It is a lack, meagerness or dearth of requisite substance or element.[11] The New Encyclopedia Britannica defines poverty as "the condition that is said to exist when people lack the means to satisfy their basic needs"[12]. Basic needs in this context, according to this definition, are the needs that are necessary for survival, narrowly speaking. But when considered broadly they constitute those needs reflecting the prevailing standards of living in the society. Basic needs in the narrow sense of definition cover only the people near the borderline of starvation and death while in the broader sense of definition it covers the people whose nutrition, housing and clothing, though enough to preserve life, do not measure up to those of the population as a whole.

The differences that exist between the living standards of the poor of the past and those of the present in underdeveloped world, on one hand, and those of the poor of the past and present in industrialized world, on the other, have made the definition of poverty difficult. Some authorities think the latter group should not be referred to as 'poor'. But the problem with such thinking is that people behave in accordance with community standards, expectations and aspirations in addition to absolute physiological needs. So,

whereas a person or group of persons living in a community may classify themselves as poor (based on the society's standard of living) somebody who is not part of the community may think they are not poor because they own automobiles, television sets and washing machines. The problem of definition is further compounded by the none-economic connotations that the word 'poverty' has acquired. For instance poor health, low levels of education or skills, high rates of disruptive or disorderly behavior, etc, have been associated with poverty. In spite of the problems of definition, both experts and laymen have agreed that poverty is better identified than defined. In other words poverty is known by its harmful effects on the individual and on the larger society.

Lott and Bollock define poverty using two main parameters, namely, economic indicators and experiential correlates. According to them a three-person family in America was considered in 1999 as poor if its cash income per annum was $13,290 i.e. $1,108 per month or $250 per week. If you further break this down per day you will end up with $3.6. In Nigeria the poverty level for the average Nigerian is abysmally low, as majority of the people live on less than a dollar per day. In the US, according to these authors, only 11.8 per cent of American households had incomes below the poverty level in 1999.

In terms of experiential correlates these scholars look at poverty from the angle of life circumstances. For instance the following description of a poor American woman's apartment explains this better:

> Small and oppressive, with sagging and broken furniture and an old stained carpet. A tired lace table cloth covers a small kitchen table…[13]

In comparative terms, one is tempted to believe that the apartment described above is quite modest when compared to the one a poor Nigerian family lives in. Obviously, our

perceptions as to what constitutes poverty vary from society to society and from culture to culture. In fact it varies from one individual to the other. These perceptions of poverty have evolved historically over the years to the extent that now every society has its own definitions of poverty. In other words, in every given society poverty indicators are there to show which class of people or individuals are poor and which ones are not considered poor.

The UNDP attempts what it described as the universally accepted definitions of poverty. According to the agency, these universally accepted definitions became necessary in order to facilitate cross-country international comparison and aggregation. These definitions identify three types of poverty, namely, absolute poverty, relative poverty and material poverty. Absolute poverty refers to a condition whereby a person or groups of persons are unable to provide for physical subsistence to the extent of being incapable of protecting human dignity. It implies lack of food, clothing and shelter, portable water, health services, basic education, public transportation and work. Relative poverty connotes the inability of an individual or group of persons to satisfy their basic needs as well as the needs of others, while material poverty, according to UNDP, implies lack of ownership control of physical assets such as houses, land and animal husbandary.[14]

There is yet another form of poverty known as periodic poverty which Anyebe [15] popularized in his work, already cited in chapter two. Anyebe reported that poverty in Benue was perceived as periodic and perennial, especially for the physically challenged and the old people. This, according to him, is a result of the seasonality of the income of a people who are predominantly farmers. It is a common thing among the rural poor to hang on to their health and other problems waiting the time when their crops will be due

for harvesting. During harvest the crops are sold (often at give-away prices) to enable them settle their medical bills. Unfortunately for many, if not most of them, they die before the time of harvest. Thus, it is common among the Tiv, for example, to say *ukpe ichan* which is translated to mean poverty was responsible for death.[16]

The UNDP also introduced certain dimensions in its definitions of poverty that we cannot afford to overlook. For instance it introduced the spatial dimensions of poverty when it stated that rural poverty is different from urban poverty. It also introduced the measurement dimensions of poverty when it stated that to measure poverty one seeks to answer two related questions: how many people are poor and how poor are they? To answer the first question several welfare indicators have been advocated. These include per capital income, mean and/or total, two-thirds of mean per capital household expenditure, per capita food consumption, calories and medical data. To answer the second question other indicators have been advocated. These include the depth of poverty, poverty-gap, and so on.

The traditional approach to measuring poverty begins with the specification of a "poverty-line" which is the value of basic needs considered adequate to meet the level of decent living in that society. For instance, if the society accepts that N100 per day for an average Nigerian can provide the basic needs considered adequate, then N100 becomes the poverty line. Our concern, in this chapter is not really to dabble into the complicated models and approaches to measuring poverty or drawing poverty lines. Suffice it to say that every society knows the poor within it, and every society knows whether it is poor or not. As noted somewhere in this section poverty is more easily identified than defined.

3.3.2 Gender Dimension of Poverty

Rosenberg and Wilson provides us a launch pad, as we discuss the gender dimension of poverty, when they said: …the fact is that historically more women than men in relative terms are found on the lower rungs of the socio-economic ladder.[17]

Gender disparity in access to economic and political opportunities is a common feature in Nigeria. This is obvious because social relations in the country are ordered patriachally, resulting to male domination [18]. Women (and children) are often confined to the domestic sphere and their economic activities, apart from being insignificant, are often under-valued. Moreover, women and children in Nigeria, and indeed in most of the LDCs, are saddled with the burden of childcare. Thus there is little or no time left for them to pursue economic activities. This condition keeps them (women and their children) perpetually on the lower rungs of the ladder.

Narayam paints a more graphic picture of this scenario when he said:

> In most societies women are socially, culturally, and economically dependant on men. Violence against women is an extreme expression of male dominance and one of the most intractable violations of women's human rights[19].

Citing specific cases, Narayam reports that in Cameroon a woman requires the permission of her father or brother or husband, as the case may be, to go outside of the home. In addition, a woman's husband or brother has access to her bank accounts, but not the other way round. The situation is not different in many Nigerian communities. For instance, among some communities in Benue, when a woman's husband dies the relations of the man swoop upon all the assets of the man, leaving the woman and her children desolate. In some cases the widow is compelled to re-marry a member of the family. In addition, some communities in Benue use women as cheap labour on the farms. They (women) do more of the hard work and bring in the foodstuff while the men

do a little, and spend more time drinking and loitering. Moreover, battering of women to 'discipline' them and "call them to order" is a common phenomenon in all Nigerian communities. When a woman cannot endure the suffering and opts to go back to her father's house, she goes with nothing. All she has, including jewelry, are taken from her. The case is the same when a man is 'fed up' with his wife and decides to chase her out of the home. Although time and space may not permit us to go on and on describing the nature of gender disparity in the Nigerian context, we shall not conclude this sub-section without applying the gender dimensions of poverty to health.

Once again, Narayam gives us something to think about when he quoted two expressions on gender and health from a South African woman and another from the Philippines: [20]

> When women are sick, there is no one to look after them. When men are sick, they can be looked after by women..
>
> - South Africa 1998

> Lack of access to medical services traumatized a mother who found herself "holding and singing lullabies to my baby until she died in my arms".
>
> - Philippines 1999

These two quotations underscore the degree to which women and children in LDCs are vulnerable to disease and death. This situation is attributable to some obvious factors. Firstly, the men who are responsible for taking decisions on scarce family finances don't often consider the health of their wives and children a priority when it comes to the issue of healthcare. They will often prefer to use family finances to marry a healthier wife than provide medical care to the sick one already at home. Secondly, women are typically the providers of health care rather than recipients, especially when resources cannot provide

for them and the other members of the family. Women would naturally prefer to defer treatment for their disorders in order to provide care for their families.

Furthermore, children have continued to suffer adversely from malnutrition, disease and lack of health care, even though infant mortality has declined worldwide. In Nigeria this situation is due to poor diet, poor water supply and poor government health system [21]. It is reported that in Nigeria when children are sick and resources are scare the male ones are preferentially treated so that they can survive and carry on the family tradition. And in Benue State "if the child is not 'special' in any way the sickness may be interpreted as an 'act of God' and treatment may not be vigorously pursued".[22]

Finally, another factor responsible for the vulnerability of women and children to disease and death is exposure to theft, sexual abuse and prostitution with its resultant exposure to HIV/AIDS infection, sexually transmitted diseases (STDs) and street trading/begging. Of course, it is the harsh economic and financial conditions in poor families that force women and children out of their legitimate homes, exposing them to all kinds of deprivations.

3.3.3 Poverty in Nigeria.

Nigeria is a highly populated country, the most populous in sub-Saharan Africa, strategically located along the West African coast with a population of 126 million people, by the 2003 estimates. The country has an average annual growth rate of 2.83% , spread over 250 ethnic nationalities who contribute to the development of the nation in ways that complement each other. The nation has a land mass extending over an area of 924,000 square kilometers and blessed with a tropical climate that produces a variety of vegetational belts ranging from forest, in the south, to Savannah, in the north. Food and

cash crops are produced all year round, through irrigation practices carried out during the dry seasons. [23] Apart from endowment with agricultural resources Nigeria produces crude oil and solid minerals and is potentially viable for natural gas. The country is also very rich in human resources. It has 36 states and Abuja, the Federal Capital Territory, as well as 774 Local Government Areas (LGAs)

The poverty conditions in Nigeria from 1980 to 1996, according to the UNDP Report (referred to earlier), were unacceptably high. Nigeria has a large population of poor people. Since 1980 the incidence and severity of poverty has changed, fluctuatingly, over time. For instance while between 1981 and 1985 agricultural production stagnated and the rate of unemployment increased, the period between 1985 and 1992 was characterized by some measure of economic recovery. But generally speaking, the incidence and depth of poverty in the country increased. The period also witnessed increased economic inequality, a situation whereby the rich became richer and the poor became poorer. One of the social indicators of this period was the decline in government expenditures going to the social sector. For example the total expenditure on health declined from 3.1 per cent in 1986 to 2.0 percent in 1992.

The Tables published by the Federal Office of Statistics (F.O.S),[24] as shown on pages 88 to 91 (Tables 1-4) may provide a clearer picture to the situation we are trying to describe. It is important to note here that since the publication of FOS's Poverty Profile for Nigeria 1980-1996, no follow-up publication was done until 2003/2004 when a Report of Nigerian Living Standards 2003/2004 was published. We could not use this figures because they fall outside the duration of our study.

Ordinarily, one would have expected a steady progress towards poverty eradication with the passage of time. But unfortunately the Human Development Report

Table 1: Trends in Poverty Level: 1980-96 (in %)

Year	Poverty Level	Estimated Total Population	Population in poverty
1980	28.1%	65m	17.7m
1985	46.3%	75m	34.7m
1992	42.7%	91.5m	39.2m
1996	65.%	102m	67.1m

Source: F.O.S. Poverty Profile for Nigeria, 1980-1996, Abuja.

Table 2: Percentage Distribution of the Population in Poverty (Using two Poverty Lines)

Year	Non-Poor	Moderately Poor	Core poor
1980	72.8	21.0	6.2
1985	53.7	34.2	12.1
1992	57.3	28.9	13.9
1996	34.4	36.3	29.3

Source: F.O.S Poverty Profile for Nigeria, 1980-1996, Abuja

Table 3: Poverty Headcount (in %) by Sector (Urban/Rural)

Year	Urban			Rural		
	Non-Poor	Moderately	Core Poor	Non-Poor	Moderately	Core-poor
1980	82.8	14.2	3.0	71.7	21.8	6.5
1985	62.2	30.3	7.5	48.8	36.6	14.8
1992	62.5	26.8	10.7	54.0	30.2	15.8
1996	41.8	33.0	25.2	30.7	38.2	31.6

Source: F.O.S. Poverty Profile for Nigeria, 1980-1996, Abuja.

Table 4: Poverty Incidence (In %) by the 19 State Structure (1980-1996)

State	1980	1985	1992	1996
Anambra/Enugu	12.8	37.7	32.3	51.0
Bauchi	46.0	68.9	68.8	83.5
Edo/Delta	19.8	52.4	33.9	56.1
Benue	23.6	42.9	40.8	64.2
Borno/Yobe	26.4	50.1	49.7	66.9
C/River/Akwa-Ibom	10.2	41.9	45.5	66.9
Adamawa/Taraba	33.4	47.2	44.1	65.5
Imo/Abia	14.4	33.1	49.9	56.2
Kaduna/Katsina	44.7	58.5	32.0	67.7
Kano/Jigawa	37.5	54.0	38.7	71.0
Kwara/Kogi	33.3	39.3	60.8	75.5
Lagos	26.4	42.6	48.1	53.0
Niger	34.0	61.4	29.9	52.9
Ogun	20.0	47.3	46.6	69.9
Ondo	24.9	47.3	46.6	71.6
Oyo/Osahun	7.89	28.3	40.7	58.7
Plateau	49.5	64.2	50.2	62.7
Rivers	7.2	44.4	43.4	44.3
Sokoto/Kebbi	25.5	45.8	37.9	83.6
FCT			27.6	53.0
All Nigeria	28.1	46.3	42.7	65.5

Source: F.O.S Poverty Profile for Nigeria 1980-1996- Abuja.

on Nigeria in 1998 did not provide cheering news. The Report indicates that 48.5 per cent of the country's total population lived below the poverty line. The report reads, in part:

> Poverty in Nigeria is on the increase despite the country's sixth position as oil exporter in the world. Causes and effects of poverty in Nigeria are wide, diverse and complex. Variations in poverty status exist even between and among households in the same locality. In spite of the Government's avowed concern and the preponderance of poverty alleviation programmes over the past few years, there is very little to suggest that the resultant benefits have adequately reached the poor [25].

The UNDP Resident Representative for Nigeria gave the country a bashing for failing woefully to live up to expectation. He wondered why such monumental poverty should still exist in a country where human, natural and material resources abound. He lamented thus:

> It is clear from the report that the absence of an enforceable political contract between the people and the government, a less than required synergy, competitiveness, efficiency as well as social discipline in the factors of production, and deprivations especially, in the areas of education and health have contributed largely to the current low level of human development in Nigeria[26].

With this poverty condition Nigeria became, according to this report, one of the 25 poorest countries in the world with more than one third of the population not expected to survive to the age of 40. Forty-five per cent of the population were deprived educationally while another 49% had no access to safe water and sanitation.[27] As a matter of fact the UNDP 1998 Report on Nigeria scarcely provided encouraging statistics and information

Two years after the UNDP 1998 Report on Nigeria, a document titled "Nigeria Poverty Reduction Plan" was prepared for Poverty Reduction Inter-ministerial Technical Sub-Committee of the Federal Ministry of Finance. One does not seem to have any

indication, from this document that after two years, since the 1998 UNDP Report, the poverty situation in Nigeria changed for the better. The document quoted the Human Development Report of 1999, which ranked the country as 146th out of the 176 poorest countries in the world.[28] The document admitted that Nigeria faced mass poverty and this had serious social, political, economic and security consequences which should not be ignored. This situation, according to the document, was made worse due to rapid population growth rate of about 2.83% since the 1990s which gave rise to high dependency ratio, putting severe pressure on resources in many areas.[29]

Similar studies and researches had been carried out with a view to assessing and /or providing solutions to the poverty situation in Nigeria, apart from the ones highlighted. In 1992, Dr. Dave Todd of ETC Foundation International, The Netherlands, managed a study which was financed by the Overseas Development Administration of the United Kingdom and the World Bank, to assess Nigeria's poverty situation. The report of this study was published in 1994. The study covered 10 States, namely, Akwa Ibom, Benue, Cross River, Kaduna, Kwara, Lagos, Ondo, Osun, Oyo and Sokoto. Forty-five LGAs participated, and 37 urban and 58 rural locations were covered. A total of 14 studies on seven themes was commissioned, namely, access of the poor to basic social services (3 States); operational strategies and business linkages in the informal sector in Lagos; role of the poor in participatory and informal structures (3 studies in 2 states); price changes and poverty. Others included access to natural resources (3 states), women and children in poor households (3 states) and opinion leaders and poverty (1 state) [30.]

In summary, the study found out that there was a very broad based agreement across rural and urban areas that government had failed to address squarely the issue of development and poverty eradication. The study showed that the people were

dissatisfied with government health services especially in the rural areas. On rural infrastructure the study discovered that the absence or poor state of rural roads which has multi-sectoral implications was considered by the people as one of their greatest problems.

Additionally, poor water and sanitary conditions, especially in the rural areas with multiple implications on the health of the people was discovered as another serious problem of both the urban and rural populace. In the area of agriculture, the research identified lack of access to inputs and constraints on marketing surplus output, coupled with this problem was the lack of food security affecting the poor in both urban and rural areas. On education it was discovered that several Nigerian children faced difficulties of access to schooling for two main reasons, namely, the need to work on family farms to generate money to pay for their education, and lack of learning facilities in schools, especially in the rural areas.

Finally, the research discovered that women and children were overburdened. They combined domestic activities with income generation. This brought negative consequences for the educational possibilities of both the women and children.

In 1995 another study was commissioned by the Poverty Alleviation Programme Development Committee of the National Planning Commission in order to assist in poverty alleviation. The work was co-sponsored by the World Bank and the UNDP. It carried out consultative surveys in 36 communities in Taraba, Enugu, Bauchi, Borno Katsina, Keffi, Kano, Kwara, Kaduna, Abia, Anambra, Ondo, Ogun Oyo, Cross River and Edo States. Just like the study headed by Dave Todd, the researchers in this study agreed that poverty in Nigeria as perceived and experienced in the communities surveyed was a phenomenon with many dimensions, both individually and collectively. They

noted that poverty among the communities and individuals consulted, varied between rural and urban setting, and according to the gender, age and socio-economic status. The study team rated roads, water supply and health facilities as the highest development priority of the people.[31]

There was yet another study carried out in 1996 on prospects for development in Nigeria sponsored by the Central Bank of Nigeria (CBN) in collaboration with the World Bank. Also known as Vision 2020, this study, which was organized in form of a workshop, was aimed at initiating a vision for Nigeria up to 2020 for effective and result–oriented economic engineering that will lead to growth and development. In the preface to this publication the then Governor of the CBN, Dr. Paul A. Ogwuma wrote:

> Nigeria is a country blessed with favorable vegetation, alluring topography, vast deposits of mineral resources and a large hard-working and resourceful manpower. Its population size and some inherent dynamics should make it not only the largest market in black Africa but also a haven for foreign investors. However, mismanagement of the economy, political instability and an unstable macro-economic policy environment have subjected the economy to slow growth, and internal and external disequilibrium.[32]

Also in the introduction to this publication the effects of bad economic management were decried as follows:

> The distress signs, which are palpable, include widespread poverty, disappointingly low return on public sector investment, deteriorating infrastructure, low industrial capacity utilization and high unemployment.[33]

These quotations summarized the poverty situation in Nigeria as a larger entity.

In 1998, the CBN organized the Seventh Annual Conference of its Zonal Research Units to brainstorm on Nigeria's poverty situation. The theme of the conference was "Measuring and Monitoring Poverty in Nigeria." Several scholars and professionals delivered papers on the theme. All of them agreed that poverty in Nigeria was real and

chronic. For instance, Professor Ajakaiye saw poverty in Nigeria beyond the economic phenomenon. He saw it as encompassing socio-cultural and political issues that has continued to defile solution. He suggested a holistic approach to the problem; otherwise it would be impossible to alleviate it. [34]

Also Professor Ozo-Eson agreed that "a large part of the populace remained at the fringes, within the framework of the chequered fortunes of the nation's economy." [35] He called for policies that would lead to faster growth in income components which would in turn reduce income inequality. In his paper titled "Poverty Alleviation Strategies in Nigeria," Ogwumike recognized poverty as a global phenomenon which has engulfed Nigeria as well. He said attacking poverty in Nigeria through the implementation of projects such as River Basin Development Authorities, Agricultural Developments, Rural Electrification, etc; as it was done in the past, without the specification of the target population of the programmes exacerbated inequality in the country. In other words, it was the view of Ogwumike that fighting poverty must be done strategically, if results were to be achieved at all. He suggested that for poverty alleviation programmes to be effective, the identification of the poor and their characteristics was an imperative. According to him, after the poor were identified, programmes such as employment opportunities, creation of enabling environment, skills development, good leadership, etc, would follow. [36]

Furthermore, before the CBN conference of 1998, the Nigerian Economic Society (NES) organized its 38th Annual Conference in 1997 with the theme: "Poverty Alleviation in Nigeria." It was the general consensus of NES that although Nigeria achieved some macroeconomic stability through economic growth, poverty was not reduced. It was agreed that economic growth was meaningless if poverty remained

prevalent. NES noted that in spite of previous numerous programmes in the past to tackle poverty, such as the National Directorate of Employment, Peoples and Community Bank Schemes, Better Life and Family Support, etc, poverty in Nigeria persisted. The conference was, therefore, to (among other things), articulate reasons for the failure of poverty alleviation measures in the past, and make concrete suggestions for the design of a framework for poverty alleviation in Nigeria. [37] Some of the papers presented at this conference x-rayed, graphically, all ramifications of Nigeria's poverty.

For instance, Aku, Ibrahim and Bulus, in their article titled "Perspectives on Poverty and Poverty Alleviating Strategies for Nigeria" observed that the exclusion of labour as an important instrument of growth was responsible for the cyclical poverty situation in Nigeria. It was their arguments that until members of the society were gainfully employed and exercised their full potentials, poverty would persist. It was also their strong opinion that growth objectives alone were incapable of addressing poverty problems in Nigeria. They concluded that for a poverty alleviation policy to be successful, it should be founded on just social system that was free from all forms of social malfunctioning and geared towards increased food production, employment opportunities and the bridging of the income gap. [38]

Examining poverty alleviation in Nigeria in 1983/84 and 1991 against the backdrop of some macroeconomic issues, Aigbokhan observed that inequality was higher among males in urban areas but higher among females in the rural areas during the Structural Adjustment Programme (SAP) era. He also observed that in general terms, poverty was lower in the rural areas, suggesting that the sector benefited more from SAP. According to Aigbokhan, cuts in government expenditures on education, retrenchment of

workers in the public service and the rapid devaluation of the currency severely exacerbated poverty and irregularity in Nigeria. [39]

In agreement with the UNDP's development paradigm 'thesis', Achime and Afemikhe, in their article titled "Health and Education Issues in Poverty Alleviation: Macroeconomic Policies" argued that there was a bidirectional relationship between financial investment in health and education and the existence of poverty. They averred that adequate investment in education and health programmes would produce positive developmental results including poverty reduction. [40]

The series of researches, conferences/seminars, surveys, etc, carried out (as highlighted in this sub-section) were meant to lead to solutions to the poverty 'pandemic' in Nigeria. Unfortunately, the poverty alleviation programmes and measures put in place by successive governments failed to bring about the much needed relief to the citizenry. Although well-conceived and well-intentioned, some of these measures hardly took off from the drawing boards. Some only had false starts, while others made very insignificant impact on the lives of the people. For instance, it is puzzling and ironical that Nigeria is still rated as one of the poorest nations in the world when colossal sums of money was spent, and is still been spent, on poverty alleviation programmes such as Directorate of Foods, Roads and Rural Infrastructure (DFRRI), River Basins Development Authorities (RBDA), Agricultural Development Projects (ADPs), National Directorate of Employment, Community Action Plan for Poverty Alleviation (CAPPA), National Urban Mass Transit Programme, the recent National Poverty Eradication Programme (NAPEP), etc.

In our estimation the answer to this puzzle is not far-fetched. The root cause of the abysmal failure of these programmes lie with official corruption, unpariotism,

ineptitude, and a lack of vision on the part of the leadership, from top to bottom, to deal with this malady squarely. Until the correct and inevitable approach to tackling poverty is adopted by our leaders, poverty alleviation, talk less of poverty eradication, will continue to be a mirage. To us, this approach is simple: implement, to the letter, all the beautiful recommendations arising from the researches, workshops, conferences, seminars, etc, carried out in the past and recently by government agencies, non-governmental organizations, the UN agencies and other multilateral and bilateral agencies.

3.3.4 Socio-Economic Poverty of Benue State.

It was needful for us to have discussed in depth the poverty conditions in Nigeria. However, it is now imperative to look at poverty in Benue State, which is the main focus of this research. Benue State featured prominently in many of the studies carried out on poverty conditions in Nigeria. For instance Benue State featured in the study headed by Dave Todd in 1992; The poverty profile for Nigeria, 1980-1996; the 1995 Poverty Alleviation Programme Development Committee study on community level institutions and poverty alleviation in Nigeria; the 1998 UNDP Human Development Report on Nigeria; the 1999 DFID Poverty Audit for Nigeria; and other DFID Poverty Surveys carried out exclusively for Benue State, etc. All these point to the fact that Benue State poverty was, (and still is), real and worthy of attracting the interest of researchers.

Undoubtedly, the most valuable information on the socio-economic and health poverty of Benue State during our period of study is the report of a survey for the State co-ordinated by Drs. G.B. Ayoola and E.P. Ejembi for ETC Foundations in 1992 and published in 1994. Titled Access of the Poor to Basic Social Services in Benue State

Nigeria, the study was only part of a national study carried out by Dave Todd of the ETC Foundation, as earlier stated. The report of this study describes the Benue poverty profile in a fairly vivid way.

The specific objectives of this study were to identify, ascertain and describe the following:

i) Priorities of the poor for basic social services

ii) Availability of social services in poor communities

iii) Affordability of available services to the poor

iv) Views of the poor about quality of available social services

v) Constraints faced by the poor in obtaining satisfactory access to service

vi) Coping mechanisms employed by the poor to survive in the situation of inadequate access.

vii) Improvements proposed by the poor themselves in addressing the access problem.[41]

Villages and communities in three LGAs were selected for the purpose of this study by the study teams. Logo community was selected from Makurdi LGA, Adankari and Adoka Villages from Otukpo LGA, and Anyuwogbu and Adum villages from Oju LGA.

The team studied urban poor/living in unofficial housing areas; not enjoying pipe-borne water or formal sanitation services, lacking adequate transportation access, lacking medical facilities, lacking adequate schools and child care facilities, having a preponderance of child labourers and terribly constrained socio-culturally. It also studied the rural poor (distant from any urban center, poorly starved by transport infrastructure and services, lacking facilities for health, education, etc, growing more subsistence rather than cash crops).

The findings of this study showed, among other things, that only primary health care (PHC) facilities were available in rural areas. However these facilities were very, very, poor. An obvious lack of staff was observed. For instance, in Adoka Clinic only one person, a male Community Health Extension Worker (CHEW) attended to the sick in the Clinic. The drug store was completely empty while essential equipment such as sterilizing units and hand gloves were absent. The team observed that patients who were admitted slept on mats on bare floor while drips administered on them were hung on windows.[42] This was the picture in virtually all the rural areas studied. Makurdi, the state capital, which was the urban center studied, had only one General hospital servicing the entire population. To reach this facility, its suburbs such as Logo traveled distant or medium ranges.

In terms of water and sanitation the team discovered that the rural poor had no access to good water and sanitation. A few rural areas had tube-wells and bore-holes. But for instance, the rural poor of Adankari had no form of water and sanitation services at close range. They relied on an all- season stream for their water supply. The urban people of Logo in Makurdi, according to this study, depended on water supply from the metropolis which was within close range. They transported the water on bicycles or other means of transportation. Even this water supply was often erratic.

The survey further indicated that only primary schools were available to the rural people of Benue State at close range, while secondary schools were available at medium or distant ranges. If the rural people wanted higher education they could obtain that by going to the urban centers. The case was different for the urban poor who could avail themselves of primary, secondary and higher education at closer ranges. But in spite of the availability of primary schools at the rural areas it was observed, for instance in

Adoka, that the school buildings were made of thatch and wooden poles. There were no playing grounds and the floors were not cemented. Generally speaking poor quality of education services were observed in rural schools in terms of infrastructure, availability of teaching materials and staffing.[43]

Benue poverty was also discovered from complete absence of electricity supply in rural areas except in Adoka where the people attributed this feat to the role of an influential son that occupied a top post in government and was on the committee that implemented a World Bank-assisted electrification project in Nigeria.[44] The people of Logo, though close to Makurdi with electricity, had no electricity. In fact some LGAs created over twenty years ago, such as Oju and Kwande still do not have electricity supply up till today. The rural people of Adankari and Adum had roads that were impassable during the rainy seasons, neither did they have postal or telecommunication facilities at close or medium ranges.

In summing up their findings, the team observed that the impact of the programmes for infrastructural build-up such as the World Bank-assisted Agricultural Development Project and the Directorate of Foods, Roads and Rural Infrastructure (DFRRI) made little or no impact on the Benue poverty situation. They admitted that the poor of Benue were poor indeed.[45]

Corroborating the findings of G.B. Ayoola and his team, the Federal Office of Statistics (FOS) in its publication titled Major Social Indicators by LGAs in Nigeria provided useful data on the health situation in Benue for the year 1993/94. According to this report, about half (51%) of the children under one year were not immunized in the State. Katsina-Ala and Ukum LGAs had the highest figure (75%) of children not

immunized. Kwande had 66%, Gboko and Buruku had 62%. The lowest figure was Makurdi LGA with 6%.[46]

On water, the report said three-quarters (75%) of households in Ado LGA used stream water, ponds or unsatisfactory sources. Okpokwu and Ogbadibo 86%, Guma and Oju LGAs 82%. The lowest was Makurdi with 21%. The total figure for the State was 48%[47] when compared to national figures.

In terms of sanitation, it was reported that half of the households in Benue (55%) used unconventional toilets like pails, rivers/stream or the bush, etc. Guma's figure was 91%, Ushongo 84%, Gwer and Gwer west 75% while Ado had the lowest figure of 18%. The percentage of unsatisfactory refuse disposal for the State was 92. Apart from Makurdi LGA, which recorded 65%, the percentage for other LGAs ranged from 81% to 100% that disposed of their refuse in compounds or other unauthorized places.[48]

Also, the FOS's <u>Social Statistics in Nigeria in 1994</u> showed percentage distributions of poor and non-poor by 22 states. The percentage poverty, in Benue was 54.99 and ranked among the 10 poorest states in the Federation.[49] The incidence of poverty, in percentages, by 1992 for Benue was 41.1%. But by 1996 the figure rose to 65.5% placing Benue State as the ninth poorest State in Nigeria.[50] Just as stated in section 3.3.3, it should be stated here that since the FOS's publication, in 1994, of <u>Major Social Indicator by LGAs in Nigeria</u> and <u>Social Statistics in Nigeria</u>, the figures have not been updated.

The Benue poverty incidence was also revealed in the Poverty Alleviation Programme Development Committee study. The researchers that anchored the study in Benue looked at two communities in Guma LGA. They seemed to have a similar story to tell about Benue. They reported that Guma LGA, with its headquarters at Gbajimba, was

created in 1987. It is one of the LGAs closet to the state capital, yet one of the poorest and most inaccessible. Gbajimba is only 37 km from Makurdi but it takes more than an hour to get there from Makurdi due to the poor condition of the road which is almost inaccessible for much of the year. Although Gbajimba is rich in agricultural land and fish, these potentials remained undeveloped due to poor market facilities/infrastructure and access roads. The LGA had (and still has) no electricity supply. Only a few Clinics existed there. In view of all these, local and state government staff posted to the area lives in Makurdi and go there, irregularly, to work.

Abinsi, one of the communities studied, has a long tradition of poverty and neglect in spite of its long colonial antecedent as a colonial sea port and headquarters of the Benue Province before 1927. The researchers discovered that Abinsi's only Clinic was established in 1920. And apart from the road that by-pass the village to Gboko and beyond, Abinsi has no road, while its fish market declined severely. Moreover, the village has no other source of drinking water except the untreated water from the River Benue. Its sanitation and refuse disposal arrangements were very poor.[51]

Another community that came under the scrutiny of the study team was Mbabegha, a farm settlement eight kilometers from Gbajimba. The road to this village is untarred and seasonal. The settlement is scattered and therefore difficult for infrastructural facilities to be put in place for it. Also, though with fertile land, the people could not get farm inputs such as seedlings and fertilizers due to the inaccessibility of the roads. The implication of this was the inability of the local farmers to get good prices for their products, thus keeping them (the people) perpetually poor.[52] This was the same fate for several other communities in the area. Mbabegha had no secondary school, no market and no good source of drinking water. This poor water condition in particular, gave rise

to water-borne diseases that troubled the people, such as guinea worm, bilharzias, diarrhea and so on.[53]

Yet another study, like the previous ones considered, which gave a synchronized view of the Benue socio-economic and health poverty conditions is a baseline survey conducted by the Benue Health fund (BHF) project, anchored by Graham Gass, the then Social Development Technical Co-operation Officer of the project. He led a team of researchers who studied health and heath care issues in rural Benue using five communities, namely, Otobi, Ipolo, in Otukpo LGA; Gbemacha, in Gboko LGA; Kiishi, in Vandeikya LGA and Tyogbenda-Udende, in Katsina-Ala LGA.[54]

In summary Graham Gass and his team discovered that poverty in Benue was characterized by small farms, low annual agricultural production per capita and/or high food insecurity. They also discovered that in Benue only few families were able to train or educate their children while the most vulnerable groups included children and women who had relatively little or no control over access to financial resources unless they engaged heavily in agricultural processing such as turning cassava into garri or rice milling. The team also observed that the people lived mainly in thatched huts, an indication of extreme deprivation.[55] Moreover, the researchers noted a high prevalence of sicknesses and diseases among the communities studied such as cholera, dysentery, malaria, guinea worm, etc. Severe water shortages and unsanitary environments gave credence to this degree of poverty. The near-absence of infrastructures such as access roads, electricity, health facilities and so on spoke volumes on rural poverty in the state.[56]

In February 2001, the FOS piloted a Core Welfare Indicators Questionnaire (CWIQ) survey in Benue State, following the Lagos State pilot in 1999. The report of the Benue CWIQ survey was ready six week after. CWIQ was funded by the DFID. The

British Council managed the fund while the Benue Health Fund Project provided office accommodation. [57]

From the Main Report of CWIQ it was revealed, among other things, that about four in every five members of the Benue population lived in the rural areas; only about ¼ of households had safe water with urban households taking 70% while the rural ones took 16%. The Report revealed further that 57% of Benue people had some means of sanitation while only 35% had a good means of sanitary disposal. On education the Report revealed that adult literacy rate stood at 58%. Out of this figure the males took 74% while the females had 41%. While 60% of Benue households had access to primary education only ¼ of the population had access to secondary education. Whereas primary school enrolment rate was 73%. Primary school enrolment rate for males was 77% while it was 69% for females, a gender gap of 8%. Secondary school enrolment rates for males were 41% and 29% for females with a gender gap of 12%. [58]

Furthermore, on medical services, the Report showed that about ⅓ of the population had access to a health facility with urban households having ⅔ of services and the rural areas with ¼. Also, the Report revealed that 10% of the population consulted a health practitioner, in the 4 weeks preceding the survey. About ½ of those who were sick were dissatisfied with the medical services rendered, giving cost as the major reason. Twenty-nine percent cited the long waiting time and 18% cited non-availability of drugs. The child nutrition situation indicated that 31% of under-five children were stunted, 11% wasted and 17% underweight. Stunting and wasting, according to the Report, was higher in rural (33% and 12% respectively) than in urban areas (18% and 10%). [59]

We intend to conclude on our examination of the Benue poverty profile by briefly looking at Odey's findings, as contained in his recent study. Citing M.G. Meier[60], Odey maintained that the diet of rural Benue people which according to the 1986 Report of the Benue Agricultural and Rural Development Authority (BNARDA) constituted about 89% carbohydrates was not balanced. According to him malnutrition and protein–calorie deficiency were part of the everyday experience of several old people, pregnant women and children who were perpetually exposed to diseases in their rural settlements. It is his belief that 90% of Benue farmers live in rural farm settlements.[61] True, the Benue rural communities produce plenty of food crops but, according to this study, they are unable to use the sales from their farm produce to alleviate their sufferings. This is because middlemen and 'outsiders' who have the means to get the local markets purchase these items cheaply, hoard them, and later sell at exorbitant prices to the people.[62] Therefore increased food production has not really alleviated Benue's rural poverty. In this study, Odey also observed that although Benue State is underdeveloped, it does not imply a complete absence of development. Rather, it means that when compared to other areas in Nigeria it seems to be lagging behind in many respects. Although strategically placed in the center of Nigeria and has the epithet of the "food basket of the nation" the political economic history of the state shows relative underdevelopment, comparatively.[63]

3.3.5 Health-Poverty Relationship in Benue

A good part of the reasons for the poverty of the Benue community is ill health, poor nutrition, poor environmental conditions, inter- and intra-ethnic wars and so on. Although the people of Benue are hardworking and determined, these conditions,

especially poor health, has sadly amputated their productive capacities. Chambers corroborates this view when he said:

> Rural poverty is… to varying degrees attributed to… ill health and poor nutrition; to war; to natural growth and its pressure on resources; to degradation of the environment… and the failure of government services to provide for basic needs.[64]

Ayoola and Ejembi, who examined the relationship between health and poverty in Benue State also believe that the health of the rural poor determines, to a large extent, their physical and mental potentials to participate in the development process. The situation in Benue showed that PHC facilities, which directly benefit the rural grassroots communities, were not available to them within close range. Ayoola and Ejembi discovered that priority services in these PHC centers (where they existed and were accessible), especially essential drugs, were grossly inadequate or completely absent while less important services (in the ratings of the poor) such as family planning and health education were available, to a large extent.[65] This clearly shows that integrated PHC services were not operated in PHC centers. The poor preferred that essential drugs and good sources of water be provided for them in the centers before family planning services and health education. The truth, however, is that no amount of essential drugs would possibly help the people if they lack basic knowledge and education about simple hygiene and child spacing and other preventive methods. For instance, the people of Adoka considered cholera epidemic as an annual event before 1993. But in 1993 they recorded no cholera epidemic. This was associated with a major health education campaign mounted by the local government officials and also increased community efforts to improve their water supply. This then underscores the need for Integrated PHC services as advocated by the study team.

Apart from the PHC facilities put in place by the LGAs, it is the responsibility of the State government to establish Basic Health Clinics or Comprehensive Health Centers in the rural areas. Unfortunately, these facilities were not located within close range, and where they existed they were poorly equipped. For instance, the researchers gathered that the quality of services in these health centers were so poor that women in labor and those with sick children preferred to travel over 40km to access general hospitals in urban centers.[66] Apart from the fact that none of these centers had a Doctor in attendance the number of Midwives or Nurses that staffed them was grossly inadequate. Furthermore, the cost of treatment (payment for card, laboratory tests and drugs) was considered too high by the rural poor. Moreover, they complained of laissez-faire and snobbish attitude of the service providers who, by these attitudes, discouraged services seekers.

In view of all the difficulties enumerated above, the rural poor were compelled, to adopt coping measures which included, among other things, patronage of local chemist shops (patent medicine stores), private hospitals, traditional healers, traditional birth attendants and itinerant drug hawkers and service providers. Sadly enough, these measures ended up creating more health problems or compounding them for the poor clients.

In our opinion the fact that poor health is directly related to poverty and vice versa is obvious because as we said earlier, sick people can hardly generate revenue, neither do poor people have ready access to good health care services.

3.3.6 The Anatomy of Benue State Underdevelopment

With a long tradition and antecedents of rural poverty, Benue society today is, obviously, underdeveloped. The characteristics of underdevelopment are manifest. This

socio-economic underdevelopment is a paradox of scarcity in the midst of plenty. Benue society is predominately agrarian, allegedly capable of producing enough food to feed the entire Nigerian population but has remained underdeveloped because the agricultural potentials have remained untapped, and also because the products scarcely have access to major markets, due to lack of access roads, where the farmers would have got the monetary value for their products. In addition to this, there are no storage facilities anywhere in the State where the state government could store excess products for auspicious seasons of hunger. The only grains reserve in the State is the one put in place by the Federal government which has been there as a monument, so to say, because it has been underutilized.

It was probably because Benue State and its Local Governments did not live up to their obligations to the people in terms of good governance that the British aid in the State includes a programme for good governance (the content of this programme will be highlighted later). Revenue accruing to the State and local governments are not put into productive ventures. That is the reason there is a general breakdown of existing infrastructure such as schools, health services, roads, industries, to mention only a few. For instance, there still exist perennial water shortages in the state including, strangely, the State capital which has river Benue running through it. Many general hospitals and health Clinics have still remained mere consulting Clinics. The situation in the PHC at the grassroots level is worse, as earlier analyzed.

Educationally, the state has made little or no serious improvement. Some of the higher institutions owned by the State government are still operating on temporary sites. The College of Education Katsina-Ala, for example, which was established in 1976 is still operating on its temporary site. The same goes for the one at Oju. Some institutions

existed on temporary sites until the ‘temporary’ gave way to ‘permanent’. The Benue State Polytechnic in Ugbokolo, and the Benue State University are good examples of this condition. Until recently, when the government, which came into office on May 29th 1999, attempted to massively renovate secondary schools in the State, the situation in Benue State secondary schools was deplorable. It was ‘fashionable’ to see school buildings without roofs, see children taking lessons on bare floors, or at best see six students sharing a three-feet long desk. In addition to this misery, there were no learning facilities such as teaching aids, school record books, etc. The situation has barely improved now. The condition of primary education was equally very bad. The fact that scores of primary schools had no buildings was obvious as pupils used shades of trees as classrooms or make-shift structures to accommodate them. They sat on uncemented floors, even during wet and cold seasons, and received lessons, which took place erratically, due to the dampened morale of teachers who abandoned their pupils in search of means of sustenance, for most of the lesson time. Because teachers were owed salaries for several months most of them sought alternative means of survival outside their classrooms. For instance, some resorted to using their pupils as labourers on their farms, while others took to petty trading. Some went out to other places in search of greener pastures. The intervention of the Federal government through the establishment of the National Primary Education Commission (NPEC) and now Universal Basic Education (UBE) has improved the situation to some extent. But schools in rural Benue are yet to really feel this impact.

Benue State government-owned companies went bankrupt and closed shop as a result of mismanagement. The people who were entrusted with the management of these companies, most of which were built to produce at optimum capacities, squandered both

the capital and the profit. Good examples are the Taraku Mills, Benue Bottling Company, Benue Breweries, the Burnt Bricks Industry, just to mention a few. None of these companies is viable presently. Even the Benue Cement Company, a Federal Government Company (the Federal Government sold its shares in the company in 2000), in which Benue State had substantial shares is no more viable. If nothing desperate is done to salvage it, it will collapse eventually.. The present regime has made promises and false starts to get some of the ailing industries back on their feet. But this remains to be seen with the passage of time.

With no meaningful economic base for rapid development; Benue State has continued to remain a predominantly agrarian and Civil Service State, living from hand to mouth, as it were, from revenues accruing to it from the Federation Account. To compound the problem of Benue State underdevelopment, the state has no good and stable electric power supply. The State is one of the very few in the country yet to be hooked to the national electricity grid. Efforts were made recently to hook the State to the national grid but are yet to succeed. The federal authorities have continued to merely promise the people adequate power supply, without practical performance. Meanwhile this lack has, more than any other factor, discouraged private investors in the industrial sector from establishing industries in a State that does not have enough power to run their machines.

Development is further hampered in an environment that is not peaceful. Benue society has a long antecedent of inter-and intra-ethnic wars. These communal clashes and disturbances have slowed down the pace of development in the State. Land hunger which has, on several occasions, set one Benue community against the other and Benue people against their neighbors has led, on several occasions, to the destruction of lives,

properties, farmlands and crops, thus aggravating an already bad condition of poverty and underdevelopment. The thesis of war as a factor in underdevelopment agrees with the views of Chambers.[67] As a matter of fact, conflicts in Africa, generally, are blamed on poverty. In October 1998 the Nigerian Tribune reported Tanzania's Foreign Minister, Jakaya Kiwete as saying:

> The African continent is haunted by the absence of peace and security because of constant conflicts, which were aggravated by poverty.[68]

He stressed further that unless poverty is eradicated in Africa, peace will continue to elude the continent. He called for international support in the fight against poverty in Africa.

With this profile of an all-embracing poverty and underdevelopment, it is no wonder then that Benue State has become one of the foci for development assistance from the British government and other donor agencies.

This all-embracing poverty conditions in Benue State, and Nigeria at large, could be traceable to governments' unwillingness to pursue a holistic development paradigm which links sustainable human development with economic growth. It is the strong view of the UNDP that people are the real wealth of a nation and the basic and paramount objective of development should be to create an enabling environment for the citizens to enjoy long healthy and creative lives. The UNDP also believes that this development ought to be sustainable, sharing development opportunities between all categories and classes of people, between the poor and the rich, between the present generation and the future one. The benign neglect of human development in preference for economic growth by international financial institutions and economists was condemned by the UNDP. It was because of the sorry neglect of human-centred development that the

UNDP adopted the human development index (HDI) as a strategy and tool for measuring and analyzing development in a more human-centred manner rather than in economic terms.[69]

The UNDP, from this Report, identified health, education, and the purchasing power of an individual as critical areas of human development. Put it differently, the key components of HDI, according to the Report are longevity, knowledge and income. Sadly, however, these are areas our governments have neglected most for several years. This neglect has cost Nigeria several intellectuals and professionals who fled to other greener pastures in what is popularly known as the brain drain. Other consequences of this neglect on the economy, social and political well being of the Nigerian people are better imagined than explained. For instance, how can we explain a situation whereby majority of Nigerians scarcely afford quality health care; or several hundreds dying untimely deaths due to lack of access to good health? Or, how can we explain the situation whereby majority of Nigerian children and youths lack access to quality education and have to take to unwholesome practices in order to survive? Moreover, a situation whereby majority of Nigerians live below the poverty line, with its attendant consequences can better be imagined. The implications of the neglect by our governments of human-centered development are too obvious to be over flogged in this research.

3.4 THE BEGINNING OF BRITISH AID IN HEALTH AND SOCIAL DEVELOPMENT IN BENUE STATE.

What we consider as the beginning of British aid in health and social development in Benue state during our period was the ODA-sponsored Family Planning Situation Analysis Study in the State in 1992. Alarmed by the rapid population growth

rate of 2.7% annually and a total fertility rate of 6.3%,[70] coupled with an infant Mortality Rate of 104/1,000 and a Maternal Mortality Rate of 800/100,000 [71] the Federal government approved a National Policy on Population for Development, Unity, Progress and Self-reliance in 1988. The policy aimed to, among other things, promote health and welfare, especially through preventive measures. It was also to prevent premature death and illness among high risk groups of mothers and children and to "achieve lower population growth rates through reduction of birth rates by voluntary fertility regulating methods."[72] To achieve this, the government put in place a number of strategies including the provision of affordable, safe and culturally acceptable family planning services, which for a long time were championed by the Planned Parenthood Federation of Nigeria (PPFN) and a few university teaching hospitals in the 1960s and 1970s. But since 1983 the USAID, UNFPA, the World Bank and other donor agencies added impetus to this project by increasing their technical and financial assistance to the government through training, equipping health facilities, distributing contraceptive commodities and assisting in the development of policy.[73]

The Family Planning Situation Analysis Study in Benue State, although carried out under the auspices of the Federal Ministry of Health was, as stated earlier, sponsored by the ODA. The purpose of this situation analysis was to use the results to assist policy makers, administrators, and service providers to diagnose supply strengths and weaknesses, describe and asses the quality of services provided, develop policy recommendation for programme guidance and possible redirection and identify areas of operations research field experiments. Other purposes of the situation analysis results were to make necessary improvements in the range, type and quality of services

provided, evaluate previous technical assistance, inputs, and establish baseline measures for planning and evaluating future technical assistance.[74]

Before this period (1992) a baseline survey on knowledge, attitude and practice of family planning programme was carried out in Benue State by the Johns Hopkin University, in 1985. The result showed only two Clinics that operated service delivery points (SDPs) for modern contraceptive methods, 1,105 acceptors and 1,152 continuing users were recorded.[75] By 1988, according to Ayoola who headed the study team, 22,138 persons were reported to have accepted modern family planning methods, representing 2% of the target population in the State, then. [76] This shows that there was a growing awareness of family planning programmes and people were already embracing them. This could be attributed to the combined efforts of government, non-governmental and donor agencies. For instance, International Training in Health (INTRAH) trained Benue State family planning management staff, Clinical service providers and community health educators; UNFPA supplied vehicles and injecTables; Pathfinder International expanded Clinic facilities, intensified outreach efforts, established pilot community-based development activities in six areas, in its two- years sponsorship of “Support for Benue State Family Planning Programme”. Other efforts included Johns Hopkins/Population Communication Services joint responsibility for information, education and communication (IEC) activities in Benue State (e.g. printing of multi-lingual posters, drama jingles in the electronic media; and Association for Voluntary Surgical Contraception which organized training for doctors and Clinical service providers on voluntary surgical contraception.[77]

The 1992 analysis study was, therefore, to build on already laid foundations by Johns Hopkins and other efforts as highlighted above. The ultimate objective of the

study was to supply comprehensive information on the availability, functionality and quality of family planning services in Benue State so that needed improvements and expansion of services could be planned for and implemented, while the immediate objective was to describe the quality of care provided to clients, availability and functionality of 30 SDPs of the government, NKST [78] and PPFN facilities.[79] Data for the study was collected using already developed and customized instruments by the Population Council. The instruments were used through observation and interviews of the following sources:

i) Services statistics available at the SDPs

ii) Service Providers

iii) New family planning clients on the day of the visit

iv) Random sampling of up to five continuing family planning clients at the SDP.

v) A random sample of up to 10 maternal and child health (MCH) clients at the SDP.[80]

The study commenced from December, 1991 and lasted till July 1992 with field work lasting from March to April 1992. Data was collected from SDPs as shown on Table 5, page 118.

The data collected was geared towards answering, in the long run, the following questions:

i) Are the SDPs in place, ready to provide services? In other words are logistics/supplies, facilities/equipment, staffing, training, IEC and record keeping in place?.

ii) Are services provided of good quality?

Table 5: Survey of 30 Family Planning SDPs in 13 LGAs in Benue State.

S/No	Name of LGA	Name of SDP
1	Gboko	General Hospital, Gboko
		NKST Hospital Mkar, Gboko
		PHC Center, Gboko
2	Guma	comprehensive Health Center, Agasha
		Local Government Clinic, Gbajimba
3	Gwer	General Hospital, Aliade
		Local Government Clinic, Aliade
4	Katsina-Ala	General Hospital, Katsina-Ala
		PHC Center Katsina-Ala
		NKST Hospital Anyiin
		NKST Hospital, Sai
5	Konshisha	Basic Health Clinic, Gungul
6	Kwande	General Hospital, Adikpo
		NKST Health Center, Ahobee
		NKST Hospital, Adikpo
		NKST Hospital, Jato-Aka
7	Makurdi	General Hospital Makurdi
		72 BN Nigerian Army Health Center, Makurdi
		NKST Hospital, Apir
		PPFN Clinic, Makurdi
8	Ogbadibo	Comprehensive Health Center, Owukpa
9	Oju	General Hospital, Oju
10	Otukpo	General Hospital, Otukpo
11	Ukum	NKST Health Center, Gyenku
12	Ushongo	NKST health Center, Korinjo
		NKST Comprehensive Health Center, Aku
13	Vandeikya	General Hospital, Vandeikya
		NKST Hospital, Mbaakon
		Comprehensive Health Center, Shangbum

Source: G.B. Ayoola Benue State Family Planning Situation Analysis Study

iii) Are services provided being received?[72]

After data sampling and analysis the study team came out with the following recommendations based on their findings:

i) A close collaboration between NKST, PPFN and Ministry of Health (MOH) to put in place modalities for providing uniform family planning services in Benue State. This, according to the researchers, might include joint co-ordinating committee, regular joint review of family planning services in the State and joint training programmes.

ii) The need to revamp and revitalize existing technical back-up support through more effective mobilization and monitoring activities. This involved counseling expertise, uniformity in service provision, among other quality of care aspects; regular feedback through the production of monitoring report and general information on family planning services to SDPs; and periodic conduct of monitoring and evaluation studies.

iii) Relationship between the State and Local Governments be facilitated to achieve uniform service quality. This, according to the researchers, could be achieved through the establishment of joint administrative committee and uniform conditions of service for providers.[82]

The team also recommended the following long-term measures:

i) Aggressive training and re-training of family planning manpower.

ii) Expansion of service coverage through functional and/or administrative integration of family planning services with other compatible public sector projects by exploring alternative modes of family planning services

> delivery as well as integrating community-based development activities with rural development projects.[83]

The essence of Section 3.4 is mainly to underscore the fact that British aid in Benue State commenced, effectively, from 1992. Our examination of the Benue State Family Planning Situation Analysis Study is, therefore, to bring out this point more pungently. It must be admitted that our work could not accommodate all the aspects of this family planning study in great detail but could only bring out the salient points in order to help us appreciate the ODA efforts in this regard. Actually, we have observed, critically, a gap in the entire exercise in the sense that this analysis study was neither evaluated nor reviewed by the Federal Government that initiated it. [84] It is only hoped that the study served the purpose for which it was intended.

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CHAPTER FOUR
THE OJU AND OBI WATER AND SANITATION PROJECT

4.1 INTRODUCTION

In chapter three we painted a picture of the poor situation of water and sanitation in Benue State and stated that the situation was worse in Oju and Obi LGAs. As part of the British Government's assistance to Benue State in health and social development, the DFID funded a water and sanitation project in the area and was implemented by WaterAid, a British NGO. The project commenced in September 1996 and was to cover Oju, then the only LGA in the area. However, in December of the same year another local government creation exercise was carried out by the Federal Government in which Obi LGA was carved out of Oju. Thus the project was now going to cover the two LGAs whose people speak the same language and live within the same geographical location that is notorious for a difficult hydrogeology.[1]

There were three different technical aspects to this project. Firstly, hydrogeological investigations were carried out by the British Geological Surveys (BGS). Secondly, there was provision of improved water supply from groundwater sources especially through boreholes and hand-dug wells and from other sources such as rainwater harvesting. The third stage was the provision of improved sanitation through the construction of pit latrines.[2] As we begin the study of this project we intend to first examine what the Benue State Government achieved, in her efforts to provide water and improve sanitation for the people of the State. This, to us, is necessary because donor assistance ought not absorb the recipients of their own responsibilities. In other words,

the British Government's intervention in Benue State was to complement government efforts and not to encourage it to abdicate its responsibilities to its people.

During the period of study, the government of Benue State put in place water and sanitation infrastructure, in an attempt to meet the water and sanitation needs of the people even though in spite of these efforts lack of adequate safe water supply has continued to plague the people of the State. According to the Benue State Rural Water Supply and Sanitation Agency (BERWASSA), Benue State got on board a Federal Government of Nigeria/UNICEF programme of co-operation on Water, Environment and Sanitation (WES) as a UNICEF – assisted Water and Sanitation (WATSAN) project, in 1991.[3] However, it was only in 1996 that the State Government enacted an edict giving the project a new status known as BERWASSA with the responsibility of supplying water and improving the sanitation of the rural communities. As partners with UNICEF in the WES project, BERWASSA was required to also do the following:

i) Contribute to a significance reduction in the death of young children from dehydration caused by diarrhea diseases related to water and sanitation,

ii) Reduction of transmission of excreta-related diseases,

iii) Reduction in diseases caused by unsanitary conditions,

iv) Eradication of guinea worm in Benue communities and,

v) Overall improvement of the communal environment

This was in line with WES project content of water supply, mobilization of the communities, sanitation development, primary environmental care/waste management and water, sanitation and hygiene development in schools.[4] BERWASSA has six departments, namely, Water Supply, Sanitation, Mobilization and Health Education,

Workshop and Stores, Finance and Administration, and Planning Monitoring and Evaluation.

Although established in 1991 the Agency started drilling activities only in 1995. It claimed to have recorded achievements in the areas of community mobilization and health education, sanitation development and water supply. In the area of community mobilization and health education the Agency claimed to have mobilized 378 communities on water and environmental sanitation, formed 202 Water and Environmental Sanitation Committees (WESCOMs) in the rural communities, formed 55 mothers clubs in the State, mobilized and trained 80 Primary/Secondary schools and trained 296 teachers in the State on WES. Other achievements, according to the Agency, included the mobilization of 2l7 community and religious leaders on WES, establishment and training of 80 school environmental health clubs, developments and airing of 87 radio and television jingles in the State, the training of 5,200 women on fixing of plastic taps to clay pots as well as training them to manage diarrhea using sugar/salt solution. These radio and television jingles were, however, not translated in the local languages.

In the area of sanitation development, BERWASSA, according to its news bulletin, produced 8,365 sanplats, trained l2, 000 community artisans on sanitation and sanplats latrine construction, built 1,000 latrines in communities, schools and markets, upgraded 30 sanicentres to cottage industries for the production and sale of sanplasts and other sanitary wares. Also, other achievements in this area, according to the Agency, included promotion of smokeless oven to reduce smoke pollution in rural kitchens, promotion of bathroom concrete slab in the rural communities, among other achievements.[5]

The Department of Water Supply is said to have sunk 580 boreholes in the rural communities while l20 hand-dug wells have been sunk. BERWASSA is also said to have constructed 5l rain water harvesters in schools and communities, developed 10 pond filtration systems, developed five springs and trained 300 hand pump mechanics in the communities, etc. Apart from these the Agency claimed its laboratory unit carried out physical, chemical and bacteriological analysis on water and soil samples from the points to determine water quality and to advise the Agency on water quality related issues. According to this report a total of 500 waster points have been analysed.[6]

These achievements have been, probably, exaggerated in view of the fact that the overall water and sanitation profile of the majority of Benue rural populace remains poor. For instance BERWASSA's efforts in Oju and Obi were quite negligible. Few water and sanitation facilities in the two LGAs are credited to BERWASSA such as the borehole at Ebonda, Oju LGA, the ones each at Opirikwu Odiapa, Okutungbe, Adum East, Ikponyire and Ijamke-Ito, Obi LGA. Two other boreholes were sunk at the Obi LGC office and one at the LGA Chairman's residence, according to our sources.[7] Also, the UNDP/World Bank – assisted Water and Sanitation Project in the area in the late 1980s and early 1990s code-named RUSAFIYA (from *Ruwa, Tsafta, Lafiya*; water, sanitation and health in Hausa) failed to satisfy the desire of the communities for water due to the difficult hydrogeology of the area. In spite of this a few water and sanitation structures in the area have been credited to RUSAFIYA. For instance in Obi LGA RUSAFIYA sank four boreholes at Ito Barracks now Headquarters of Obi LGA, one at Uwobe, Adum-East and one hand-dug well each at Udegi, Ugbodom, Adum East, Abode, Iwogogo, Anyode, Ikponyire and Eddi Adona. RUSAFIYA also constructed two institutional latrines at the Local Government Education Authority (LGEA) Primary Schools at Ogore and Adum

East, in Obi LGA, two institutional latrines at the General Hospital and LGEA Primary School, Ogengen in Oju LGA and four household latrines at Obarike and Onyinke. [8] Although the efforts of BERWASSA in this regard, coupled with previous efforts by RUSAFIYA, provided some kind of relief to the Igede people of Oju and Obi LGA, their water and sanitation needs remained acute until the intervention of the DFID through WaterAid.

This brief preamble gives us a glimpse into the efforts of the Benue State government in water and sanitation and sets the stage for us to discuss the DFID intervention in this area.

4.2 PROJECT CONCEPTION

The Oju and Obi water and sanitation project was conceived as a direct response of the British government to international efforts through the United Nations and other agencies and, of course, as her bilateral policy to implement 'Key Principles for Sustainable Integrated Water Management' as set out in Agenda 21. [9]

Actually, Agenda 21 was a comprehensive plan of action to be taken globally, nationally and locally, of organs of the UN System, Governments, and Major Groups with a view to making human impact on the environment. It was the "Rio Declaration on Environment and Development" adopted by more than 178 Governments at the UN Conference on Environment and Development (UNCED) held in Rio de Janeiro, Brazil from the 3rd to l4th June 1992. [10] In December of the same year the Commission on Sustainable Development was created with a mandate to follow-up on UNCED to monitor and report on progress made towards the agreements at the local, national, regional and international levels.[11] It was agreed that there would be a review of the

programme by the UN General Assembly meeting in a special session in 1997. The World Summit on Sustainable Development held in Johannesburg, South Africa from 26th August to 4th September 2002 was to reaffirm and re-enact the principles of Agenda 21.[12]

In response to Agenda 21, therefore, the British government set out to achieve the following:

i) Treat water as both a social and economic good,

ii) Increase support for programmes that bring clean, safe water to poor people,

iii) Encourage all those whose interest in its allocation and use (especially women) to be involved in decision making and management of water resources,

iv) Adopt a comprehensive framework that takes account of impacts of water use on all aspects of social and economic development.[13]

In view of the fact that the British government's development assistance in Benue was (and still is) in line with her international development targets for poverty reduction, the water and sanitation project in the State couldn't have been better located. This is more so because the DFID believes that Benue State is central in its aid programme for the improvement of the health of the people of Nigeria.[14] Benue State is central for reasons already discussed in chapter three. For instance the national average of access to safe water in 1997 was 39% while Benue State's average was l6%. On access to sanitation, the national average was 48% while Benue State took 35%.[15] But back in Benue State Oju and Obi LGAs had the worse water and sanitation problems resulting

from incessant outbreaks of water-borne disease epidemics such as cholera, guinea worm and malaria. [16]

The Oju and Obi water and sanitation project was funded by the DFID but managed by WaterAid, hereinafter referred to as WA, a UK NGO with considerable expertise in village level technology and community development, providing training to local partners. These local partners, in the case of this project were the two Local Government Councils (LGCs) of Oju and Obi. The LGCs' Water and Sanitation Units (WASUs), the Water and Sanitation Management Committees (WASMCs and the communities represented by the Water and Sanitation Committees (WASCOMs) were trained by WA to manage water and sanitation in target communities. After acquiring the relevant skills through participation in training events, the WASUs were to perform the following roles, among others things.

i) Develop criteria for defining vulnerability in the two LGAs;

ii) Assist target communities to set up WASCOMs;

iii) Train WASCOMs, particularly women, in health and hygiene issues;

iv) Train primary school teachers to carry out hygiene promotion in target community schools;

v) Train WASCOMs and local artisans in the construction of latrines; and,

vi) Train WASCOMs in the construction of hand-dug wells. [17]

WSMCs' primary role was the monitoring of WASU effectiveness. Actually, the WSMCs acted as governing councils, so to speak, to the WASUs. Membership of this Committee was drawn from very senior citizens of the LGAs, both within and outside the LGCs. The Chairmen of the Committees were not to be staff of the LGCs, however. [18] WA was supported in the location of water sources by the British Geological Survey

(BGS). The project was, initially, for three years, beginning from late 1996 and ending in 1999 and was to cost ₤1.4 million. [19] But was later extended to March, 2002.

As it is common, nowadays, with development projects worldwide, the Oju and Obi Water and Sanitation project had a logical framework, which guided its implementation and reviews/assessment. For the avoidance of doubt a logical framework of a project is:

> An attempt to think in an integrated, systematic and precise way about:
> a) Project objectives, distinguishing between various levels;
> b) The causal linkages between these different levels;
> c) The assumptions about the other factors that are needed for the connections between the different levels to be valid;
> d) How to assess the degree of the fulfillment of the various levels of targets and objectives". [20]

Ferron, Morgan and O'Reilly define it as:

> A tool for project planning, which employs a four square matrix detailing different levels of objectives and what is necessary for achieving these. A logical sequene can be traced between each square of the matrix and the next square, such that without fulfilling one condition another condition cannot be met. [21]

The logical framework has become a widely employed and influential tool in the planning and management of development aid work worldwide. Presently, it is used by nearly all development aid agencies and in some cases the log frames or project frameworks or project matrices, as the logical frameworks are sometimes called, are obligatory.

The origin of the use of logical frameworks in relation to the design, implementation and estimation of effects of projects is traceable to 1988 when the African Development Bank Group's "Synthesis of project performance results, 1982 –

1987" showed weaknesses concerning project design, implementation and the assessment of project effects. [22]

With the introduction of the logical framework approach the ADB Group has realized improvements in the quality of Terms of Reference (ToR) drawn up for appraisal and technical supervision missions and for external consultants recruited. The Oju and Obi water and sanitation project log frames were drawn after the pattern widely in use by development aid agencies. The general goal and purpose of the project as stated in the log frames was sustainable improvements in the quality of life of poor people of Oju and Obi LGAs. Therefore the project was to provide sustainable safe water and sanitation to target populations. Details of this project's log frames could be seen in the project document titled Mid-Term Output-to-Purpose Review: Oju and Obi Water and Sanitation Project, 21st to 27th September, 1995, already cited in the references.

4.3 PROJECT IMPLEMENTATION

It is not very clear how the implementation activities in the Oju and Obi water and sanitation project (hereinafter referred to as Oju and Obi WAS project) were ordered. According to Onah, [23] the implementation activities began with feasibility studies by WA, followed by signing of a memorandum of understanding (MOU) with the LGC; then participatory rural appraisal (PRA). This PRA was also referred to, as needs assessment exercise or Rapid Survey. This was followed by hydrogeological surveys by BGS and finally with the putting in place of organs such as WASCOMs, WSMCs, etc.

Obviously, for a big project such as the Oju and Obi WAS project it was fairly difficult to follow a hard-and-fast implementation agenda. Activities were reviewed and changes made here and there. Some of the activities had to take place simultaneously.

Bibby,[24] however, provide us a fairly orderly implementation procedure for the project. This will be discussed in section 4.3.2.

4.3.1 Agreements

Before the commencement of work on the Oju and Obi WAS project there was need for agreements. This was the starting point, in view of the fact that the project was built on partnership. In the MOU [25] jointly signed by WaterAid Country Representative; Chairman, Oju LGC, Secretary, Oju LGC; Head of WASU, Oju LGC and WA Team Leader, the terms of the project were clearly spelt out and agreed upon by the parties. Some of the key issues in the MOU agreed upon included the following:

i) The Local Government Council (LGC) and WaterAid would be equal partners in the project but would maintain different roles and responsibilities,

ii) WA would not directly implement the project. Rather the LGC WASU would be responsible for all project activities including mobilization of communities, construction of water and sanitation facilities, provision of hygiene, project management, information collection and compilation. The role of WA was to provide technical advise to WASU.

iii) The LGC would provide office accommodation for WASU staff, release vehicles and equipment, especially those used by RUSAFIYA.

iv) WA would provide all materials for community mobilization, hygiene education and training; all imported construction materials, tools and construction equipment; transport facilities, fuel and maintenance.

v) A joint implementation account would be set up by WA and the LGC. The WA Team Leader and the Head of WASU would be signatories to the account.

Continued operation of the account would depend on satisfactory returns and progress reports under the discretion of the WA Country Representative.

vi) WA would provide refresher training, on-the-job training and in some circumstances additional long-term training for WASU staff as considered necessary. WA would also pay the salaries and allowances of LGC WASU staff.

vii) There would be a spread, throughout the LGA, of selected sites for improved access to water and sanitation facilities, following agreed criteria.

The MOU was signed in November 1996 between Oju LGC and WA. However, in December 1996 Obi LGA was created out of Oju LGA. Obi LGA did not sign a separate MOU.

4.3.2 Partnership, Rapid Surveys and the Formation of WASCOMs

According to Bibby, [26] the establishment of a genuine partnership in the Oju and Obi WAS project was the first step in the project implementation. It is his belief that failure to plan and create a genuine sense of partnership was one of the reasons responsible for the failure of previous donor initiatives in the area such as the Water and Sanitation Projects of the World Bank, UNDP and UNICEF. [27] This standpoint corroborates Onah's view earlier stated. It is with this firm belief that there was need for the signing of the MOU discussed in section 4.3.1. As a matter of fact, the Oju and Obi WAS project, from its inception to its completion, was anchored on partnership. The formation of WASUs, WASCOMs and WSMCs gives further credence to this fact.

The second decisive step in the implementation of this project was the Rapid Surveys. This was perhaps the first major social development input to the project. It began in September/October 1997 when there were investigations aimed at identifying

the most vulnerable communities in Oju and Obi. Actually, rapid surveys were carried out in communities that indicated interests, in writing, in water and sanitation facilities. Whenever a community applied for both or any of these facilities, the survey was carried out to determine the degree of vulnerability of that community. Since the facilities were not inexhaustible, only very vulnerable communities were targeted. Efforts were made, however, to ensure equal spread of the facilities in the communities. Sarah Gelpke of WA introduced various PRA tools such as Structure Observation for Rapid Survey, Key Informant Interview Guide, Rapid Survey Focus Discussion Group, etc, to determine the vulnerability level of target communities. Subsequent efforts in this area by Bibby also helped to develop working criteria to assess relative vulnerability and a series of wider recommendations. [28] For instance access to medical services was included in the vulnerability criteria.

The Rapid Survey was applied in communities from which 14 were initially selected for project activities. More communities were later considered when existing criteria were revisited with a view to making the project more equitable and available to communities not selected under the first criteria. [29] In this way both very vulnerable and less vulnerable communities benefited from the project. Both were expected to contribute to the provision of water and sanitation facilities. Table 6 on page 139 provides a summary of the cost for the facilities by vulnerable and less vulnerable communities, excluding cost of imported materials and machine tools used in the project.

From the table it could be observed that both vulnerable and less vulnerable communities made contributions to the cost of drilling a borehole. However, the more vulnerable communities had longer period to collect the deposit of N10, 000 and were exempted from paying for the starter packs of materials for the latrine revolving fund.

The less vulnerable on the other hand were made to pay the deposit of N15, 000 up front for the borehole and N10, 000 for the latrine materials revolving fund.

Table 6: Costs for Vulnerable and Less-Vulnerable Communities

Sanitation (materials to establish revolving loan fund):	Vulnerable	Less-Vulnerable
Gravel – 1 trip Sand – 1 trip Cement – 4 bags	No contribution	Community contribute ₦ 10,000
Vent pipes – 5 Screen – 5	WaterAid Subsidy ₦ 17,500	WaterAid subsidy: ₦ 7, 500
Total cost ₦ 17, 500		WASCOM must recover and deposit ₦ 10,000 with WASU to qualify for another delivery of materials
Hand-dug well		
Deposit		
Labour	₦ 2,000	₦ 2,000
Materials	Community	community
Windlass	WaterAid	WaterAid
Subsidy	Voucher	₦ 4,000
Borehole		
Deposit (double for 2)	₦ 10,000	₦ 15,000
Pre-pump fitting	₦ 20,000	₦ 15,000
Tool kit	Voucher	₦ 7,000
Spares	Voucher	₦ 3,000

Source: Simon Bibby. Sanitation, Water Supply and Hygiene Promotion with Vulnerable Communities: A Report for WaterAid

WA subsidized N17, 500 for vulnerable and N7, 500 for less vulnerable communities, respectively, for sanitation facilities. Subsequently, to qualify for another delivery of sanitation materials (apart from the starter packs) each community's WASCOM was to collect and deposit N10, 000 for vulnerable communities and less vulnerable ones each. Also, whereas the less vulnerable communities had to pay a total of N40, 000 as contribution to the cost of sinking of a borehole, the more vulnerable paid N30, 000.

As for hand-dug wells the vulnerable communities paid a total of N2, 000 for each well while the less vulnerable paid a total of N6, 000. Both vulnerable and less vulnerable communities provided labour for hand-dug well drilling while WA provided all the materials.

Another important step in the implementation activities was the creation of WASCOMs. In order that water and sanitation facilities in the target

communities were effectively managed, WA and the WASUs facilitated the communities in selecting men and women of proven integrity for this purpose. Each target community selected between 10 to l5 persons, with women constituting about 50% of the number, to form WASCOM. This was a deliberate policy of the project to ensure that women participated in the management of water and sanitation facilities. The WASCOMs performed such roles, among other things such as:

i) Making informed decisions about appropriate water and sanitation systems for the communities;

ii) Organizing labour and/or collecting financial contributions from the communities;

iii) Establishing sustainable systems for spare parts supply for water and latrine facilities;

iv) Organizing hygiene promotion and education activities for the communities. This role was specifically entrusted to the women WASCOM members;

v) Deciding on the sites of boreholes in accordance with information supplied by the BGS.

At the initial stage, l4 WASCOMs were formed in l4 target communities. The number increased with the expansion of the project. When fully constituted the WASCOMs were now set for the series of training events that would enhance their water and sanitation management capabilities in their various communities. Training manuals were produced to guide in the training. There were three main areas in which WASUs provided training for the WASCOMs. [30] These included the following:

i) Community Management Training. This entailed training in team building, group dynamics and management of resources.

ii) Hygiene promotion. The WASCOMs were exposed to faeco-oral disease transmission; how to break the routes of the transmissions; and setting objectives for monitoring hygiene promotion.

iii) Construction. In this training the WASCOMs were taught hydrological cycle, water point construction, larine construction, water abstraction methods (explaining its advantages and disadvantages).

The issue of hygiene promotion was very critical in the Oju and Obi WAS project. In underscoring the importance of hygiene promotion in water and sanitation project's success, Charker Kerr has this to say:

> Heath benefits cannot be achieved to any great extent through improved water supplies alone: improved sanitation must be implemented simultaneously. Even then, health benefits will result with proper hygiene, and this demands education. Hence the equation; Health = Water + Sanitation + Hygiene education. [31]

According to Kerr, this equation has been accepted by the World Summit Goals and the Water and Sanitation Decade Goals set by the member countries of the UN and is part of the policy agreed upon in February 1993 by the UNICEF/WHO Joint Committee on Health Policy.

Therefore, to properly position hygiene promotion in the project, the Oju and Obi WASUs, apart from training the WASCOMs, also employed other means such as school hygiene (School Health Clubs) and Focused Group Discussions (FGDs) for hygiene promotion. They used drama, models and posters to educate the communities on risky behaviours such as open defecation, poor handling of water at home and at source. Signboards such as Plate I on page 144 are seen in some of the communities for the purpose of educating the public on good hygiene behaviour. There were no indications, however, that these messages were translated into the Igede language.

To break the transmission route of faeco-oral infections the WASU introduced and promoted a modified pit latrine, the ventilated improved pit (VIP) latrine, which has a ring beam to prevent collapse, a concreted slab, a vent and a roof. See Plates II and III on pages 145 and 146. Communities were trained, through their WASCOMs, to use latrines instead of open defecation, to properly dispose faeces of children in latrines and to wash their hands with water, which was to be made available at the entrance of the latrines, using soap or ashes, after ‘easing themselves’.

4.3.3 Hydro-geological Surveys/Test-drillings

While the needs assessment exercise and the formation of WASCOMs were going on, the BGS was investigating the ground water potentials of Oju and Obi LGAs.

The investigations demanded scientific vigour and technicalities, which may not be necessary for us to incorporate into this historical study. However, the salient aspects of the investigations will necessarily be incorporated for us to understand the role of BGS in the project.

The BGS had been working with WA to help improve water supplies for poor communities in rural Nigeria. Part of the information we could gather on the implementation strategy of this aspect of our study was got from a technical report presented to John Gibbs, Head of the West and North Africa Department of the DFID, London and to several Members of Parliament (MPs) in the House of Commons, and senior British scientists in April 2000 by Alan MacDonald of the BGS. [32] According to this report, the people of Oju and Obi (approximately 300,000 people) dreaded the dry seasons, year in year out, due to severe water shortages experienced from November to April. The consequence of this was that the communities were badly affected by water related diseases.

In view of the fact that speculative borehole drillings in the 1980s and 1990s proved abortive, RUSAFIYA had concluded that groundwater should be abandoned in favour of large reticulated (piped network) systems. But according to BGS the technical and institutional capacity required for reticulated systems was much higher than for local groundwater sources. [33]

Plate I: A Signboard in Oju LGA for Education on Good and Bad Hygiene Behaviour

Plate II: A Concrete Slab for Pit Latrine Construction.

Plate III: A Typical Pit Latrine in use in Target Communities in Oju and Obi LGAs

Convinced that if available, groundwater would offer the safest, easiest and least expensive water supply to the Oju and Obi communities, the BGS began a thorough investigation of the available groundwater sources in the area and devised appropriate methods of sitting wells and boreholes.

The BGS discovered that the geology in Oju and Obi was complicated and highly variable, underlain by low permeability mudstones and shale. These sedimentary rocks are composed of clay particles and only store water in fractures or thin sandstone layers contained within the mudstone. The rock type can change significantly within a few metres. Prior to BGS's research, little was known about the potential of mudstones to supply groundwater. The BGS set out to understand why there was plenty of water in the wells and existing boreholes in the wet season but as the dry season progressed most of the wells and boreholes dried up. The BGS became even more curious when a few boreholes and wells contained water all year round. To unravel this riddle the BGS created a base map from satellite images and published maps (for example see Figure 4 page 149 and 150), undertook more than 75km of geophysical surveys; carried out the drilling of 54 exploratory boreholes and examined the rocks; carried out pumping tests on 30 boreholes; and 150 water samples taken for analysis. [34]

The BGS discovered after this intensive research, that groundwater resources existed in Oju and Obi. However, it was discovered that the presence and chemistry of the ground depended on the geology. For instance, BGS explained that the thick laterite soil found throughout the area was highly permeable and full of water during the rainy season but with the coming of the dry season water stored in the laterite soil rapidly drains away. To overcome this difficulty BGS discovered that only wells or boreholes that penetrated water-bearing rocks below the laterite contained sustainable water in the dry season. The

BGS also discovered that whereas some rock units contain much groundwater to the extent that anywhere boreholes are sited they could yield water, some rock units contain water only where the rocks have been significantly faulted and fractured so that only boreholes carefully sited on fractured zones could yield sustainable water. It was discovered also that a particular rock, the Awgu Shale, contains little or no useable water. It is no wonder then that WA could not successfully provide water in some villages in Obi LGA.

The BGS believes that the geology of much of Benue State and surrounding States of South-eastern Nigeria is similar to that of Oju and Obi. It is their belief that the knowledge and exploratory techniques developed during their research in Oju and Obi could be used to apply to other parts of Benue State and the adjacent States. The BGS's research and surveys covered about 250 villages. It used simple geophysical techniques such as the standard methods commonly used in Africa, e.g. EM34 and resistivity which could identify fracture zones or distinguish sandstone from mudstone. The other method is magnetic profiling which is used for locating dolerite intrusions, the most important water bearing rock in Obi. [35]

The BGS enjoyed quite some partnership during its work in Oju and Obi. While the research was carried out for WA and their partners, and funded by DFID, BERWASSA was contracted to do the drilling of the wells and boreholes using BGS's guidelines. Moreover other agencies such as UNICEF – assisted rural water supply from other States with similar geology as well as the Geology Department of the University of Nigeria, Nsukka were interested in the outcome of the research. [36]

Refer to Figure 4a

Refer to figure 4b

Of particular interest was the partnership with the LGA WASUs. It was the WASU staff that chose sites for groundwater investigations based on community vulnerability (a measure of poverty), geology and access road for the drilling rig. The

WASU staff also introduced the BGS team to villagers and helped explain to community members the reasons for the research.

Moreover, WASU staffs were involved in the ground water research in several ways. For instance, a member of the WASU team visited sites every day to check progress of work; they were briefed thoroughly about the geology of the area and research methods; they were familiarized with various equipment that the BGS team were using, they watched all the processes and procedures and as time progressed WASU team members were invited to watch drilling exercises. All these were part of capacity building strategy for the WASU members. Also, formal training was conducted for the WASUs to increase their knowledge and skills during the period of the project. Furthermore, as soon as a trial borehole was successful it was the duty of the WASU to integrate the community into the water and sanitation programme. Apart from these interactions BGS ran three main workshops, with the aid of WA staff, for the WASU staff. These took place in October 1997, October 1998 and January 2000. The first workshop introduced WASU staff to groundwater and the need for research. The second provided guidelines for developing groundwater in Oju and Obi while the third workshop was a feedback from WASU, after using the guidelines [37]

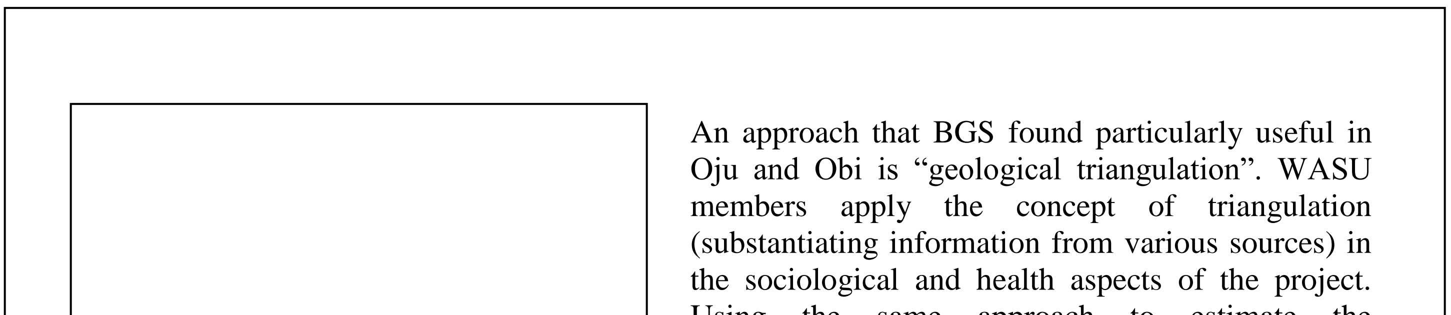
As a fall out from these series of workshops, BGS designed a simple model known as Geological Triangulation to assist the WASUs assess the groundwater potentials of a site. [38] See Figure 5 on page 153. WASU staffs were able to competently use the Geological Triangulation, in locating groundwater sources on their own, although with some difficulties in areas where the research had been inconclusive.

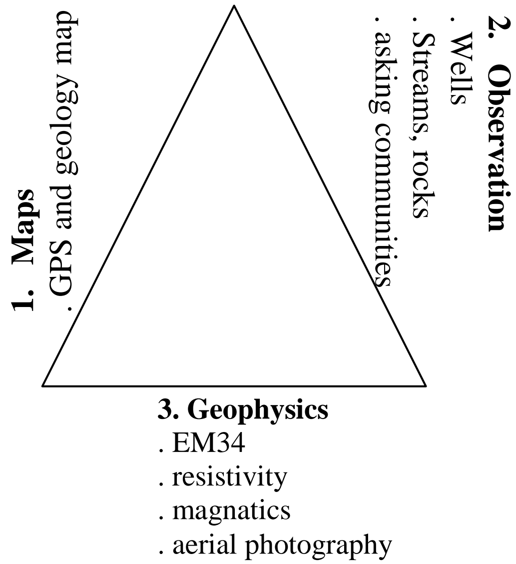
The relationship between BGS and the communities was given high priority. Consequently, guidelines were clearly established with WASU and WA to ensure that the

conduct of the research did not compromise community trust. The communities being fully informed of all activities carried out within their land developed this trust. In fact often times hundreds of community members came out to watch drilling and pumping tests. However, once in a while problems arose where it was rumoured that BGS was actually prospecting for oil or other minerals rather than water. These speculations were occasioned by the poor image of oil exploration in the Niger Delta. These speculations were however cleared once the WASU took time to sit with community leaders to address their questions. The relationship between BGS and BERWASSA was also cordial. The detailed investigation carried out by BGS provided BERWASSA and WA geologists the techniques to find and develop groundwater in Oju and Obi. In other words, a significant component of the project was to transfer the skills and knowledge to BERWASSA and WA from BGS. Workshops and field training were held for BERWASSA and WA staff to discuss the findings of the research. These workshops were more technical than those held for WASU. In fact WA and BERWASSA engineers spent two to three months working directly with BGS to acquire the skills.

Finally, during the research BGS established cordial relationship with various bodies that were interested in the research. These included the UNICEF Co-ordinator for Zone A, professors and students of the Department of Geology, UNN who attended technical workshops organized by BGS. In fact three of the students worked with BGS for several months learning about groundwater investigation techniques.

Figure 5: Geological Triangulation





Source: British Geological Surveys

4.4 PROJECT'S SELF-ASSESSMENT

In this section, we tend to approach Oju and Obi WAS assessment by examining DFID assessment as contained in the OPRs. The Oju and Obi WAS project was reviewed twice during the project's lifespan. The first review was carried out between the 21st and

27th September 1998. [39] It was considered a mid-term review since the project was, initially, to terminate in 1999. It was later extended to 2002, as earlier stated. A DFID team from London led by Robin Milton, Social Development Field Manager, carried out the review. We shall examine in detail, as much as possible, the issues raised in the OPR report.

The DFID team reviewed all the outputs as outlined in the project's log frame to see whether or not the targets were being met. And for each of the outputs reviewed they made recommendations.

4.4.1 Establishment and Operationalisation of WASCOMs, Representing All Women and Men in Target Communities.

The DFID OPR team observed that the WASCOMs were formed in target communities representing the interests of all sections of the community. The team observed further that although good progress was made in establishing the WASCOMs, they were at varying degrees of development. As at the time of the review only l4 were operational. The team wondered if the target (35 WASCOMs) would be met at the end of 1999. The team was however impressed by the fact that, with the facilitation from the WASU, all the WASCOMs evolved through a process of selection by communities, representing all splinter groups in the communities. Also, the team observed that gender considerations were observed in the formation of the WASCOMs. Women were well-represented, led in hygiene promotion but were under represented in key committee positions (as chairpersons or secretaries) but held the positions of treasurer where women are generally considered trustworthier.

Furthermore, it was observed that whereas some communities felt well represented by WASCOMs, in others the WASCOMs were perceived as a separate group

pursuing selfish interests and undertaking work for the WASU rather than for the community. The team suggested that regular meetings be held to inform the communities about the role of the WASCOMs. It was also observed that all the WASCOMs received operational trainings in three key areas, namely, community management, hygiene promotion and construction. The WASCOMs demonstrated a good appreciation and application of the training received. In the area of community mobilization the OPR team observed good level of involvement in the construction of wells and to a lesser extent, the household latrines. They also observed good success in the collection of household contributions towards the capital cost of hand pumps for boreholes, although households who relied on intermittent remittances from relations who were migrant farmers to Western Nigeria were reluctant to pay. The team suggested that with the planned upward review of subsidized operational costs for water points and larine installations the WASCOMs would need to be equipped to monitor the impact of these mechanisms on the ability of poorer households to contribute their financial quota for the facilities.

Finally, on the first output, the OPR team observed that only about two WASCOMs operated a bank account and updated records of community contributions for cost of hand pumps. That notwithstanding, the team observed that several WASCOMs still kept their monies intact without lodging them with the banks. The team hoped that by the end of the project, record keeping, account management, and so on, would be practiced by the WASCOMs, if adequate training in financial accounting and administration was given. The OPR team recommended, among other things, that priority was to be given to promoting the effectiveness and sustainability of the individual WASCOMs; and that the target number of WASCOMs was to be met by the end of the

project. Also, they recommended that continued emphasis be placed to ensure that women's interests were firmly safeguarded by the WASCOMs and that WASCOM women members were encouraged to hold regular meetings to discuss issues of common interests. Also, that all WASCOMs were to hold regular community meetings to sort out community concerns.

Additionally, the OPR team recommended the assessment of the training needs of WASCOM members on an on-going basis as their roles became more complex. Such complex roles included implementation of cost recovery mechanisms, community mobilization, monitoring of access and the use of facilities and hygiene behavior changes; management of community action plans and financial accounting and administrative skills.

4.2.2 The Provision and Use of Accessible and Protected Water Facilities for Target Communities

The team observed that the Rapid Survey to assess and identify levels of vulnerability was effective but also observed that there was need to find a way of assessing the willingness or the ability to pay for water and sanitation facilities. The team feared that if this aspect was not taken care of, the efficacy of monitoring the use and equitable access to new water points over time was going to be hampered. For instance, community applications and attendance at meetings alone were not enough demand. The real demand was payment of the counterpart funds for the facilities. Additionally, the OPR team wondered if the target number of boreholes was going to be met at the end of the project. Their fear was borne out of the fact that as at the time of the OPR visit only 11 hand-dug wells and 2 boreholes with hand pumps were installed in

11 communities while in three communities, boreholes were drilled but without hand pumps because the aggregated community contribution of N30, 000 was yet to be paid. In view of the slow progress in developing new water points, the team could not adequately assess the levels of use across benefiting communities. However, the communities that had water accepted that the water points were accessible and well patronized. In fact, in some communities a single water point was inadequate due to either large patronage or low water level during the dry season or both. This insufficient availability of safe water from new water points during the dry season made some WASCOMs to either ration or charge rates for the water. This, the team feared would cause poorer households to revert to unsafe water points.

Furthermore, the OPR team observed that while some of the target communities, which used safe water, reported lower levels of guinea worm infection, it was too early to assess the full impact of the project on the benefiting communities.

Finally, the team noticed that the focus of water point was on new facilities and less attention was paid to re-vamping existing ones.

The team recommended that WA/WASU ensured that WASCOMs were well trained in hand pump maintenance, specifically, and water points maintenance generally. Also, it advised that consideration of alternative water development technologies such as rain harvesting should be developed. In addition, methods of assessing demand and monitoring the willingness and ability of households to pay for water point construction, use and maintenance was recommended for WASUs and WASCOMs.

Finally, the team recommended that with the inclusion of some less vulnerable communities in the project, the revamping of traditional water points was considered.

WASUs and WASCOMs were to devise low cost methods of upgrading traditional wells and ensuring environmental sanitation around them.

4.4.3 The Provision and Use of Safe Sanitation Facilities by Target Communities

Here, the review team discovered that demand for latrines was lower than for water points. It wondered if the target number of latrines was going to be achieved during the project's period. Therefore, plans were being considered to adopt a social marketing approach to latrine provision which was to focus on providing a wide range of options tailored towards identified incentives and appropriate health messages.

As at the time of the OPR visit 111 latrines were completed in the initial l4 target communities. Between 400 and 600 latrines were in different stages of completion. Although there was no concrete data to measure use of latrines and increases in the safe disposal of excreta, there were strong indications that completed latrines were in use, at least by the adults. But generally, the team observed slow progress in the completion of latrines. This was attributable to collapsing pits, high water table, bottlenecks in materials supply and reluctance of community members in contributing money and materials for construction.

Furthermore, the OPR team observed that the WASUs successfully worked out a costing profile for the latrines. On the whole, households, contributed up to 60% (including manual labour) of the total cost of latrines while DFID contributed 40%. It observed further that demand for latrines, at least from some households, increased. However, the issue of willingness and ability of households to pay in cash for latrines was to be addressed by the WASUs and the WASCOMs. Methods of payment and possible exemption mechanisms for poorer households were to, ideally, evolve through a

process of consultation and negotiation between WASUs and WASCOMs on one hand and the communities on the other hand.

The OPR team recommended that WASCOMs were to be trained in the fabrication of coverlids for the latrine slabs in order to keep the latrines closed when not in use. Also the assessment of the need for a vent pipe was to be made. The team also recommended that a method for assessing and monitoring willingness and ability to pay for latrines was to be developed. It suggested alternative payment mechanisms such as the Community Revolving Latrine Fund for materials as recommended by the Bibby Report. The potential for adopting a social marketing approach to latrine provision was to be further explored, as recommended by the Bibby Report.

4.4.4 Improvement of Hygiene Behavior in Target Communities.

The OPR team was impressed by the fact that institutional structures for promoting hygiene education in target communities were established. Also it was observed that the WASUs trained 14 WASCOMs in participatory health and hygiene education with about 50% of the women in WASCOMs bearing the responsibility for hygiene promotion. Generally, women carried out promotional activities and checks from house to house even though an average of two promotional activities was undertaken by WASCOMs within their communities during large community meetings.

Furthermore, the team observed that promotional materials consisted of models made from local materials depicting faecal/oral transmission of diseases. Pictorial aids were also used. There was evidence that WASCOMs were well sensitized to safe hygiene practices. For instance, hand washing vessels were present in the majority of the latrines that were in use by households. Soap or ashes were also seen in majority of the

latrines. Also, household water storage methods improved. Clay pots with taps supplied and sold by the Bethesda Hospital at two designated points at a cost of N50 were seen in many communities.

Also, the team observed that the WASUs were trained in the use of drama to promote positive hygiene practices. As at the time of the visit, five WASCOMs developed story lines, which were demonstrated in the communities. Also, schools within the project areas were targeted for the hygiene promotional aspects of the project.

Moreover, according to the OPR team, the environmental situation in the communities was satisfactory, with areas around the households swept clean.

Despite the good rating of communities in hygiene promotion and education the OPR team was not impressed by a near absence of an effective method of monitoring hygiene promotion activities in the communities. In other words, indicators to measure performance in improved hygiene behavior by the community were not developed. The team was also not comfortable with the fact that the WASUs did not involve in their programmes, other health related institutional structure and other community development initiatives that existed within the LGAs with the exception of the LGAs' PHC units and the Nigeria Guinea Worm Eradication Programme (NIGEP).

On the whole the team observed that it was too early to determine whether or not there was reduction in water and sanitation related diseases in the target communities.

The team recommended improvements in skills in the use of participatory materials for the improvement of hygiene behaviour. To this end WASUs needed to develop training materials that were applicable to the specific needs of each target community and train WASCOMs to use them rather than replicating the training that they had been given.

The team also recommended that children, men and women be equally taught health and hygiene promotion. The responsibility of hygiene promotion was to be borne by both male and female members of WASCOM rather than leaving it all for the women. WASCOMs were to identify and train peer group leaders to educate the children and youths on hygiene behaviours. In addition, the team observed that not much information was available to target communities on sanitary protection of existing water points, refuse disposal, proper water storage in pots, etc. It recommended that more education was to be carried out in these areas, and educate communities on the proper positioning of pots and ensure that the quality of taps were good and ensure frequent restocking at sales point.

Furthermore, the team observed that WASU capacity was inadequate to train all WASCOMs in community drama. It therefore advised that some trained WASCOMs be used as trainers for other WASCOMs. The team also observed that hygiene promotion in schools was yet to be seriously addressed. It was therefore recommended that LGA schools units adopt a joint approach so that many schools at a time would participate in the promotions.

Finally the team recommended that WASU/WA should inform government health agencies of its activities and were to invite them for training in hygiene promotions.

4.4.4 Development of Capacity of WASU to Plan and Promote Provision of Sustainable Water and Sanitation Services in Oju and Obi LGAs

The team commended the performance of the WASUs as units under the local government system. It observed that the WASUs had the capability to undertake

community work and had accepted ownership of the water and sanitation project. In fact, the WASUs were seen by the communities to be trustworthy and helpful in a way, which is unusual with the local government units. Current indications were that they achieved an acceptable level of community training. But the WASUs effectiveness was to be seen more clearly when WA reduced its routine involvement.

While the WASUs were commended by the OPR team, the LGAs administrations were criticized for not establishing clear budget lines for the provision of counterpart facilities as originally proposed. The team was concerned about this lack of clear identification with the project by the LGCs. The team was satisfied, however, with the handling of funds transferred to WASU accounts by WA and the LGCs even though the team observed minor irregularities in payment of expenses, e.g. petrol consumption. Also, the team observed with satisfaction WASUs' current stock system to replace the existing ones, which proved inadequate and difficult to manage. In the new system each WASU was to account for all materials issued to it.

Finally, the team was satisfied with the plan by WA to enter into agreement with BERWASSA on hydrogeological interpretation and testing/borehole drilling. Whether or not BERWASSA was going to respect the terms of the agreement, when signed, was yet to be clear.

The OPR team recommended that WASUs should avoid over-formalized procedures in WASCOM trainings so that there would be flexibility to suit individual WASCOM needs. Trainings at community level were to be monitored to suit development requirements. Where appropriate, advantage was to be taken of visits by external advisers to provide refresher trainings for WASUs while WA continued to monitor WASUs' ability to plan and manage without much guidance by WA. WA was

also advised to organize workshops to assist WSMCs establish appropriate management committee approach. In addition WA was advised to identify constraints imposed by LGCs on management committee effectiveness and do what was possible to remove these constraints. When necessary, DFID's direct influence was to be sought. For instance when LGCs failed to make budget provisions for the project, they were to be told of the negative implications for the project such as non-extension and project collapse. Direct DFID influence was to be sought when necessary.

Moreover, the team recommended that WSMCs ensured that WASUs were spared non-project activities so that they could concentrate on project activities. It also recommended that should BERWASSA fail in performing satisfactorily under the terms of agreement the WSMCs should instigate the LGA Chairmen to contact BERWASSA, or invite DFID to intervene.

Finally, while advising WA to continue to review the effectiveness of WASU financial management and provide support for it, the OPR team recommended regular audit visit by the WSMCs.

4.4.5 Assessment of the Groundwater Potential of Geological Formations and the Development of Methodologies for Choosing and Sitting Water Facilities, and Information Dissemination.

Even though the physical implementation of water points was hampered by a number of factors such as the timing required for investigating the difficult hydrogeology of this region, the team was impressed that BGS drilled a total of 42 exploration boreholes, exceeding the target in the log frame. The team observed that the geological map was yet to be completed as well as the geological triangulation methods (guidelines for identifying likely locations for groundwater development). BGS was at the final sage

of its input into the project, which was the focusing on transfer of knowledge and information dissemination. The team was not yet sure of the sustainability of water sources in view of the fact that the location, assessment and development of water sources was not yet further tested and monitored.

The team also observed that the 42 exploration boreholes were drilled across all the geological formations except the Agbani sandstone in northern Obi. The team was optimistic that groundwater could be found from the Agbani sandstone when finally located. The Asu River Group formation upon which a significant number of communities live has a high potential for groundwater, subject to the presence of fractured zones. Also, 50 water samples were taken and analyzed for quality, according to the OPR team. As at the time of the OPR visit WASUs were yet to be trained to use the hydrogeological maps but BGS was in the process of arranging a workshop to train them.

The team observed further that one of the BERWASSA hydrogeologists spent one week with BGS in Oju to take part in survey work. Although BERWASSA had the equipment to conduct geophysical surveys, the quality and frequency of the BERWASSA tests and their ability to interpret the implications were uncertain, according to the team. Apart from BERWASSA the OPR team reported that University students completing their B.Sc courses in Geology spent one week with BGS and wrote their dissertations based on the findings of the project. BGS findings, according to the team, was going to be sent as a report to Universities, UNICEF, BERWASSA, WA, WASU and the Nigerian Geological Society.

The team recommended that a system of periodic yield testing of water points be established by BGS in collaboration with WA and WASU. It also suggested that

boreholes, rather than hand-dug wells were to be sunk in the Asu River Group formation. Furthermore, WASU team leaders were advised to identify a suitable individual to counterpart BGS in future activities to receive training to an appropriate level in matching suitable water point infrastructure to groundwater sources. The team also recommended that a pocket version of the hydrogeological map be produced for WASUs field use.

Finally, the team recommended that the involvement of BERWASSA to undertake geophysical survey for Oju and Obi WAS project was to be determined by BGS and the WASUs.

4.4.5 Suggestions for a Project Extension

After reviewing the output of work done on the Oju and Obi WAS project for two years, the team of reviewers observed that the actual achievements of the projects against the various targets of the project set were modest. It hoped that arrangements already put in place for the project were going to be implemented. Be that as it may, the team saw a glaring need for a project extension. Therefore, a suggestion was put forward to the DFID for an extension of the work in Oju and Obi. The team, after considering several options for the extension settled for third, for the consideration of the DFID.

The first option was that the hydrogeological investigations in Oju and Obi be extended so that areas that were not yet investigated could be covered while continuing with the same approach, procedures and arrangements, providing the same type of assistance to the vulnerable communities in Oju and Obi LGAs. The second option was that wells, boreholes and latrines, which existed before the DFID came to the scene, be rehabilitated. Finally the third option suggested a strengthening of BERWASSA's

hydrogeological skills in respect of interpretation of hydrogeological information and testing techniques.

The overriding reasons for a suggestion for extension, according to the OPR team, was the need for more time to enable an assessment carried out on the current approach and procedures to see whether the project will be more effective and sustainable. In other words, the team advocated for a continuation of the project procedures and approaches without introducing new requirements or new water technologies, which were going to impede WASUs and WSMCs from pursuing the current project approach and procedures. The team proposed a duration of at least two years as extension period for the project.

Consequently, the project was extended from 2000 to March 2002, duration of over two years, by the DFID without drastic changes in implementation procedures.

4.4.6 Second OPR Visit

The second review of the Oju and Obi WAS project was carried out from the 23rd to 27th October 2000, two years after the first visit. [40] The second OPR team was headed by Martin Sergeant, DFID Divisional Engineering Adviser for Africa. As in the first review, the team examined the outputs as outlined in the extension log frame, to see whether or not the targets were met.

Establishment and Operationalisation of WASCOMs' Capacity to Effectively Manage Project Activities at Community Level in 70 Target Communities

The team observed that a total of 55 WASCOMs (33 in Oju and 22 in Obi) were established and trained in community management, hygiene promotion and latrine

construction. The members were optimistic that the target of 70 was likely to be met by the end of the extension. The team also observed that all the WASCOMs operated an exemption and variable subsidy system with regard to latrine construction. In this system individual WASCOMs divided their communities into three categories: Rich, Medium and Poor. Vouchers worth an average of N200 per household were then divided among them with the poor receiving double the amount given to the medium while the rich received nothing.

Also, the review team discovered that in Obi, exactly 50% WASCOM members were women as required by the project while in Oju 44% were women. The Oju percentage was not perfect but not unreasonable either, according to the team. The team was informed by WA that "management" posts such as Chairman, Secretary and works Coordinator were almost always taken by men while the post of Treasurer was usually filled by women.

Finally, under this output, the team was impressed that representatives from 70% of the WASCOMs attended the LGC-wide three monthly meetings during which women's concerns were taken fully into account. Chairmen, Secretaries, works Coordinators attended these meetings, which were more of information exchange forum rather than decision making. Therefore the absence of women at these meetings did not constitute a threat to the success of the project. Moreover, there existed a forum where women WASCOM members met to express their concerns. Be that as it may, the OPR team recommended to WA that Treasurers (women mostly) be incorporated into the three monthly meetings.

<u>Strengthening of the Capacity of the WASUs to Plan, Manage, Monitor and Evaluate and Develop Sustainable Water and Sanitation Services in Oju and Obi</u>

Here the team observed that the WASUs were performing all WASCOM trainings while WA's role was the development of further training strategies. Also individual WASU members were also trained (individual capacity building). These were going to help the WASUs as they re-integrate into the LGC system when WA pulled out. The team also observed that the WASU management and operations systems were solid enough to efficiently and effectively manage a water and sanitation programme without WA. In fact, WASUs were discharging their roles with minimal level of WA involvement, especially as WA was hoping to expand their operations to other LGAs in the State.

Moreover, the team noticed with satisfaction WASUs management of funds and materials but observed that the issue of transfer of funds from the LGCs into WASU accounts was problematic.

The OPR team recommended that WA develop a transition strategy with WASUs becoming integrated into the LGCs. It suggested that DFID – assisted SLGP be approached to assist in this regard. The team also suggested that associate partners (small-scale private sector operators such as sanitation centers, latrine builders, hand pump mechanics, hand well technicians, etc, trained by the WASUs and WA) were to be utilized, while WASU developed and provided quality control for them.

Strenthening of the Capacity of the Oju and Obi WSMCs to Manage Provision of Water and Sanitation Facilities

Here, the team observed with some concern that the WSMCs, which were intended to ensure accountability and provide stakeholder involvement in the project were going to be replaced by PHC management committees of the LGCs. The members hoped that the WSMCs would continue to maintain links with the WASCOMs. The team

was also worried that the WSMCs were not an effective link with BERWASSA and feared that when WA pulled out, the LGC chairmen would politicize borehole issues. They also expressed concern that with the new national water policy, which placed water supply under the LGC chairmen, the project could suffer from lack of counterpart funding.

In view of this development, the team suggested that WA continued to work with the LGCs to develop alternative management arrangements that were going to reflect the new national water policy. Also, that WASUs should integrate their reporting, personnel management, accounting and auditing procedures with LGC structures.

Construction of 75 Viable, Fully Functional and Adequate Community – Managed Water Supplies in Obi and Oju Communities

On this issue, the team discovered that at the time of the OPR 43 water points were completed and 44 started. Some of the hand-dug wells had problems and were to be deepened. The team observed that Rapid Surveys which were carried out to determine the degree of vulnerability were undertaken but wondered how four communities not assessed as being vulnerable had water schemes. The team also observed with satisfaction the fact that all the poor in target communities had access to water points, and that target communities met at least 20% of construction cost for new boreholes while communities with hand pumps devised revenue collecting systems for the purpose of maintaining the pumps.

Furthermore, the OPR team discovered that all hand-dug wells were constructed using labour from the communities. In addition, for each well the community contributed 7% of the cost, which stood at N104,000 (£700). A community in Obi

(Obijiago) got a rain-harvesting scheme. Initially, it was the only community in the project that had the scheme, but later communities such as Okpaga and Irabi joined the scheme. The hydrogeology of the area is too difficult for either a borehole or hand-dug well. A second community with this problem, Adega, was identified but declined a rainwater scheme.

Finally, the team observed that four members of each borehole community, two men and two women, were trained in basic borehole maintenance.

Development of Sustainable Latrine Building System Within Oju and Obi

The OPR visitation team discovered that 694 latrines were completed and 623 others were started. Of these numbers, about one third appeared to be in non-target areas. The team did not explain the probable cause of this phenomenon. The team noticed that communities contributed 50% to the cost of the slabs for the latrines. The communities also provided their labour for latrine construction. Therefore the total contribution of the communities (including labour) was put at 90%.

Moreover, the team observed that latrines actually in use were relatively modest. It was pleased with WASCOMs' innovative approaches to social marketing of latrines including the use of megaphones in villages at 5.30a.m. Social marketing is actually the application of business strategies to address social and health problems or needs using marketing techniques, specifically. The team also discovered that although latrines were built in some markets, their utilization was low due to the high price placed on them.

Finally the team was impressed by the community-managed and controlled latrine subsidy system operational in all target communities

Improvement of Hygiene Behaviour in Target Communities

With regards to this output, the OPR team observed widespread hygiene promotion activities. For instance, members of the team heard an early morning megaphone call in one of the villages. The team also admitted that there was perceived reduction in levels of diarrhea cases, especially in children, in some communities. According to the team there was baseline data to this effect in eight communities. This data was not included in their report, however. The visitation team also observed an improvement in the safe disposal of children and adults' excreta as well as the provision of hand washing facilities in latrines, even though only a small number of latrines had these facilities.

Finally, the team observed, with reference to school hygiene and latrine building programme, that the process was slow. The team noticed only one active hygiene club in one private school.

The team recommended that a revised hygiene strategy was to take a broader approach involving multiple actors, channels and involving the wider community. Also, that the PHC units within the LGAs be fully involved in the new strategy. It also recommended that the focus on safe disposal of excreta be maintained.

Development and Implementation of a Monitoring and Evaluation (M & E) System

On this issue, a framework for M & E, its full system and a procedure document were to be ready by September 1999, January 2000 and March 2003, respectively. However, the OPR team discovered that WA had difficulty achieving this. In fact, WA admitted this difficulty. Nevertheless, many things were being monitored by the WASUs, without an M & E system.

The team recommended that a simple M & E system was to be put in place for the WASUs to use at the end of the project. WA was also advised to consult with other DFID projects in the State for assistance in this regard.

Summary of the OPR

In a summary of their overall impressions on the Oju and Obi WAS project, the team noted that while there were areas of concern such as the non-performance of the WSMCs, lack of an effective M & E system on ground and the difficulty to work through schools on hygiene education (due to school strikes), the project worked well at community level. The team was optimistic that the gains of the project were going to be sustained in view of the fact that the WASUs had become an effective and motivated unit within the LGC structure.

The OPR visitation team highlighted key issues and challenges that faced the project in the days ahead. First was the issue of sustainability test, which the team said was going to depend on how successfully WASUs were integrated into the LGCs. If this succeeded, the model would be replicated in other LGCs in the State. Secondly, the team noted that the movement of WA staff from Oju to Makurdi was going to achieve two things: grant more independence to the WASUs; and concentrate on possible extension to other LGCs in Benue, using lessons learnt from Oju and Obi. Thirdly, the OPR team noted with delight the cordial relationship between WA and BERWASSA and urged that BERWASSA could benefit from the experience of WA. As a matter of fact, discussions were in advanced stage on how the WA drilling rig could serve the needs of BERWASSA in the State. Also the DFID was considering assistance to UNICEF through BERWASSA.

Finally, even though the STD/HIV Management Project was on ground in the State, WA's interest in streamlining the HIV issue in its programmes, through the WASUs was seen by the OPR team as a major challenge and key issue. On the whole, the OPR team commended themselves for doing a quality review job. This, they claimed was due to the fact that the team comprised of DFID staff, BERWASSA, Benue State Ministry of Water Resources, the WASUs and WA staff and that the report was acceptable to all parties.

It must be noted that after this review no other review was carried out before the project finally came to a close in March 2002. Therefore, some of the issues, which will be raised in the next section, may not have been reflected in the OPR reports.

4.5 ASSESSMENT OF PROJECT'S IMPACT

In chapter one, while outlining the objectives of this study and also bringing out the methodology for it, we mentioned that we shall assess the impact of the DFID – assisted projects on the target communities by looking at some of the structures on the ground. That was what we did. We visited some of the communities and asked questions on the project, took some photographs of water and sanitation facilities and also visited the WASU offices in Oju and Obi LGC headquarters to talk with the staff.

After examining DFID's Assessment of its performance in the Oju and Obi WAS project, we would now examine the impact of the project on the target communities as reported by the beneficiaries themselves.

4.5.1 <u>Ownership of the Project</u>

> Go to the people, live with them, learn from them, love them, start with what they know, build with what they have. But with the best leaders, when the work is done and the task is accomplished, the people will say: "We have done this ourselves."
>
> Lao Tsu of China (700BC)

Perhaps the most striking feature of the Oju and Obi WAS project was the acceptability of the project as "our own" by the target communities.[41] On what informed this attitude of ownership, the people interviewed said they were well informed and well educated on the project from the onset, by the WASUs. Moreover they accepted the partnership extended to them by WASU and had contributed both money and labour to put the facilities in place. Also, they claimed they were trained on how to maintain the facilities by themselves without seeking for support from elsewhere. They accepted that they were very excited to own and manage the facilities on their own.

The Oju and Obi WAS project was (and still is) a success story of the Bamako Initiative (BI) model adopted by the DFID. The BI advocated commitment in health care management at the grassroots level with the communities taking responsibility in the management and financing of services by themselves.[42] The Oju and Obi WAS project thus became one of the projects that radically deviated from the general mentality of Nigerians towards public utilities and facilities. Nigerians, generally, have a tendency towards public facilities that negates decorum. It is a situation whereby public utilities are wantonly vandalized and cannibalized in the most reckless fashion. This situation contrasts sharply with what obtained in the project communities of Oju and Obi. Probably due to several decades of neglect and acute water scarcity, they have come to see their water and sanitation facilities as opportunities they would not toy with. Therefore, they were always quick to let every visitor know that the entire community owned the facilities and that sanctions awaited any member of the community that misused them.

4.5.2 Safe Water and Sanitation

All the people interviewed in the communities counted the gains of the Oju and Obi WAS project.[43] They were full of praises for the WASUs and WA (majority of them are unaware that it was actually the DFID that funded the project) for what they considered a great relief from hardship caused by lack of safe water especially during the dry seasons. They also appreciated the latrine culture with its attendant hygiene benefits. Most of the respondents were unanimous on some of the impacts of the project on their communities. For instance, they agreed that dry seasons in the two LGAs were dreaded but the water situation improved with the coming of the project. Water was now within reach and pure, as against streams and ponds from where they drank and used for other purposes. Whereas they used to trek long distances during the early hours of the morning and late hours of the night in search of water, the situation now was different. In view of this they now had time to attend to their farms, studies, businesses and gain time for their families. Some of the female respondents said because they had to search for water during late nights and very early in the mornings they had matrimonial problem arising from their inability to satisfy their husbands, sexually. They said the situation was now different.

Moreover, the respondents testified that the coming of safe water to their communities helped in the reduction of perennial outbreaks of water-borne diseases such as cholera, dysentery, guinea worm, malaria, etc, which used to be a recurring decimal in Igedeland. Also, some of the respondents said fighting at water points in the nights used to be rampant but since water points were installed within their communities the phenomenon changed.

In the same vein, a few cases of snakebites caused as a result of night trips in search of water were recorded in the past. But now such calamities were drastically reduced. Women and children who bore the greatest brunt of water scarcity seemed to show, more openly, the relief they now enjoyed. For instance, one of the students interviewed said since water came to his neighborhood he now had more time for their studies.

However, in spite of the achievements recorded by the DFID in this regard, we observed that communities that got boreholes were only those accessible by the drilling rig. It meant that there were communities that needed the facilities but could not be reached. Part of DFID intervention in the area therefore would have included opening up of access roads, just as the Benue Health Fund did in some communities in their project areas.

On the issue of latrines, the respondents agreed that the advantages of owning latrines were obvious. They could go to the toilet at any time of the day and night without fear of snakebites. They were no longer embarrassed when their visitors asked to 'ease themselves'. Moreover they came to believe that owning a latrine was a status symbol. Also, adults and children who used to defecate around the compounds have learnt to use the latrines, thus saving them from environmental pollution and diseases caused by faecal-oral transmission such as cholera, dysentery, etc.

Members interviewed accepted that hygiene education and promotion was taken seriously in the communities. For instance, Ogaga Peter and Joseph Echo, both WASCOM Secretaries in their communities, and Chief Joel Ola a WASCOM Chairman in his community said hygiene promotion was top on the agenda during their meetings. Sub-themes on the issue of hygiene promotion were: environmental sanitation,

construction of latrines, cleanliness around water points and so on. In some communities the WASCOMs placed fines for violation of good hygiene behaviors.

The gains recorded in the areas of water supply and sanitation facilities notwithstanding, some respondents had a few sad stories to tell. [44] For instance, Mama Ochi reported that the water point (borehole) in the community was not being utilized because it was almost always under lock and key due to the high-handedness of the WASCOM Chairman. Also, that the man simply refused to summon WASCOM meetings. Consequently, the community was not united and so households reverted back to getting their water from the streams. When we interviewed the Chairman, Mr. Ola, he said because his Secretary was dead he kept the meetings on hold.

The story of Okpodom-Ogore is that of a community with insufficient safe water. They were assisted with one hand-dug well but at the peak of the dry season when they needed water most the well would dry up. According to Echo, during the peak of the dry season they were constrained to go back to unsafe water sources. He however admitted that the well had, nevertheless, alleviated their hardship, to some extent.

The case of Obijago community is one of a very difficult, near impossible hydrogeology. The groundwater sources are absent so the only alternative water source the DFID could provide was rain harvesting. Although the community had eight communal harvester tanks and 13 household jars, Rachael Oga said the water was insufficient. Moreover, that some of the harvester tanks had cracks which licked water, thus making it impossible for water to serve them through the dry season. The bad situation of the community was further made worse because it is one of the guinea worm endemic communities.

Finally, our general assessment of the gains in water and sanitation is that the project succeeded in improving the water and sanitation situation in Igede land. This is evident from the fact that the land has not been in the news, over outbreak of epidemics, for years. It was discovered; as we went round that some communities had up to three boreholes, some two, others had both boreholes and hand-dug wells while some had only hand-dug wells. Some of the communities visited possessed latrines ranging from two to 32 while some were at varying stages of completion. On the whole a total of 77 boreholes, five hand-dug wells, one rainwater harvester and about 300 pit latrines were provided in target communities in Oju LGA by the DFID. In Obi LGA, seven boreholes, 24 hand-dug wells, 43 rainwater harvesters and 264 pit latrines were provided in target communities. The two WASU offices in Oju and Obi possessed statistical Tables to back up these figures. As at the end of the DFID support in the Oju and Obi WAS project, a total of 34 target communities in Oju and 47 in Obi LGAs were reached. The degree of awareness on hygiene behavior was evident as community members with little or no formal education discussed hygiene issues intelligently.

The fact however remains that the DFID did not provide water and sanitation facilities to the entire Igede land. The implication for this is that the gains we are talking about are at best moderate. What the DFID did, to us, is an example of partnership between vulnerable communities and stakeholders in the provision of water and sanitation for our governments to adopt. Perhaps, to adequately appreciate the DFID assistance in the project we interviewed some of the people involved in the project to provide us with commercial estimates for water and sanitation facilities as at the time the project assistance came to a close. [45]

While Onah put the cost of drilling a borehole at over N300, 000, Ominyi estimated it at N700, 000. Ominyi said the cost of a hand-dug well was N150, 000 with the community providing manual labour and the cost for the windlass while the DFID provided skilled labour, cement, gravels and sand. In the case of rainwater harvesters, Ominyi put the estimates at N12, 000 for a household jar of 3.4m3 with the household providing 22% of the cost, and N180, 000 for a communal tank of 82m3 with the community providing manual labour for digging, mixing of cement, etc, and 22% of total cost. Ube's estimates were higher, in respect of harvesters. He said the community tank cost ₦210, 000 with the community providing ₦ 21, 230 of the cost, and that a household jar cost ₦27, 000 with the household providing ₦ 3, 000 of the cost.

Whereas Onah said the cost of constructing a pit latrine was estimated at ₦1,500, Ominyi elaborated further when he said ₦1,500 was the cost for unlined latrines. He said for this type of larine the owner bore 50% of the cost while the project took 50%. He said the lined latrine cost ₦6, 000 with the owner bearing 30% of the cost and the DFID 70%. These figures do not contradict those on Table 1, which were not based on commercial rates.

The Plates on pages 181 to 184 (Plates IV to VII), explains further the Water situation in the Oju and Obi WAS.

4.5.3 <u>The WASCOMs</u>

The formation and functioning of WASCOMs in the Oju and Obi WAS project could be considered as one of the best social development strategies for this project. The WASCOMs became rallying points for the communities for discussing their water and sanitation needs. They proved capable of taking their destinies in their hands and facing

the challenges of community development squarely. In the WASCOMs we also saw gender adequately streamlined.

Unlike in many African communities, we saw women contributing and participating in issues that touched them and their families. This, we must admit is now becoming the trend worldwide, especially in developed and some developing societies. Barbara Thomas-Slayter and Genese Sodikoff emphasized this trend strongly in their article titled “Sustainable Investments: Women’s Contributions to Natural Resource

Plate IV: A Hand-dug Well at Ijokwe Community, Obi LGA.

Plate V: A Community Borehole at Eja Community, Oju LGA.

Plate VI: A Community Rainwater Harvester Tank in Obijiago Community, Obi LGA.

Plate VII: A Household Rainwater Harvester Jar in Obijiago Community, Obi LGA.

Management Projects in Africa". [46] They argued that prospects for improving livelihood security and building sustainable environments in Africa could be better enhanced if women have greater influence in decisions about how to manage resources. The authors highlighted enabling conditions, which facilitates effective involvement of both men and women in resource management with great impact and sustainability.

Apart from the fact that the WASCOMs had good women representation, our interviews showed that they actively participated in the training events and meetings; and also freely expressed themselves over their concerns without the fear of male domination. Both our male and female WASCOM respondents accepted that their meetings were focused and effective. According to them, issues discussed were basically, as earlier stated, on ways of improving their water and sanitation conditions. To be specific, issues such as water point maintenance, collection of tariffs, settlement of petty quarrels over water and monitoring environmental sanitation in the community and at water points were discussed. It was also during these meetings that decisions were taken on further procurement of water and sanitation facilities.

Membership of WASCOMs, in respect to the number, was elastic, depending on the size of the community but did not exceed 15. Also, the frequency of meetings was not stereotyped. Whereas some WASCOMs met weekly, others met monthly and, in some cases, we were told they met as the need arose. They were also available when their WASUs summoned them for meetings or trainings.

4.5.4 The WASUs

The WASU staffs in the two LGAs were staff of the LGCs who were seconded to WA to serve as link between the project and the communities during the project. Their

schedule of duties has already been highlighted but our assessment of what we saw on ground could be useful. From the OPRs examined, the role of the WASUs in the project was commended. We have no contrary opinion about this assessment.

One of the first impressions we got as some of the WASU members conducted us to some of the project facilities in the communities was their acceptability by the communities. This was manifested in the warm reception and lavish entertainments provided us. They were glad to conduct us round to see their facilities, and answered our questions. This cordial relationship between the WASUs and the WASCOMs/communities contributed to the success of the project.

Secondly, our visit to the WASU offices proved to us that the units were well organized. Plate VIII on page 187 shows Obi LGA WASU members at work in their modestly furnished office. The units kept very good records of their activities and were able to provide answers on a variety of issues relating to the project. Whereas the WASU staff said they were well motivated during the project, they complained that since the project wound up they were no longer paid WA rates that were better than the rates paid by the LGCs. They also lost some of the incentives they enjoyed while the project lasted. Such incentives included trainings within and outside the country, allowances for attending meetings, and so on.

Finally, the WASUs seemed properly positioned to sustain the gains of the project. According to them, they were well trained to read and interpret

Plate VIII: Some WASU Staff of the Obi LGA at Work.

hydrogeological maps as well as carry out drilling activities by themselves. They also claimed to possess different skills in water and sanitation management capable of sustaining the gains of the project.

4.5.5 Summary

DFID assistance in this project ended in March 2002. But Job Ominyi, former programme Officer to the Project and now WA Programme Coordinator for Benue State said WA has continued to give peripheral technical advise to the two WASUs. [47] Moreover, he said WA as an NGO was now spreading tentacles to other LGAs in Benue State such as in Logo and Vandeikya to explore areas of partnership in water and sanitation.

As we bring our study of the Oju and Obi WAS project to a close we intend to examine the activities of the Benue Health Fund project, another DFID-funded project that emphasized partnership in project planning and implementation.

ENDNOTES/REFERENCES FOR CHAPTER FOUR

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2 Water, Engineering and Development Centre (WEDC). Rural Water Supply and Sanitation Project Monitoring, Nigeria. 12 – 16 October, 1997 http//wedc.ac.uk

3 BERWASSA. BERWASSA At a Glance, n.d., p. 1 – 6.

4 Ibid. p.3

5 Ibid. pp.3 - 4

6 Ibid. pp. 4 - 5

7 Andrew Onah (35), WASU Team Leader at Oju LGC and Dan Ejeh (36) WASU Co-ordinator, Obi LGC provided information on BERWASSA facilities in Oju and Obi LGAs respectively, during interviews on 29th and 30th July 2003 respectively.

8 Job Ominyi (39) provided information on RUSAFIYA efforts in Oju and Obi LGAs. He is presently the WaterAid Co-ordinator for Benue State and had worked with RUSAFIYA, earlier, in the area.

9 DFID. Eliminating World Poverty: A Challenge for the 21st Century (White Paper on International Development by Command of Her Majesty, November 1997), p. 24.

10 The UN. Agenda 21.htm

11 Ibid. p.1

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13 DFID Eliminating World Poverty… Op.Cit. p.24

14 DFID. Nigeria Country Strategy Process … Op.Cit. p.27

15 UNICEF. State of the World's Children 1997. Cited in WaterAid/WASU. Targeting the Vulnerable. n.d. p.1

16 F.O.S. Major Social Indicators by LGAs … Op.Cit. pp.23 - 25

17 For some of the roles of the WASUs see the project's logframe in the project document.

18 For some of the roles of WSMCs see DFID. MID-TERM OUTPUT-TO-PURPOSE REVIEW OJU AND OBI LGAs WATER AND SANITATION PROJECT 21ST TO 27TH SEPTEMBER, 1998; DFID (WEST AND NORTH AFRIA DEPARMNT), October 1998, p.85.

19 DFID. Summary of Development Assistance Programmes Supported by DFID January 1999, p.4. In an interview with Job Ominyi, WaterAid Programme Co-ordinator for Benue State, he said the Oju and Obi WAS project from 1996 to 2002 costed €1.685.

20 Des Gasper. Logical Frameworks: A Critical Assessment Managerial Theory, Pluralistic Practice (Institute of Social Studies Working Paper Series No.264), December 1997, p.6.

21 Suzanne Ferron, et al. Hygiene Promotion: A Practical Manual for Relief and Development: London: Intermediate Technology Publications, 2000, p. 235.

22 David Akroyd. The Logical Framework approach and the post-evaluation of health-sector projects by the African Development Bank. Project Appraisal Vol.10, No.4, December 1995, pp.210- 222.

23 The information is based on an interview with Mr. Andrew Onah, Oju WASU Hygiene Education Officer on 26/11/2002.

24 Simon Bibby. Sanitation, Water Supply and Hygiene (A Report for WaterAid): Social Development and Hygiene Promotion Issues – Oju and Obi LGAs, Benue State, Nigeria. L6th September, 1998.

25 See Oju Wata and Sanitation Project: Memorandum of Understanding between Oju LGC and WaterAid Nigeria Programme, November 1996.

26 Simon Bibby. Sanitation, Water Supply… Op.Cit. p.1.

27 Ibid. p.1

28 Ibid. p.2

29 Ibid. p.6

30 OJU/OBI WASU. Situation Report Presented to DFID. September 1998, p.8

31 Charker Kerr. Community Health and Sanitation. London: Intermediate Technology Publications Ltd; 1990, p.1.

32 A. M. MacDonald and J. Davies. Communicating Groundwater Research: The Example of Oju and Obi, Eastern Nigeria. Nottingham, U.K: BGS International, April 2000.

33 Ibid. p.1

34 Ibid. p.2

35 Ibid. p.3

36 Ibid. p.5

37 Ibid. p.7

38. Ibid. p.9

39 All the information pertaining to the first OPR Report are based on: DFID. MD-TERM OPR REPORT…Op.Cit.

40 All information pertaining to the second OPR are based on: DFID. Report No. OPR2, pp.5 – 20.

41 We interviewed Paul Ode (65) of Eja Community Oju; Lydia Agbor (45) of Anyuwogbu community Oju; Jairus Egwu Udanyi (28) of Anchimode community, Oju; Grace Ogbebe (35) of Ujokwe communityObi, Peter Agawuru (29) of Obijago community Obi. All of these except Peter are memers of WASCOM. They, and several others, were unanimous on the fact that they owned the facilities.

42 Stephen W. Jarret and Samuel Ofosu- Amah. Strengthening health services for MCH in Africa… Op.Cit. p.164.

43 We interviewed Comfort Joel (36) of Eja community (a WASCOM member); Marcilina Achor (35) of Ochodu community Oju (a WASCOM membr); Emmanuel Okwu (15) of Ochodu community(a student); John Omenka (45) of Owuu-Ogengen community Oju (a teacher); Jonah Ogbu (38), Elizabeth Onah(38) and Alphonsus Onah 29 WASCOM member), all of Ijokwe community; Helen Ajiga (30), Ode Aje (30), Benedict Ona (50) (a WASCOM member) all of Irabi-Ito community Obi; Oga Peter (40) (WASCOM member) of Odaleko-Ito community Obi; Joseph Echo (38) (a WASCOM member) of Okpodom-Ogore community Obi.

44. Some of the sad stories were told by Chief Joel Ola (60) the WASCOM Chairman for Obarike community Oju; Mama Ochi (60) a member of the same community; Rachael Oga (28) a housewife in Obijago community and Joseph Echo (38) of Okpodom-Ogore, all in Obi.

45 We interviewed Emmanuel Ube (30) WASU Team Leader, Oju LGC and Job Ominyi (39) WA State Co-ordinator.

46 Barbara Thomas-Slayter and Genese Sodikoff. Sustainable investments: Women's contributions to natural resource management projects in Africa. Development in Practice, Volume 11,Number 1, February 2001,p.45.

47 An interview with Job Ominyi, (39) WA Programme Co-ordinator for Benue State on 11/9/2002.

CHAPTER FIVE
THE BENUE HEALTH FUND PROJECT

5.1 INTRODUCTION

Benue State was identified in 1992 as the geographical focus for health sector support by the ODA (now DFID) for reasons already discussed in chapters one and three. The State had lower household incomes and worse health indicators than the national average. Benue's unique ecological/climatic status made it home for all kinds of diseases such as malaria, yellow fever, onchocerciasis, guinea worm, cholera, HIV infection and so on.[1] Since 1992 ODA advisers and consultants developed close relationship with the Benue State Ministry of Health (MOH) for the purpose of project preparation. The Benue Health Fund Project (hereinafter called the BHF Project or the Project) was in the process of preparation for some years but could not take off due to lengthy processes of design and re-design until January 1997 when it was launched[2].

The DFID, in providing a rationale for the BHF project, claimed that in Benue State, as in much of Nigeria, public hospitals and PHC service had deteriorated terribly in the past 20 years. Consequently, the utilization of these services also declined to the extent that they served only 10 to 20 percent of the Benue people[3]. The DFID further claimed that both public and private health sector services were too expensive for most of the Benue population whom 66% were considered as poor, judging by the poverty headcount in 1996.[4]

The BHF project was, therefore, "to reverse this situation in one of the country's least-developed States." [5] The project intended to accomplish this task through improvement of the coverage, use and quality of basic primary and secondary health care

in order to improve care for the poor and vulnerable groups so that further impoverishment of the people through ill-health could be stemmed.

The strategy employed by the DFID was to provide assistance in health to some focal LGAs in the State and to develop models for improving health services in other LGAs and other States of Nigeria. [6] The project provided SHC assistance to nine hospitals, 160 PHC Clinics and 33 communities in seven focal LGAs in the State for a period of over five years. [7] The seven focal LGAs include Logo, Katsina-Ala, Vandeikya, Tarka, Otukpo, Ohimini and Gboko. [8] The fund was managed by a Project Advisory Committee (PAC) of about 17 members. [9]

It is important that we divert our attention from the project, meanwhile, and look at the efforts of the Benue State Government in the area of health care before the DFID intervention, just as we did in the case of the Oju and Obi WAS project. This, as we have continued to emphasize, is to underscore the fact that donor assistance ought not to absorb the recipient government of her responsibility to her people.

As at 1994 the health sector goals of Benue State were:

i) To prevent premature death;

ii) To protect the people from the hazards of avoidable and communicable diseases; and

iii) To promote an increased awareness of good health among the people of the State through basic health education and provision of curative care. [10]

These health sector goals conformed to the National Health Policy and Strategy to achieve health for all Nigerians as contained in the Federal Ministry of Health and Social Services (FMOH) document of October 1988 and also in line with the BI and the Alma

Ata Declaration. The National Health Policy and strategy aimed at attaining the goal of health for all Nigerians to enable them lead socially and economically productive lives at the highest possible level. [11]

The Benue State Ministry of Health was (and still is) the main actor for health care provision in the State, determining policy and implementing them and managing operational health services in line with the Federal Ministry of Health policy guidelines for the country. [12] The State was (and still is) assisted in the task of health care provision by voluntary agencies such as the Catholic Church, NKST Church, the Methodist Church and other religious groups. Private health institutions also complement these services. The State was also assisted in PHC activities by UNICEF through the B1 programme and at the SHC level through the Baby Friendly Hospital initiative. [13]

At the grassroots level the LGAs provided health services through the PHC units. As at 1994 all the LGAs in the State had either PHC or SHC facilities except Konshisha LGA. Nine LGAs had general hospitals. This included Makurdi, Gboko, Gwer, Katsina-Ala, Kwande, Oju, Okpoga, Otukpo and Vandeikya. [14] The general hospital in Makurdi was later taken over by the Federal Government as a tertiary health institution and re-named Federal Medical Centre. Since the provision of PHC is the constitutional responsibility of the LGAs, the Benue State MOH only provided technical assistance, staff training and other logistic support to the LGAs in their implementation and establishment of sustainable PHC systems in accordance with the guidelines provided by the FMOH.

The development of PHC in the Benue State LGAs during this period varied widely and the quality and effectiveness of these services also varied. Generally, the NPHCDA national survey rated the services very low, with Benue State LGAs scoring

37.4%.[15] However, the collaboration between Benue State and UNICEF in the development of PHC in the State assisted in improving services at the grassroots, to some extent. For instance, the State's collaboration with UNICEF helped Kwande, Ado, Gwer-West, Katsina-Ala, Ukum and Ogbadibo LGAs in B1 implementation, Expanded Programme on Immunization (EPI), household food security and nutrition, water and sanitation as well as basic education.[16] Also, UNICEF, under their collaboration programme, provided support for the State School of Health Technology (SHT). The reason for the establishment of the SHT by the Benue State Government was to train appropriate human resources for the PHC services at the LGAs. The school received a visitation/accreditation team from the FMOH and NPHCDA in 1994 and the report of the team was favourable. [17]

At the SHC level the Benue State Government catered for its people through the provision of curative care in eight general hospitals, which were run by the Benue State Health Management Board (HMB) on behalf of the State MOH. The hospitals have between 60 – 200 beds and take referrals from the PHC level. [18] Services at this level were poor. The reasons are not far to seek. The health services of Benue State suffered over the years as a result of the progressive decline in government funding coupled with lack of accountability under successive military regimes. [19] It was with the return of democratic governance that the State began to experience some modest reforms in the health sector. It was not, however, because the new administration was human-development conscious, neither was it for its love for the people, but it is our belief that they hope to come another time to ask for the people's votes. The fact is that there is a general apathy of developing nations to human capital investment and human development generally. We have already discussed this situation in chapter three.

With the establishment of the Federal Medical Centre in Makurdi, a tertiary health institution; and with the complementary services offered by Christian Missions Health Institutions and private initiatives, the people of the State have continued to have minimal access to health care.

As we come to the end on this section it is imperative to state that although the efforts of the State Government in the provision of health services to its people were rather modest, they were nonetheless steady and progressive with gradual increment in the number of facilities. For instance, Tables 7 to 9 on pages 199 to 201 show the number of health establishments in Benue State by LGAs in 1996, 1998 and 1999. [20] The figures for 1997 and 1998 were the same. The Benue State Statistical Year Book 1996-1999, from where these figures were taken has not been updated since 1999.

5.2 PROJECT CONCEPTION

In November 2000 Clare Short, Britain's Secretary of State for International Development stated that the Government's efforts towards the provision of better health for poor people were aimed at achieving key targets for international development. She said:

TABLE 7

NUMBER OF HEALTH ESTABLISHMENTS BY LOCAL GOVERNMENT AREA: 1996

LGA	FED. MED. CENTRE.	GEN. HOSP.	MAERNTY HOSPITAL	MATERNITY HOME	NEURO PSYCHIATRIC HOSPITAL	MEDICAL HEALTH CENTRE	LEPROS-ARIUM	OTHERS	TOTAL
Ado…………….		-	-	-	-	-	-	1	1
Agatu…………..		-	-	-	-	-	-	-	-
Apa…………….		-	-	-	-	-	-	1	1
Buruku…………		-	1	-	-	7	-	1	9
Gboko………….		1	4	1	-	7	1	25	39
Guma…………..		-	-	-	-	-	-	1	1
Gwer…………..		1	-	-	-	-	-	1	2
Gwer-West…….		-	-	-	-	3	-	3	6
Katsina-Ala…….		1	1	-	-	2	-	16	20
Konshisha………		-	-	-	-	4	-	8	12
Kwande ……….		1	3	-	-	5	-	9	18
Logo…………….		-	-	-	-	-	-	-	-
Makurdi ……..	1	-	5	-	1	-	-	31	38
Obi……………		-	-	-	-	-	-	-	-
Ogbadibo ……	-	-	-	-	-	-	-	7	7
Ohimini ……	-	-	-	-	-	-	-	-	-
Oju………….	-	1	1	-	-	-	-	9	11
Okpokwu ……	-	1	3	-	-	-	-	4	8
Otukpo………	-	1	2	1	-	-	-	7	11
Tarka………..	-	-	-	-	-	-	-	-	-
Ukum……….	-	-	4	-	-	2	-	6	12
Ushongo ……	-	-	-	-	-	3	-	4	7
Vandeikya …..	-	1	1	-	-	-	-	2	4
Total………	1	8	25	2	1	33	1	136	207

Source: 1. Federal Medical Centre, Makurdi

2. Ministry of Health, Makurdi.

TABLE 8

NUMBER OF HEALTH ESTABLISHMENTS BY LOCAL GOVERNMENT AREA: 1997

LGA	FED. MED. CENTRE	GEN. HOSP.	MATERNITY HOSPITAL	MATERNITY HOME	NEURO PSYCHIATRIC HOSPITAL	MEDICAL HEALTH CENTRE	LEPROS-ARIUM	OTHERS	TOTAL
Ado…………….	-	-	-	-	-	13	-	3	16
Agatu…………..	-	-	-	-	-	24	-	-	24
Apa…………….	-	-	-	-	-	31	-	5	36
Buruku…………	-	-	1	-	-	20	-	71	92
Gboko………….	-	1	4	1	-	33	1	124	164
Guma…………..	-	-	-	-	-	48	-	14	62
Gwer…………..	-	1	-	-	-	22	-	20	43
Gwer-West…….	-	-	-	-	-	27	-	10	37
Katsina-Ala…….	-	1	1	-	-	19	-	24	45
Konshisha………	-	-	-	-	-	46	-	34	80
Kwande ……….	-	1	3	-	-	5	-	9	18
Logo…………….	-	-	-	-	-	17	-	37	54
Makurdi ……..	1	-	5	-	1	36	-	52	95
Obi……………	-	-	-	-	-	16	-	14	30
Ogbadibo ……	-	-	-	-	-	35	-	14	49
Ohimini ……	-	-	-	-	-	14	-	5	19
Oju………….	-	1	1	-	-	-	-	9	11
Okpokwu ……	-	1	3	-	-	12	-	11	27
Otukpo………	-	1	2	1	-	32	-	26	62
Tarka………..	-	-	-	-	-	8	-	19	27
Ukum……….	-	-	4	-	-	2	-	6	12
Ushongo ……	-	-	-	-	-	26	-	44	70
Vandeikya …..	-	1	1	-	-	-	-	2	4
Total………	1	8	25	2	1	486	1	553	1,077

Source: 1. Federal Medical Centre, Makurdi

2. Ministry of Health, Makurdi.

TABLE 9

NUMBER OF HEALTH ESTABLISHMENTS BY LOCAL GOVERNMENT AREA: 1999

LGA	FED MED CENTRE	GEN HOSP-ITAL	MATERNITY HOSPITAL	MATERNITY HOME	NEURO PSYCHIATRIC HOSPITAL	MEDICAL HEALTH CENTRE	LEPROS-ARIUM	OTHERS	TOTAL
Ado…………….	-	-	-	-	-	30	-	4	34
Agatu…………..	-	-	2	-	-	18	-	7	27
Apa…………….	-	-	-	-	-	30	-	8	38
Buruku…………	-	-	-	-	-	35	-	15	50
Gboko………….	-	1	1	-	-	89	1	68	160
Guma…………..	-	-	-	-	-	52	-	12	64
Gwer…………..	-	1	-	-	-	30	-	11	42
Gwer-West…….	-	-	-	-	-	34	-	5	39
Katsina-Ala…….	-	1	-	-	-	51	-	15	67
Konshisha………	-	-	-	-	-	44	-	16	60
Kwande ……….	-	1	-	-	-	65	-	34	100
Logo…………….	-	-	-	-	-	23	-	11	34
Makurdi ……..	1	-	-	-	1	39	-	46	87
Obi……………		-	-	-	-	5	-	14	19
Ogbadibo ……	-	-	-	-	-	46	-	6	52
Ohimini ……	-	-	-	-	-	12	-	4	16
Oju………….	-	1	-	-	-	14	-	19	34
Okpokwu ……	-	1	-	2	-	15	-	37	55
Otukpo……….	-	1	1	5	-	34	-	31	72
Tarka…… …..	-	-	-	1	-	17	-	3	21
Ukum……….	-	-	-	3	-	42	-	37	82
Ushongo ……	-	-	-	1	-	39	-	27	67
Vandeikya …..	-	1	-	11	-	38	-	24	74
Total………	1	8	4	23	1	802	1	454	1,294

Source: 1. Federal Medical Centre, Makurdi

2. Ministry of Health, Makurdi.

> These International Development Targets have been agreed by the entire United Nations membership, following a series of summit meetings held by the UN and its specialized agencies over the past ten years or so.[21]

Some of these international development targets and consultations referred to by Short were highlighted in chapters one and three. However, some examples of such international summits include the WHO summit of 1978 that produced the Alma Ata Declaration and other subsequent WHO summits, the 1992 Rio de Janeiro World Summit that produced Agenda 21, the International Conference on Population and Development in Cairo in 1994, to mention only a few.

In an ODA publication of 1994, which was referred to in chapter one, the British Government emphasized that good health was at the heart of development, and outlined its health programmes which included managing health care services, controlling communicable diseases such as HIV/AIDS, T.B. etc; and providing health services during emergencies. Nigeria was mentioned in this package as one of the countries the British Government was working closely with. Other countries include Cambodia, Ghana, Peru, South Africa, Tanzania, etc.[22] But before this time, Britain had identified health and population as one of the priority sectors for British aid in Nigeria. To achieve this, ODA concentrated its health assistance in areas of health care management, reproductive health and communicable disease control. This fitted well into ODA's Nigeria health sector objectives, which were outlined in a publication titled Nigeria: Country Aid Programme Statement (1995).[23] Benue State was selected to be one of the foci of British aid since it is very poor and was relatively under-aided.[24]

In 1991 and 1992 an ODA mission to Nigeria and Benue State reported the deplorable health conditions in the State and set out the basis and conditions for British

support, proposing a project that will improve the quality, management and financing of health services using the B1 approach at the PHC level and also rehabilitating some general hospitals at the SHC level.[25] The project proposals went through series of designs and redesigns which eventually produced a document which reflected current EU aid policy on Nigeria which required that no funds were to be directed to Federal or State Governments. The ODA was to provide up to £4.03 million from Nigeria country funds over a period of three years beginning from April 1996 to March 1999. [26] (The first phase of the project, however, actually took off in January 1997 and ended in 1999 while a 27-month extension of the project started from January 2000 and ended in March 2002). The implication of this was that the BHF project was going to be executed directly by the DFID without funds being channeled through the Local or State Governments. The project was to also support ODA's health sector aid strategy in Nigeria, address the difficulties and needs of the poorest and most vulnerable, and complement existing ODA supported projects such as the STD/HIV project in Otukpo, among other things.

The BHF project had two logical frameworks – the initial one drawn at the beginning of the project and the one for the project extension (see project document titled Nigeria Benue Health Fund West and North Africa Department of the ODA March 1996 and Benue Health Fund Project Extension West and North Africa Department of the DFID October 1999.). The project's goal as stated in the log frames was the protection of the health status of the population of Benue State, especially the poor and vulnerable groups, people living in absolute or relative poverty. The purpose of the project, as captured by the log frames was to improve coverage, utilization of basic health services in four (later increased to seven) LGAs and develop a blueprint for improving health services in other LGAs.[27] Although some of the items covered in the log frames could be captured from the documents, the

major aspects of the issues contained in the documents are fully discussed in subsequent sections of this chapter. For instance, the sections on project implementation and OPR will take adequate care of these.

5.3 PROJECT IMPLEMENTATION

The BHF project supported both communities/PHC and SHC in the seven focal LGAs. Therefore, the activities of this project, as contained in the log frames, were carried out at the two levels (PHC and SHC) simultaneously. For the sake of clarity and convenience, we shall consider the implementation at the communities/PHC level first and then at the SHC level.

The BHF project implemented its support to communities and PHC at the LGA level under four broad activities. First was community participation. Under this activity the BHF supported three institutional structures for health namely, the Primary Health Care Management Committees (PHCMCs), the Village Development Committees (VDCs) and the Community Resource Persons (CRPs) in health. Secondly, the BHF embarked on quality of care which involved rehabilitation of facilities at PHC level, capacity building for improvement in quality of care (QoC) in PHC and the drug revolving fund (DRF) scheme. The BHF project also embarked upon measures to provide physical and finacial access to health care by constructing community roads and culverts, facilitated community deferred payment and exemption scheme, and also facilitated community micro-enterprise for health. Fourthly, and finally, the BHF project embarked on capacity building for CBOs.

5.3.1 Community Participation

The first and major step in the implementation process of the BHF project was the constitution of the Project Advisory Committee (PAC) which comprised of about 17 stakeholders. PAC met four to six times a year and was a policy and planning guide for the project. It approved proposals for expenditure of funds for the project. [27] Membership of PAC was made up of the Chief Executives of the Project hospitals, representatives from the State MOH, State Health Management Board (HMB), Roman Catholic Health Secretariat, the NKST Mission Health Secretariat, the Project Manager and at least one woman representative. Three persons (one representative from the public health sector, one from the mission health sector and the Project Manager) were signatories to the Fund. PAC invited and assessed applications for project activities in the focal LGAs. [28]

The second step in the project implementation was the setting up of PHC Management Committees (PHCMCs) at the LGA levels. The PHCMCs comprised of between 13 to 20 persons each, representing communities, health-related and traditional institutions and were responsible for PHC policy formulation and implementation. They co-ordinated technical and financial support to PHC and ensured inter-sectoral collaboration/participation of service users for the effective implementation and monitoring of PHC programmes in the LGAs. Although the practice of using PHCMCs at the LGAs was started by the Federal Government as part of the B1 in the 1980s the system failed in Benue State because it was hijacked by the LGC Chairmen, with their supervisory councilors for health, HODs for Health and treasurers. In the new dispensation BHF-assisted LGAs, together with the MOH, reviewed the selection criteria and the formation of the PHCMCs. This time, the LGAs together with Community-Based Organizations (CBOs)

identified, nominated and selected their PHCMC members. [29] The PHCMC composition was as follows:

i) Supervisory Councillor for Health (was the Chairman)

ii) PHC Co-ordinator

iii) Deputy PHC Co-ordinator

iv) Community Development Officer (CDO)

v) State Technical Support Person (from the MOH)

vi) Traditional ruler

vii) Medical Officer in charge

viii) Representative of LGA Health Unit

ix) Representative of Local Women's Organization

x) Representative of Community Development Organization

xi) Representative of Religious Bodies

xii) Representative of Private Sector

xiii) Heads of Health related Departments.

Before the selection, communities and organizations were sensitized on the need to select members who would adequately represent them. After their selection the PHCMCs were officially inaugurated by the LGC Chairmen, thus authenticating and recognizing their formation and functions. Thereafter, the BHF organized and conducted training workshops for 84 PHCMC members. The workshops were in four phases. Phase I was on terms of reference (TORs) and operational guidelines and Drug Revolving Fund (DRF) operations and procedures. It was conducted in1997. Phase II was on DRF financial management and was also conducted in 1997. Phase III workshop was on community integration and planning for PHC. It was also conducted in 1997 while Phase IV workshop was conducted

in 1998 and was centred on planning and financial management, budgeting skills, and development of action plan. [30]

A PHCMC monitoring mechanism was put in place by the BHF. In this system, the Exco of the PHCMC sent quarterly reports on all activities of the period and a work plan for the following quarter indicating the budget required to the BHF. Also, minutes of meetings containing records of decisions taken were checked by the BHF. In addition, BHF attended quarterly supervisory meetings at the LGA level. [31]

Moving from the LGA level (PHCMCs) to the village/community level, the BHF facilitated the establishment of a functional representational Village Development Committees (VDCs) as another important step in the project implementation agenda. Actually, the VDCs were committees of community-nominated and elected representatives with responsibility for the management of PHC services and activities in their communities, as proposed by the NPHCDA based on the B1 guidelines. [32] As a matter of fact, the VDCs were established in Benue State in 1993/94 in some selected LGAs but were inherited and restructured by the BHF in 1997. The BHF project, apart from facilitating the selection and election of VDC members, funded their training, trained PHCMCs to undertake supervision of VDCs and community outreach activities, provided transport and funding for LGA supervision and also established Drug Revolving Funds (DRFs) managed by the VDCs. [33]

The VDCs were composed of:

i) The Primary and/or Secondary School Principal and/or Head teacher

ii) Representatives of religious groups

iii) Representatives of Women groups

iv) Representatives of age groups, youth association

v) Representatives of occupational and professional groups

vi) Representatives of NGOs

vii) Representative of staff of the PHC Clinic

viii) Respected person appointed by the Committee as the Chairman

ix) Any other community member as deemed fit for membership.

The selection of VDCs and their preparation for DRF and exemption schemes were preceded by ‘night halts’. Actually, ‘night halts’ were evenings of drama and dance organized by the BHF project for communities to sensitize them and create awareness on the roles and responsibilities of VDCs, their selection criteria, managemet of DRF, and so on. During implementation, each community was trained in the management of essential drugs in a series of participatory DRF Health Facility Training Workshops. Also, PHC supervisors were trained in DRF procedures and supervisory skills. The BHF project provided vehicles for the focal LGA PHC Departments to enable them carry out regular supervision of PHC Clinics VDCs were monitored monthly. During the monitoring visits projects undertaken by the VDCs were reviewed and the DRF records were scrutinized. [35]

The roles of the VDCs included the following:

i) Plan, implement and supervise the health and welfare of the community including the prevention of STDs, HIV/AIDS.

ii) Set achievable local health goals.

iii) Identify available human and material resources within the community for health services.

iv) Monitor and evaluate the impact of services on the health status of the community including STDs, HIV/AIDS prevention.

v) Supervise the activities of the village health worker (VHW), traditional birth attendants, (TBAs) and community health worker (CHW) where they exist.

vi) Establish a village health post.

vii) Liaise with other government officials living in the village to provide necessary support to the VHW.

viii) Forward Clinic health plan to district level. [36]

The VDCs operated within the framework of guidelines stipulated by the BHF. They were to meet once monthly, record minutes of all meetings and ensure that minutes of meetings were signed by the Chairman and Secretary, after adoption, at the next meeting. Also, the VDCs were to agree on the number of members that could form a quorum at meeting, authorize the treasurer to record and keep monies and disburse same only after approval by the Committee. Where VDCs operated a Bank account, signatories would be the Chairman, Treasurer and Secretary.

The VDCs were to the BHF project what the WASCOMs were to the Oju and Obi WAS project. The formation of the VDCs, just like the WASCOMs was a social strategy that was to enhance community participation in health projects. The DFID's experience in Nigeria has proved that community participation in projects helps to fulfill the needs of poorer people, improve quality and reduce costs. [37] It was also with this in view that the BHF project created the role of Community Resource Persons (CRPs) in health, in the first phase, to complement and strengthen the role of the VDCs. On the surface, it looked like CRPs were a duplication of VDCs but looking at it closely the CRPs had a special role to play in the project. They were made up of four individuals from each of the focal communities representing younger and older women and men, nominated by their peers and trained to support CBOs in developing, implementing and monitoring community projects thus, addressing their health priorities. The CRPs existed in 33 focal communities in seven LGAs. The communities were selected on the basis of geo-political concerns, evidence of

community interests in health and the existence of a functioning PHC Clinic. Whereas the VDCs members were not necessarily literate, the CRPs were selected from among the basically literate members of a community. This was necessary because BHF needed people who could be trained in the use of PRA tools in facilitating the identification and prioritization of health problems, project proposal writing, etc. [38]

5.3.2 Quality of Care

With institutional structures put in place, the BHF Project took another step by facilitating quality of care (QoC) in PHC Clinics. In its QoC programme the BHF project embarked, first, on rehabilitation of PHC facilities in the seven focal LGAs. Remedial work on buildings and water supply was carried out in order to provide a conducive environment for the delivery of basic PHC at the grassroots level. This was necessary because these facilities had not been renovated for as much as twenty years and were in dilapidated state, thereby discouraging their utilization by the communities.[39] The procedure for rehabilitation was straightforward. The VDCs indicated to the PHCMCs if the Clinics in their communities required renovations. After consultations with the VDCs, the PHCMCs made a list of Clinics, in order of priority, in the LGAs and the list was then forwarded to the BHF. The BHF presented the list to the PAC for approval. Once this was done the BHF recruited contractors for assessment of the work and bills of quantity. Thereafter a cheque covering the cost of the renovation for the first phase was issued by BHF to the VDCs, in the presence of community members, PHCMC members and the officers in charge of the Clinics. It was the responsibility of the communities to provide unskilled labour for all renovation work, it was the duty of BHF or its focal person to supervise renovation work from the beginning to the end. During supervision visits the BHF examined the accounts

ledgers, reviewed the work done against the expenditure, and held post-review discussions with the VDCs, officers in charge (OICs) and members of the community. The release of funds for the next phase depended on satisfactory performance of the first phase of work.

As at February 2002 the BHF rehabilitated 114 out of 160 (71.3%) targeted Local Government Clinics in the focal LGAs and two out of five (40%) NKST PHC Clinics. Some Clinics, according to the BHF, were not rehabilitated because they were either on temporary sites or too dilapidated that both the BHF, the LGA and the community were not prepared to bear the cost.[40]

In 1999 and 2000 some basic equipment such as forceps, thermometers, stethoscopes, sted receivers, stoves, etc, were presented to 147 out of 160 (92%) Clinics assisted by the BHF in the seven LGAs while 16 Clinics had their wells rehabilitated. Also, 11 Clinics had their boreholes rehabilitated and 17 had rainwater harvesters installed. Additionally, 11 Clinics had medical waste management systems (incinerators) built while 8 had VIP latrines built.[41]

The second issue in BHF project's QoC programme was capacity building for improvement in QoC in PHC. Essentially this involved the provision of Clinical training and the production of standing orders and protocols for nurses and community health workers at PHC Clinics. This was to help in the improvement of diagnosis and treatment for priority health problems, such as malaria, STDs, childhood diseases and antenatal care following best practice models. This issue became critical because in the 1997 baseline survey for the BHF project which we made reference to in chapter three, QoC in Benue's PHC Clinics was found to be very poor. It was therefore recommended that the QoC be considered as one of the project's priorities.[42]

Consequently, the BHF project organized a five day training of trainers (TOT) course for thirty participants from the State MOH, Schools of Nursing, Midwifery and Health Technology. The participants at the ToT in turn trained staff from the health departments of the focal LGAs and Clinics. After the training events, 156 out of 160 Clinics whose staff participated were provided with protocols and basic equipment such as dressing forceps, gallipots, stainless steel receivers, thermometers, stoves, cash boxes calculators, scissors, circumcision forceps, etc. [43]

The QoC was monitored in PHC Clinics by LGAs' health department staff monthly and the report was sent to BHF for data collation and analysis, after which the results were sent back on monthly basis to the LGAs who were expected to send feedback to the Clinics. This was to enable the Clinics assess themselves on QoC. According to the BHF, the QoC at the PHC level recorded some measure of success. For instance the project, apart from building the capacity of health workers in the LGA PHCs, brought about an increase in the number of people who attended the Clinics from an average of five per day in 1997 to 15 per day in 2000. In addition, the provision of basic equipment and protocols enabled treatment at the PHC to conform to acceptable standards. Furthermore, when patient satisfaction was measured it was discovered that 90.8% patients waited for less than 30 minutes before receiving treatment; 57.6% patients said the staff attitude was very good while 41% described them as good. Generally, 67.1% clients said they were very satisfied with services in the Clinics while 30.2% were satisfied. [44]

Another step in the BHF's QoC agenda was the facilitation of the DRF in PHC. In this system the BHF provided a 'seed stock' of drugs in the focal LGA Clinics under the management of the PHCMCs and VDCs to permit accumulation of funds for self-reliance to ensure sustained purchase of drugs for the PHC Clinics. This was to ensure that quality

essential drugs were available and affordable at the Clinics for the rural populace, in fulfillment of the WHO concept of the B1. The DRF scheme of the BHF became imperative because, according to the project, the baseline survey of 1997 indicated that drugs were often not available in Benue PHC Clinics. Even when available they were rather too expensive for the rural poor.[45]

Therefore, the project trained PHCMCs and VDCs of the focal LGAs for a period of five days. The trainings covered areas such as quantification, financial control and accounting procedures, pricing, reordering, general drug management and Clinic DRF supervision. Moreover, the project-trained auditors of the LGAs and OICs of the Clinics, in a five-day workshop, in DRF concepts, accounting, record keeping, and general QoC. It took the project six months to set up the DRFs in 153 Clinics. This involved opening all the record books such as stores ledger, cashbook, bank book and the initial stock and fund valuation. It also involved the distribution of DRF procedure manuals, forms and other record books such as treatment register, store ledger, prescription forms, etc. Apart from these, the project provided a 4-wheel drive jeep to every focal LGA for supervision of PHC activities.[46]

Intensive monitoring was carried out after the DRFs were set up to ensure that the procedures were being followed. Local accountants and GRID, a financial consulting firm, were engaged by the BHF to assist in monitoring and assisting the DRF operators to follow the procedures. The State MOH’s Technical Support Persons team also supervised the DRF at the LGAs on quarterly basis.

5.3.3 Access to HealthCare

The next step the project took was to assist the poor and vulnerable in the focal LGAs gain physical access to healthcare facilities. In this regard the BHF supported small, community-initiated road improvement and culvert construction project. This was in view of the fact that many communities in Benue State are rural and isolated especially during the rainy seasons. Since bad roads hinder access to health facilities and services, better access roads would contribute, not only to access to health services, but also improve access to markets, and consequently improve the income of the people, especially women.

Therefore, communities through their PHCMCs and VDCs, in the LGAs that requested for this assistance submitted project proposals, contributed the stipulated quota of finances for the project, contributed unskilled labour and locally available materials such as bamboos, gravel, sand, water, etc, for the work. It was also part of their contribution to supervise the projects and maintain them when completed. The LGAs whose communities requested for the rehabilitation of their roads and culverts were also expected to contribute to the cost. But, according to the BHF project, only two LGAs out of the 11 that benefited from the projects made such contributions. Katsina-Ala LGA contributed N100,000 for a N1.7 million project while Logo LGA contributed N1.35 million for a N5.1 million project.[47] The BHF project recruited local contractors, through the competitive bidding process and a consultant contractor to handle the jobs. The project also got the DFID Engineering Advisor to provide crucial technical guidance at the planning stages of the construction work. The BHF put a ceiling cost of N3.5 million per construction project. In other words, the project avoided major road works and major bridges but concentrated rather on improvement of key access points. For instance, the BHF project claimed that the ceiling for road projects (including culverts) ranged from N1.7 million to N5.1 million at each

community. Out of this amount each community contributed monies ranging from N150, 000 to N408, 364.[48]

To ensure that quality work was achieved the consultant contractor monitored the construction activities on the sites closely for BHF project. It was the duty of the relevant LGA organs to ensure community awareness of project progress, raise mobilization for labour and resolve disputes that could hinder work progress. To be sure that quality work was carried out, a 5% retainer was deducted from the contractors' fees and withheld for six months, pending satisfactory outcome of inspection of work by an independent engineering consultant. If at the end of six months it was discovered that the work was defective, the 5% retainer sum was used to rectify the fault. This check kept local contractors on their toes and urged them to do quality jobs.

According to the BHF project, the improvement of access roads for 11 communities with a total population of 153,000 (1/3 of the population of the seven focal LGAs) had enhanced access of PHC Clinics by making them accessible all year round. The BHF project could not, however, quantify the proportion of this increased Clinic utilization. Additionally, improved access roads provided important links to markets, thus providing the potential for economic empowerment of the communities. For instance, the road from Tyemimongo linked the popular Tsar market in Vandeikya LGA, while the Amaafu to Tyogbenda Udende provided access to the yam market of Tyogbenda Udende and Ugba in Katsina-Ala and Logo LGAs respectively.

Furthermore, as part of the BHF programme of access to healthcare, the project introduced the deferred payment and exemption scheme, often referred to as the D & E scheme. The scheme was meant to enhance financial access to PHC by poor and vulnerable members of the community in line with the B1 recommendations that the D & E be a

component of the PHC DRF. Usually, the deferral fund enables access to healthcare by those who could not pay immediately, due, sometimes, to the seasonality of their income, but should pay later. The exemption fund enables access to healthcare by the very poor (disabled and socially isolated) who are not able to pay at all. The two funds are usually managed and sustained by the community. [49]

The BHF tried the D & E scheme in 100 Clinics in the seven target LGAs but the system did not work well. Therefore, it carried out an operational research covering six communities in both the Tiv – speaking and Idoma – speaking areas. [50] The report of the research team headed by William Anyebe [51] identified factors, which were inhibiting the D & E mechanism and developed a strategy for implementing a pilot. Other members of the research team included Graham Gass, Oko Igado, Krista Maxwell and Samuel Unom. The research also helped in the springing up of D & E Management Committees (ManComs), through community feedback visits. One other interesting aspects of this research was the compilation of exempted persons by the communities themselves, following the criteria set out for eligibility for exemptions.

The BHF project also developed financial operating procedures for the scheme as well as conducting training for ManComs, VDCs community representatives, PHC Clinic staff and LGA PHC supervisors to effectively manage the scheme. Additionally, the BHF provided matching grants of N20,000 each to four of the six pilot communities, as soon as the Communities raised N10,000 per account. Two communities each received N10,000. Separate bank accounts were opened for the D & E funds.

The D & E scheme recorded quite some initial successes as ten communities effectively operated the scheme. For instance, Ukazo in Gboko LGA, Otukpo-Nobi and Opa-Adoka in Otukpo LGA and Ayilamo in Logo LGA did well. However, the BHF project

lamented the non-repayment by some deferred cases. The project also noticed that there were no plans by the communities to fund the scheme on a long-term basis. It was only in Opa-Adoka that the scheme worked effectively. For instance it was reported by the project that in the last two quarters of 1999, 77 people used the scheme while during the first quarter of 2001, 34 people used the scheme. [52] This 'feat' was attributed to the fact that the traditional ruler provided support to community mobilization.

The D & E scheme was monitored by a team of BHF and LGA staff with support from GRID consultants. Initially, monthly supervision visits were undertaken by the teams but later quarterly monitoring visits were carried out. Specific aspects of the visits included meetings with ManComs and VDCs to reflect on the progress of the scheme, checking of record books in possession of ManComs and Clinic staff, visits to some beneficiaries of the scheme especially those on exemption list and sometimes meetings with the larger communities to discuss issues such as long-term funding and the creation of awareness. The monitoring teams also met with the LGA M & E and community development officers and accountants to discuss essential drugs for the D & E scheme.[53]

Another step in the series of activities by the BHF project to ensure access to health care was to facilitate the establishment of micro-enterprise for Health, a socio-economic strategy whereby small-scale income generating businesses were established by the poor and vulnerable groups, especially widows, to enhance their ability to meet their health needs. This was to help reduce financial barriers in access to health care and raise money for the poor to improve their nutrition, increase availability of food through local food processing and also generate income for D & E schemes. [54]

Therefore, the CRPs prepared project applications for the benefiting communities. The CBOs and communities initiated the projects, raised counterpart funding of 15% project

cost, provided land for machine housing and constructed the housing. Thereafter, the BHF project provided 85% of machine costs, provided materials for the housing, designed the structures and supervised the construction process. Local NGOs with expertise in Micro-Enterprise for Health (MEH) were contracted to provide training for LGA staff to enable them support community groups in the implementation and monitoring of MEH projects. Local architects were contracted to design and construct machine houses while local suppliers provided and installed grinding engines and other relevant equipment and also trained machine operators. Machine costs ranged from N73, 000 (mobile gari processor) to N301,151 (rice milling) while machine housing ranged from N45,550 (corn grinder) to N16,660 (fixed gari processor). However, in some communities existing structures were provided at no cost. [55] After this efforts, series of training events were carried out for CBOs, local NGOs and LGAs, M & E officers covering topics such as team building, micro-enterprise, environmental sanitation and waste management, gender, participatory M & E, marketing, financial management, and so on.

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

i) Number of women who were able to have access to quality health care as a direct benefit from the MEH project.

ii) Average increase in income per household benefiting from the project.

iii) Value of financial contribution made to the community's D&E scheme by the project.

iv) Rate of Clinic utilization by members of the target group, the very poor and vulnerable, especially the widows.

v) Proper financial records kept by the MEH group. [56]

In all, 21 MEH schemes were established in 16 communities in six of the focal LGAs in Benue State, supporting the income generating capacity of about 1,120 members of the CBOs and their families (about 5,500 people in all) at a cost of over N8 m to BHF and over N.5m to the communities (excluding value of land and labour which was provided free).[57] According to the BHF project, five of the l6 communities supported D & E schemes. Also, the BHF believed that involvement of CBOs in MEH projects had empowered women especially widows and enhanced participation by women in community activities.

5.3.4 Civil Society

Another step of the major efforts of the BHF project at the grassroots level was the intervention in the area of Civil Society. In this regard the project embarked upon capacity building of rural CBOs to enable them participate more actively in the planning and management of their health services and to assist them demand and advocate to government for their community health interests. In other words, rural community CBOs were strengthened to a point that they could form pressure groups to demand for their health rights from the government for improved quality, accessibility, utilization and accountability. In this approach CBOs were strengthened to represent the interests of all social groups in the communities, including women, the unmarried and the very poor and marginalized who were hitherto unrepresented in traditional community leadership. [58] This approach was also informed by the fact that the BHF project encountered substantial difficulties in implementing community projects, especially roads and culvert constructions and also in the establishment of MEH projects due to lack of well equipped staff to

supervise them. Building of CBOs, it was hoped, will provide this needed human resource.[59]

To achieve this, the BHF worked with Organizational Development Consultants who, through rapid participatory assessment of the many CBOs in rural Benue, informed the selection process based on laid-down criteria. The CBOs that met the selection criteria were trained by NGOs, staff of the LGAs, BHF project personnel and State MOH. These trainers had been previously trained in a ToT workshop by Christian Rural and Urban Development Association of Nigeria (CRUDAN), BHF and Centre for International Development and Training (CIDT) University of Wolverhampton, UK. CRUDAN and CIDT were contracted by the project to carry out the trainings. CBOs training modules included:

i) Group Development and Management

ii) Leadership

iii) Record Keeping and Fund Raising

iv) Health Rights and Advocacy Skills

In view of the fact that the last two modules were a bit complex, only literate member of the CBOs were encouraged to participate in them. But in all, both literate and non-literate CBO members participated in the training events. This was made possible because proceedings were translated in both Idoma and Tiv languages. The BHF insisted that female participation in the training was not compromised.[60]

The BHF's civil society agenda was executed with a considerable measure of success with 42 CBO projects implemented in the seven focal LGAs. Thirty Benue-based staff were trained as trainers for CBOs to ensure continuity and sustainability of the BHF project's efforts. The total cost of capacity building for CBOs was put at over N10 m.[61]

As stated earlier, the BHF project's intervention in the strengthening of CBOs in Benue State brought to an end the project's major input at the community and PHC level. From now on our attention will focus on inputs at the SHC level. It is our intention that the accounts on this segment should follow the accounts on communities/PHC as a continuum.

The project's efforts at the SHC level were categorized under five broad divisions:

i) Rehabilitation at SHC level

ii) Financial Management

iii) DRF at SHC level

iv) Deferral Scheme at SHC Level

v) QoC at SHC Level

vi) Strategic Health Planninbg Process.

5.3.5 Rehabilitation at SHC Level

The emphasis of the BHF project with regards to this aspect of its support was remedial work on water, electricity and buildings at hospitals with particular focus on theatres, outpatient departments, maternity ward, and the repair or provision of basic equipments. This was in order to provide safe and conducive environment for health care delivery at the secondary level, considering the fact that Benue State hospitals' infrastructure and basic equipment were in a State of disrepair for over 20 years.[62] This discouraged utilization of services by the poor and vulnerable who would have naturally patronized them in view of the high cost of health care services in private facilities.

To implement this aspect of the support, the BHF project provided funding and technical support through consultant contractors to handle the various aspects of renovations and rehabilitation activities at the target hospitals. During the first phase of the project,

hospitals developed their bills of quantities for which tenders were made and the top three contractors were presented to PAC. When PAC's approval was given funds were released to hospitals who managed the local contractors while BHF supervised the process. However, during the extension phase, both hospital managements and the local contractors first discussed and agreed on the bills of quantities before submitting to PAC for approval. This became necessary in order to avoid frequent requests by local contractors for contract reviews.

The project released funds in two or three installments. Each installment was released depending on the extent of work done and on the advise of consultant contractors supervising the work. In addition to the renovation work in the hospitals, the BHF project opened maintenance workshops to underscore the importance of hospitals allocating funds for regular maintenance of buildings, medical equipment and vehicles provided, to ensure viability and to protect their capital assets. [63]

The project claimed that extensive renovation work was carried out in six general hospitals and three mission ones. Also, functional water supply systems and power supply was provided for the hospitals except at the General Hospital Kastsina-Ala where attempts to sink boreholes failed due to the nature of the hydrogeology there. According to the BHF, 95% of priority equipment necessary for providing basic secondary care services, judging by an agreed local standard equipment list, was provided for the assisted hospitals.[64] Although there does not exist adequate data to prove that the increased attendance at the assisted hospitals after the renovations and provision of drugs and equipment was due to these efforts alone, it must be stated that these contributed in no small measure to the quality of care in the hospitals.

5.3.6 Financial Management at SHC Level

The BHF project, as another important component of its assistance to SHC hospitals, embarked upon the upgrading of the financial management system at the assisted hospitals and built local capacity to operate them. The BHF project felt this was necessary because the effective management and utilization of hospital resources required availability and use of accurate financial information. As a matter of fact there was need for sound financial management system in Benue hospitals, especially as the communities were involved in their day-to-day running. There was need for them to demonstrate transparency and accountability and manage a sustainable DRF and a deferral system.

To accomplish this task of upgrading the financial management system, the BHF project contracted GRID Finance Consultants who provided financial management skills, built capacity in the nine hospitals, namely, the general hospitals at Oju, Gboko, Otukpo, Katsina-Ala, Adikpo and Okpoga, and the NKST hospitals at Mbaakon and Anyiin, and the St Vincent's (Catholic) hospital at Aliade and monitored them for a period of about 12 months. Subsequently, the BHF project continued with the monitoring. The HMB provided the necessary political support and also sent its finance and auditing staff who were closely involved in all aspects of the process. Finance staffs, management staff and other key persons in the nine hospitals and the HMB were trained in various financial management aspects such as principles of double entry book-keeping and file ledger accounting, opening and writing up the books of account, and so on. The BHF project also supplied operational books to the hospitals and developed hospital accounting manual, HMB Accounting Manual, Budgeting Manual and computerization.[65]

The BHF project claimed that the financial management system was fully operational in the assisted hospitals and at the HMB. At least one or two staff in each of the

hospitals were trained to operate the system. The BHF project hoped that the technical knowledge would be spread so that the hospitals could continue to effectively run the system should those trained leave. It also hoped that the HMB would continue with capacity building and monitoring after the project was closed.

5.3.7 Drug Revolving Fund at SHC Level

Moreover, as part of BHF's support to selected SHC facilities in Benue State, the Project reinvigorated the DRF schemes by providing seed stock of drugs and establishing strict management systems to permit accumulation of funds so that hospitals could become self-reliant in purchasing drugs and medical consumables. This was to ensure that high quality drugs and medical consumables were always available at affordable prices at both public and mission hospitals, in line with the international concept for improved drug management system for the benefit of the majority of the people. Unfortunately, before the BHF intervention, there were severe drug shortages in all hospitals in Benue State and the DRFs were ineffective.[66]

Therefore, in order to revive and strengthen the DRFs, the BHF project negotiated a charter with the State MOH for public hospitals to have more autonomy in the management of their finances in line with the HMB Edict No.8 of 1994.[67] (Essentialy, a charter is a written statement of right to a lower body by a superior body delegating to the former powers to carry out functions on behalf of the latter). Other aspects of the charter included autonomy in human resource management, management of infrastructure and equipment, involvement of host communities in the running of hospitals, the composition of the Hospitals Management Committees (HMCs), etc. On the HMCs, specifically, the hospitals

were required to select, based on agreed criteria, nine members, charged with the responsibility of running a hospital, as follows:

i) Two representatives from the host community (one of who must be a female) and one of them shall be the chairperson.

ii) The Medical Officer incharge of the hospital shall be the Secretary.

iii) Administrator/Hospital Secretary.

iv) Chief Nursing Officer of the hospital

v) Pharmacist

vi) A representative of the HMB

vii) Two representatives from the host LGC and one of the representatives must be from the PHC department. [68]

With the charter successfully negotiated, the BHF project together with the HMB, the NKST and Catholic missions provided technical assistance for developing the framework and subsequent establishment of the DRF. They also, together, developed a manual for assessment of the DRFs at inception and on-going monitoring with GRID Consultants providing technical support. Full-scale implementation commenced with two-day training for all hospital staff. Thereafter all the drugs on site (hospital's own supply and the newly supplied ones) were valued. Receipts, registers and stock books were opened, signaling the commencement of the 'new' DRF scheme. [69]

In the present dispensation drugs and consumables were sold to or used for patients and the cash regularly banked into DRF dedicated accounts. To ensure that funds accumulated in the dedicated accounts were intact for the six-month establishment period, the BHF project paid all drug related debts in the hospitals. The project continued to replenish drugs in the hospitals for six months, free of charge, so that at the end of the six-

month establishment period the hospitals were to have two months worth of drugs in store. Hospitals requested for replenishments submitting information on in-patients and outpatients and drug utilization. In addition, the project provided guidance to the hospitals' on tendering, contracting, and monitoring quality of drugs. The HMB, the hospitals management, pharmacy and accounting staff were taught the principles in pricing drugs manually and on the computer. All these were to prepare the organs to assume responsibility for the DRF operation, after the six-month establishment period.[70]

With the BHF intervention, the DRF scheme succeeded considerably. In- and out-patient attendance at the hospitals ranged from 30% to 50% while the increase in revenue generation was 100%. However, these increments were not maintained in all the hospitals. For instance, in NKST hospital Mbaakon the utilization of facilities went down. Moreover, the project believed that staff capacity in financial and drug management improved while there was increase in awareness by HMC members on the operations of the DRF. The project however admitted that while there were few out-of-stock circumstances, 90% of drug needs of patients were met. Also, on the basis of market survey carried out in June 2001, the project argue that drugs were generally cheaper in the assisted hospitals than in the open market.[71]

5.3.8 Deferral Scheme at SHC Level

Furthermore, the BHF project, as part of its support at the SHC level resuscitated the deferral mechanism with a view to removing the barrier to access to care for the very poor and vulnerable. The deferral scheme is a formal system that allows for delayed payment for health care services based on locally agreed poverty assessment criteria. Deferral funds were taken from a 4% or 5% turnover in the pricing of DRF. The project provided funding and technical support, through GRID Consultants, for the design, implementation and

monitoring while the HMB provided both political and management support. It was the responsibility of the individual hospitals to accept the scheme and to ensure that the capacity of the staff was built. The communities hosting the hospitals, on the other hand, were required to accept the scheme, participate in it and assist in the recovery of deferred payments. [72]

In implementing the deferral scheme, the BHF project established a Deferral Committee charged with the responsibility of approving deferrals suggested by the Community Liaison Officer (CLO), reviewing deferral cases, developing strategy for debt recovery and reporting to the HMC. The project trained this committee in one-day workshops to enable it perform its role efficiently. Also, the project held advocacy meetings with medical and nursing staff for several two-hour sessions. Furthermore, CLOs were appointed and trained to supervise awarding of deferrals and debt recovery under the guidance of the Deferral Committees. He/she was also required to assess cases for deferred payment, document information on beneficiaries, reconcile financial information within the accounts department, etc. They were trained in a two – day workshop on record keeping, basic accounting, approaching community members for debt recovery, reporting, etc. The CLOs also had on-the-job training and were supervised by the HMB and BHF Project staff.

Furthermore, the project designed, printed and supplied operational forms and books for documentation of all deferral activities including financial transactions, signaling the take-off of the scheme. [74]

The BHF project, in conjunction with the HMB monitored the scheme in the assisted hospitals. The BHF project collected from the CLOs completed monthly monitoring forms, through the HMCs, analyzed the data on category of patients deferred, funds involved and the recovery rates, and sent feedback to the HMB and the hospitals. The HMB then,

reviewed these records on quarterly basis in order to assess utilization and extent of debt recovery. [75]

The BHF Project believed that the deferral scheme succeeded, to a large extent, in achieving the purpose for which it was set-up. For instance, the project claimed that the scheme was running in five hospitals in Benue State, namely, the general hospitals at Gboko, Katsina-Ala and Otukpo, the NKST hospitals at Mbaakon and Anyiin. And that each of the hospitals raised between N9, 000.00 and N30, 000.00 per month for the scheme from their DRF sales. Also, that at each of the hospitals between two and 17 people were granted deferred payment of between N1,000.00 and N2,000.00 while two hospitals recorded between 70% and 80% debt recovery. Also, the project, as a proof of success, claimed that traditional rulers provided support for debt recovery by mobilizing community members for recovery exercises. [76]

5.3.9 Quality of Care at SHC Level

The ODA inception visit to Benue State, before the take-off of the BHF project, observed that the quality of Clinical care in hospitals was very low. It was recommended that the project incorporated measures that would improve the quality of care (QoC). Therefore, the BHF project established mechanisms to enhance monitor and regulate QoC against agreed standards in order to improve the care provided by hospitals in Benue State. To achieve this, the project trained Clinical staff and produced protocols incorporating user views on Clinical services. The project also formed Quality Audit Teams at hospitals to implement and monitor the impact of QoC activities and established Total Quality Management Team at the HMB for the purpose of setting QoC policy and supervision at the hospitals.

Moreover, the BHF project organized advocacy to create awareness and build motivation for QoC among managers and staff of the schools of Nursing and Midwifery and HMB. It also procured medical books and journals for each hospital, set up resource centres, produced Clinical protocols and developed standards of care using participatory methods, with staff, and based on current literature on the subject.

Furthermore, the project trained 30 doctors, 300 nurses and 20 laboratory staff in one-week workshops over a period of one and a half years. Some doctors and other hospital staff were trained in the UK under the TCT programme. It developed supervision schedules based on the workshop trainings. It also reviewed workshops on the QoC system introduced to collectively monitor progress on set targets, identify problem areas and develop strategies to move forward.[77]

QoC monitoring was at four levels. The Quality Audit Team facilitated implementation of internal QoC activities at the hospitals and sent reports on monthly basis to BHF project and HMB. The Total Quality Management monitored hospital Quality Audit Teams twice a year based on agreed indicators. The third level of monitoring was by the BHF project. It supported all monitoring activities and received report from the HMB and the hospitals on QoC. The last level of monitoring was by the HMB which received monthly Quality Audit Teams reports and quarterly services statistics reports from hospitals for analysis and decision making.[78]

On the extent of success in improving QoC, the project believed that its efforts succeeded to some extent. For instance, the attitudes of staff were gradually changing, to understand that QoC was important, even though it was going to take some time for the impact to be fully measured. Also, the project carried out a survey of users views on QoC, and discovered that between 55% and 97% patients were satisfied with waiting time,

examination by health staff, cost of drugs, emergency care, non-preferential treatment and expressed preparedness to return to the hospital when ill.[79]

5.3.10 Strategic Health Planning Process [80]

The BHF project also supported the Benue State MOH to develop a strategic health plan that incorporated the views and health aspirations of all and sundry, i.e. women and men, young and old, rich and poor, rural and urban, health providers and health consumers, etc. This participatory approach in gathering the views of Benue people concerning their health was informed by the fact that in the past, the poor were excluded from political, economic and social processes and were unable to present their demands to their elected representatives and public officials.

The objectives of the Strategic Health Planning Process (SHPP) were:

i) Ensure proper involvement of stakeholders and the Benue public, especially the poor and vulnerable, in deciding ways to improve their health

ii) Confirm, clarify, refine and prioritize the findings of the eight study groups

iii) Improve public awareness of simple roles individuals; families and communities can play to reduce mortality.

However, sequel to the commencement of the process, eight study groups were formed to identify the priority problems and needs of the people of the State. These groups were as follows:

i) Priority health care needs and problems

ii) HIV/AIDS

iii) Access to health care

iv) Delivery of health services

v) Organization and management of health services

vi) Health care financing and expenditure

vii) Human resources in health, and

viii) Facilities, equipments and supplies.

Five stages were involved in this process as follows:

i) Studies and data collection

ii) Dissemination of study findings to stakeholders

iii) Widespread discussion, analysis and consensus building amongst stakeholders

iv) Drafting the Strategic Health Plan and submitting to the state for approval and

v) Advocating the plan and launching its implementation.

5.4 PROJECT'S SELF-ASSESSMENT.

Just as we did in the last chapter, we shall give an account of the DFID's assessment of the BHF projects based of it's OPR. All the issues raised in this section are based on OPR document titled Benue Health Fund OPR Report, August 2001. [81] From July 31 to August 3, 2001, nineteen months into the 27 month extension phase of the project, an OPR was carried out. A previous exercise was carried out in November 1998. Although the report of the 1998 exercise was not found. Anyebe [82] believes that the latest OPR usually supercedes the earlier ones because the issues raised in the latest OPRs are a product of the issues raised in earlier ones. He believes that the latest OPRs are the ultimate. The July to August 2001 OPR team comprised of Dr. James Zasha (Benue State DFID Co-coordinator) Sam Unom (Assistant Governance Advisor), Margaret Joshua (National Planning Commission), Ebere Orizu (NPHCDA), Funmi Esan (Project Officer), Liz Tayler (DFID Health and Population Advisor) and the BHF Project senior Team.

Members of the OPR team were already acquainted with the Project and therefore its complexities were easily understood and analyzed. Be that as it may, this familiarity with the project was also capable of compromising objectivity, to some extent. The review work was based largely on data provided by the project staff, review of project documents and meetings with selected stakeholders. The team was as systematic as possible in the review of the project's activities by examining the actual work done in relation to the stated output in the log frame.

5.4.1 Strengthening of Institutional Capacity to Plan and Develop Health Service With Special Attention to Linkages Between Levels of Service and Broad Participation.

On this issue, the OPR team discovered that the Strategic Health Planning Process, an important and innovative approach to health services reform was started. Although the process had just started, the team was impressed by the useful data collected and the broad, evidence – based consultative process initiated. What the team was not sure about was how far the State MOH would own the process and implement the findings in future. These fears were informed by some unhealthy relationship which existed between some State MOH officials and the Project Management arising from some distrust for one another.

Also, the OPR team observed that although the BHF project allowed flexibility, local ownership and fairly rapid dispersal of resources during the first phase, the second phase only recorded moderate success. This was partly due to some 'selfish' interests of PAC members who scrambled for resources for their own institutions. It was also partly due to the prevailing culture of not paying attention to rigorous reading and analyzing documents, which became a major minus for many of the PAC members. Consequently the body was seen more as a rubber stamping institution than the project's think-tank and life wire. The

review team members were not impressed with the lack of community representation on PAC and suggested a review of this practice.

Furthermore, the OPR team observed that although progress in expenditure review/financial management was slow, it was beginning to generate important data and establish important linkages. The team admitted that for the behaviour of the people towards public expenditure and financial management to change, there would be need for a cross-sectoral task force to implement it. They suggested that the Governor or the State Reform Team should convene such a group. The team members were worried by the problems associated with public expenditure. For instance, they wondered why only less than 20% resources allocated to health were disbursed in 1998 and 1999 by all the levels of governments in the State. They also cited the case whereby funds were allocated for TB drugs but were not released in spite of express commitment to the issue by the Governor and the Commissioner for Health. The OPR team suggested that basic capacity building and system strengthening activities were required to deal with this problem. Unfortunately, the SLGP, a DFID – funded programme in the State was not yet successful in confronting the problem. Attempts by the BHF project to liaise with the programme were met with considerable difficulty.

Moreover, the OPR team reported that the relationship between the project and its institutional partners (State MOH, Local Governments and the HMB) was cordial. As for the State MOH it was only in the extension phase of the project that the BHF developed partnership. As stated earlier, the relationship between the two partners was initially frosty, characterized by mistrust and hostility. The relationship improved considerably, with the passage of time. This notwithstanding, certain factors continued to weigh down on this partnership. For instance, the personnel in critical directorates of the State MOH such as

Clinical services and PHC were weak while the allocation of funds to the MOH by the state Government substituted donor funds for its own expenditure on health and allocated the funds meant for health to other sectors. The BHF project management was not happy about this. All these significantly compromised the development of effective partnership with the ministry. It also strangulated, to some extent, ability of the project to sustainably build capacity.

The OPR team was very impressed by the relationship between the Project and its Local Government partners. At a meeting with heads of health departments from six LGAs the team commended their insight, commitment and analytical skills. A major taint in this relationship was, however, the report from the six heads of health departments which indicted their LGAs for small and slow release of funds to health and their lack of control over personnel policies. They confirmed that LGA chairpersons perceived health as consuming funds but preferred projects with more scope for immediate political and financial gains. Also, the heads of departments reported that staff postings in health departments were politicized. For example, wives of politicians who were health workers and other health workers with ‘connections’ ensured that they were posted to urban locations even when this did not bear any relation to need or utilization patterns. Furthermore, the OPR team discovered, from the report of the heads of departments, that supervision at many of the LGAs was not effective due to problems in accessing, maintaining and fueling of vehicles. The team was told that the Deputy Governor, whose duty it was to supervise the activities of the 23 LGAs in the State, was strategic. The team did not comment, however, on how the Deputy Governor could be used in influencing more funding for health services at the third tier of government. This was probably because it was obvious that he could not do so since he did not influence funding to SHC.

On the relationship between the project and the HMB the OPR observed that the latter was the project's landlord (it provided accommodation to the project within the HMB's premises) and a key stakeholder and beneficiary of the project. The team met with the directors of the HMB and was told that the accounting, administration, Clinical quality, monitoring and human resources systems had been strengthened. The team felt, and it was confirmed by the project, that the ability of the HMB to sustain such activities after BHF was variable, although in principle the chances were good especially in areas such as monitoring DRF, QoC and pharmacy.

5.4.2 Improvement of Access to Responsive, High Quality and Sustainable PHC Services, in Five Priority Areas of Public Health Within 7 LGAs.

Here, the OPR team observed that under-funding of health services (as seen in output 1) was capable of undermining the BHF project's capacity to make major differences to service provision. They observed that lack of capacity and funding in the State MOH's PHC department meant that it was unlikely to be able to sustain and supervise many of the initiatives developed by the project. From available records at the team's disposal they noted that utilization levels were high in 1998 when DRFs began to function effectively, but declined subsequently, due to incessant strikes that caused frequent closure of facilities, thus undermining consumer confidence in the services. Another factor responsible for the decline in utilization level, according to the OPR team, was the project's insistence on cost recovery and compliance with financial system, and the slow bureaucracy of D & E schemes. In spite of these factors the team believed that utilization levels were still above pre-project levels.

In order to maximize the chances of success in the DRF scheme, the BHF Project invested so much on the training and monitoring over and above the BI/NPHCDA models.

However, the process was complicated by the excess injection of drugs through the PTF. The team observed that the PTF drugs were already expiring, resulting in substantial decapitalization of an overcapitalized system. The team concluded that so many management components were involved in effective drug management and cost recovery that it seemed unlikely that a model could be developed which could be widely and affordably replicated and sustained. That DRF in PHC seemed to be very much more difficult to implement than in SHC mainly because smaller groups and costs were involved, capacity was weaker and the overall system was more diffuse at the grassroots level and therefore difficult to monitor. Finally, the team noted that user fees compromised access to health care especially for the poor and vulnerable who wished that health care should have been free from charges.

On the D & E scheme, the team discovered that only limited number of communities implemented it. They also discovered that the exemption component of the scheme was more popular among the poor. Thus, it was evident that the chances of sustainable success of the D & E were slim. Even though the Project’s experiment in MEH projects as an engine to support D & E schemes was commendable, it was too early to assess any impact on access.

On PHCMCs the OPR team observed that conflicting roles and responsibilities with other organs and lack of capacity and clarity of roles inhibited successful operation of this body. Moreover, the team expressed disappointment over difficulties in PHC supervision. They discovered that difficulties in fueling and maintaining vehicles for supervision hindered this vital exercise in PHC. Moreover, the team noted, with disappointment, that even the NPHCDA and the State PHC department did not engage in effective supervision for over a year.

On QoC the team observed that substantial inputs into training and the supervision that occurred resulted in significant improvements in QoC. Health workers administered decreased injections, increased compliance with protocols especially in key areas such as management of simple ailments such as malaria and STIs

5.4.3 SHC Hospitals Providing Accessible, Good Quality, Effective and Responsive Services.

With respect to this, the OPR team observed that utilization levels in BHF-assisted hospitals were low. Ironically, the hospitals that came late into the project, namely, the general hospitals at Oju, Adikpo and Okpoga, and the St. Vincent's hospital Aliade, seemed to perform better, in terms of utilization, than those that the project had been working with earlier. The team also discovered that ironically the two hospitals that were supported most, namely, the general hospitals at Otukpo and Gboko performed worst. A discussion on the factor responsible for this scenario revealed that the performance and attitude of the doctors and a few other key individuals in these hospitals, more than any other factors, was responsible for this low utilization 'syndrome'

In spite of the above, the team was satisfied with the work on financial and management systems which worked well in all the hospitals with a few on a more sure financial base. The NKST hospitals' management gave the OPR team source for concern in this regard. Also, the OPR team discovered that the DRF in the hospitals functioned well, ensured supply of quality drugs at prices lower than commercial rates. The team was optimistic that the scheme was sustainable after the closure of the project. Similarly, the team was impressed by the D & E workings in the hospitals and was optimistic that it had a good chance of sustainability. This good chance of sustainability, the team observed, was due to the emphasis the project placed on the deferral. However, on the whole the OPR

team's verdict on the D & E scheme was that with a generally low utilization levels in the hospitals, the impact of the D & E on the poor and vulnerable couldn't be all that great.

On QoC, the team commended the project's efforts at improving QoC. They expressed satisfaction with measures adopted to monitor and evaluate QoC but observed that the traditional Clinical training that was taken in the first phase was rather expensive and unpopular with some Clinicians. Similarly, the team observed that the quality, pragmatism, and user friendliness at many of the plethora of protocols generated by the project were not clear. They suggested that two or three protocols with associated audit be encouraged.

In concluding, the team commended the involvement of the HMB in the BHF project activities but expressed concerns over little progress towards referrals between primary and secondary health care in the State. They also expressed concerns over the domineering representation of secondary care at PHC – SHC meeting.

5.4.4 Empowerment of Communities to Plan and Manage Improvements in Their own Health Care

Here, the OPR team expressed satisfaction with the way and manner the Project managed the change in focus between the phases. With community projects receiving the needed attention, the anticipated disappointment of communities did not materialize. The team observed apparent enthusiasm for the work with the CBOs but suggested that it was behind schedule and far too early to assess. They recommended that in view of the potential strategic relevance of the work it was to continue under the auspices of Community-Based Decentralised Development (CBDD), a DFID – assisted programme that worked in Kaduna State, or an evolving DFID civil society strategy. The team also suggested that in view of pressure of work on the project, the CBO curriculum development and training for IEC was

to be restricted to areas such as adolescent health and HIV where high quality work was achieved. The team pointed out that the BHF project's efforts in other areas of IEC did not succeeded well.

On community participation in the management of health services, the team was disappointed that the project did not achieve much, in spite of its spirited efforts towards the process. According to the team, the roles of VDCs both as managers of the DRFs and as monitors of LGAs and health staff performance were too cumbersome. The team felt that VDCs could do better performing the latter roles to which they were more suited given the limited capacity and the complexities of effectively managing DRFs. It was also the opinion of the team members that the possibility of using indigenous CBOs to manage DRFs be explored. As a matter of fact, the team advocated for a complete reorganization of the VDC structure and suggested that the matter be discussed with the NPHCDA.

5.4.5 Establishment of An Effective Monitoring System Established to Enable An Evaluation of the Project And Its Component Parts, Providing Models for Future Replication.

The team rated the project's performance in this regard very low. According to the members, it was difficult for the Project to carry out effective monitoring due to a number of factors. First, local counterparts in PHC such as the State MOH PHC department and NPHCDA which were to partner in this regard were very weak. Therefore, no substantial inputs came from that end. Secondly, the methodology for monitoring was problematic; and finally the members observed that monitoring was not effectively linked to the log frame.

This notwithstanding, the team observed that many people in Benue rated the BHF project very highly, even though to them (OPR team) the project did not make great progress towards its purpose. For instance the representative of the Catholic Dioceses on

BHF project argued strongly that private health practitioners in the area were forced to lower their price in order to compete with BHF services. If this was so, then it meant that the project's benefits in this area affected the poor positively. Also, the OPR team discovered that the BHF project enjoyed trust and the goodwill of many target communities and LGAs. The communities testified that the project, unlike many government and other initiatives, delivered what it said it would. Key partners such as the Catholic Church and LGAs agreed to join the project and discussed finance together. Moreover, the BHF project delivered goods, both in terms of assets and improvements in services to communities and to other partners.

Furthermore, the team observed that although it was difficult for them to assess progress toward reform, policy makers were getting acquainted with principles and concepts of health and social development – an indication that there was some kind of reformation. Moreover, the team noted with satisfaction increased confidence, articulacy, analytical skills and possible influence of the project on the HODs of health in the LGAs, PAC members and HMCs, to mention only a few. They attributed this scenario to the project's capacity building strategy that produced a crop of human resource persons, many of whom are consultants across the country. Also, by way of capacity building, the project facilitated links between the Benue State University, Makurdi and Queen Mary's College Edinburgh with the aim of collaborating research endeavours.

The OPR team also observed with satisfaction the BHF project's efforts towards gender awareness. Even though the Benue State Government was becoming increasingly gender sensitive in the representation of women at high levels, the team did not say categorically that the project influenced this but believed it may have contributed in some measure. Similarly the team expressed some satisfaction with an understanding of 'poverty'

by target communities, as a result of the project's efforts. Members also gave credit to the project for embarking on programmes that increased openness in discussions around sexuality among policy makers and young people.

5.4.6 Summary of the OPR

The team observed that the general goal of the BHF project which was to improve the health status of the population of Benue State, especially of the poor and vulnerable groups, and inform the process of achieving improved health systems nationwide, was not fully actualized. They felt that poverty in Benue State was not abated.

They also felt that the HIV epidemic, coupled with further collapse of basic infrastructure and support services such as education, water and sanitation was still the bane of the people. Moreover, the OPR team did not see how the activities of the BHF project informed an appreciable improvement in health systems nationwide.

The general purpose of the project was to improve coverage, utilization and quality of basic health services in seven target LGAs, especially among poor and vulnerable groups. It was also to develop models for improving health services in other LGAs. Based on the above, the team observed that the project succeeded fairly well. They said the project did a good job but admitted that the tasks were complex since it was difficult to effect change and show impact when working through other partners rather than direct implementation. In essence, the team said the project was overambitious to think it could achieve this purpose within five years of the project's life span. For instance, the project was too optimistic to assume that LGAs, and the State would increase funding and commitment to health because the system was being democratized. What the BHF project did not understand was that the total commitment of the political leadership to the new human development paradigm i.e.

human capital investment was still held suspect. The political leadership changed but the processes, personnel and prevailing culture did not change. The team hoped that the efforts of DFID Nigeria in identifying and working for achievable change (change models) would influence, positively, the attitude of Nigerians towards development.

5.5 ASSESSMENT OF PROJECT'S IMPACT

This section examines the BHF Project's impact on the assisted communities based on our field trips and interviews with stakeholders. Whereas the OPR team scored the BHF project low on its performance with respect to the project's goal of improving the health status of the population of Benue State and informing the process of achieving improved health system nationwide, they commended it for achieving the general purpose. Generally speaking the project recorded lapses in the implementation process, as reported by the OPR team, and from our on-the-spot assessment. This notwithstanding, from our assessment tour of communities and stakeholder-partners it was evident that target beneficiaries were full of praises for what the project did for them. For instance, some of the key stakeholder officials interviewed were unanimous in their view that the health system, both at the State and LGAs, was grinding to a halt, before the intervention. They said the infrastructures were decaying very fast and services were also declining rapidly. They believed that the coming of the BHF project to the rescue was timely.[83] This assessment was probably based on the fact that in the midst of colossal lack little becomes much. In this section, we intend to take a critical and analytical assessment of the BHF project, as we saw things during our field trips.

5.5.1 Community Participation

There were strong indications that communities participated actively in the BHF project. The PAC had a preponderance of Benue indigenes representing institutions sited in Benue communities and had the responsibility of managing the fund for the health and social development of Benue communities. Moreover, the six out of eight general hospitals assisted by the project, namely, the general hospitals at Oju, Otukpo, Adikpo, Gboko, Okpoga and Katsina-Ala had active participation from the host communities who were represented on the HMCs. Additionally, the PHCMCs, VDCs and CRPs provided ample opportunities for the grassroots people of the State to have a say in the management of their health.

However, we discovered that the active participation of the communities lasted only as long as the project was in place. With the closure of BHF many of the various committees went into a coma, as it were. Some of the people interviewed claimed that while the project was on, committee meetings were accompanied by handsome financial remunerations from the 'white people'.[84] They actually admitted that without financial benefits most people lost interest in meetings. It was therefore not strange that many of the VDCs met epileptically or never met at all.[85] It was discovered from our investigations that three critical factors were responsible for this state of affairs. Firstly, the project seemed to have over pampered the communities. For instance, a situation whereby the project held meetings with communities and entertained them sumptuously, instead of the other way round, gave the communities an impression that another 'national cake' was available for them to enjoy.[86] Moreover, whenever the project organized workshops and training events for communities, the people were paid exaggerated allowances, giving them an impression that the money would always flow to them. It was little wonder that with the closure of the project, and thus the cessation

of personal financial benefits, the committees became weak in their operations. It is quite apparent that for the communities to decisively influence their health status in particular, and development in general, their attitudes to ‘free lunch’ must change.

This brings us to the second factor which borders on the project’s crash-programme approach to workshops and training. True, the BHF project did its best in terms of capacity building. It trained many Benue indigenes abroad for periods ranging from three to twelve months. However, the majority of the grassroots people were trained in workshops and seminars which lasted for only a few days or sometimes for a few weeks. These training events were too short to affect the attitudes of the people appreciably and also too short to enable them understand their roles more clearly. Probably, a longer duration of project activities would have consequently elongated the duration of the training events.

The last of the factors was lack of monitoring and supervision of health activities in the LGAs, after the project closed. Our interactions with the PHC coordinators in the seven focal LGAs revealed that monitoring and supervision seemed to have ended with the closure of the BHF project. In fact, in one of the LGAs the PHC coordinator said emphatically that there was no supervision in his LGA. For each of the seven focal LGAs the project donated a four – wheel drive and a couple of motorcycles for the purpose of monitoring and supervision. We discovered, however, that only the jeeps in Gboko and Otukpo LGAs were functional while a few of the motorcycles were still on road. Even where these vehicles were functional, the PHC coordinators complained of lack of funds to fuel and maintain them for the purpose of supervision. This neglect of the health sector, which the OPR team had observed, became evident to us when we talked with the PHC coordinators. Most of them did not give their chairpersons good ratings. We discovered that PHCMC meetings were not supported with finances by the LGA chairpersons. In other words, members were not given

incentives therefore most members boycotted meetings. One would have thought that the State MOH Department of PHC and the NPHCDA would exert some kind of pressure on the LGAs to take the issue of monitoring and supervision more seriously so that the gains of the BHF project could be sustained. But this was not to be, maybe because the LGAs, the State PHC department and NPHCDA were, apparently, waiting for another donor initiative. Other factors such as frequent changes in LGA and PHC leadership also contributed to poor M&E activities specifically and primary health care generally.

5.5.2 Rehabilitation of Health Infrastructure and Equipment [87]

Our tour of PHC and SHC facilities in the focal LGAs revealed that the project actually renovated all PHC and SHC facilities supported by the project, and in some cases such as the general hospitals in Gboko, Otukpo and Kastina-Ala, NKST Hospital Mbaakon, St. Vincent's Hospital Aliade, PHC Clinic Opa-Adoka, in Otukpo LGA, to mention only a few, the project constructed VIP latrines, incinerators additional blocks of buildings and staff quarters. Also, we discovered that the project refurbished broken down hospital equipment such as theatre equipment, dental equipment, X–ray machines, hospital ambulances (such as the one in Oju), hospital beds, and so on. The project also replaced unserviceable equipment in the hospitals and bought new items for both PHC and SHC facilities in the State. For instance, new dental, X-ray and theatre equipments were bought for Gboko, Otukpo, and Kastina-Ala hospitals. Four-wheel drive ambulances and motorcycles were bought for Gboko, Kastina-Ala and Otukpo, general hospitals as well as for NKST hospital Mbaakon and St. Vincent's hospital Aliade. Other equipment such as computers, hospital books, accounting books, furnishings, powers generating sets, water supply schemes, etc. were provided for several of the SHC facilities. For the PHC facilities,

the BHF provided equipment such as beds and mattresses, delivery equipment, scales, blood pressure apparatus, dressing equipment, etc.

Our visits to some of the SHC and PHC facilities revealed the extent of the gratitude of the staff of this facility to the project. The medical directors, hospital secretaries, the OICs of the PHC Clinics and other health personnel interviewed were unanimous in their view that the project made a difference.[88] At the NKST Hospital Mbaakon, while responding to the question on what impact the BHF project intervention had on his hospital, the medical director said: “Take a look at the hospital. The BHF facilities speak by themselves.” [89]

In spite of the seemingly overwhelming view that the project made a difference in the health status of Benue communities, a few out of the people interviewed expressed concern on some aspects of the assistance. For instance, the Hospital Administrator of General Hospital Kastina-Ala believed that the project choose the type of equipment it preferred for the assisted hospitals. He said when the DFID Health Advisory team visited his hospital he advised that vehicles and equipment donated were to be the types that could be locally serviced. He said further that the Nissan 4 X 4 ambulances donated were costly to maintain. He cited the case of plug heaters, which could not be got locally, causing the grounding of the vehicle. Also, he cited the case of the generating set that were bought, for which there were no mechanics to service them. Actually, our findings revealed that some of the equipment supplied to hospitals and Clinics grounded shortly after installation. The Hospital Administrator revealed further that it was the policy of some donors to donate obsolete equipment to poor recipient nations. He suggested that this syndrome should be stopped. It was also his strong opinion that rather than repair broken down equipment which did not last for long it was better for DFID to have bought new ones, no matter how few. He

cited an example of his hospital's X-ray machine which was repaired at the cost of N900, 000 but worked for only a few months and broke down again.

Commenting on this aspect, the Medical Director of the General Hospital Gboko opined that the project ought to have gradually withdrawn the British Government influence by withdrawing its management staff and transferring management to Benue people, rather than staying on till the last minute. He was also not comfortable with the way and manner the project "forced down our throats all kinds of equipment and programmes"[90]

As we end this section, it must be emphasized that in our opinion the DFID assistance, by way of infrastructural rehabilitation/ construction and refurbishment/purchase of equipment for primary and secondary health care, was impressive, in spite of observable lapses here and there. Plates IX to XX on pages 248 to 259 show some of the rehabilitated and constructed infrastructure, as well as refurbished and new equipment provided by the BHF project.

5.5.3 Drug Revolving Fund Scheme, Deferral and Exemption Scheme and Quality of Care

Our visits to hospitals and Clinics revealed that the BHF project supplied sufficient drugs and medical consumables enough to sustain the DRF scheme. The drug stores and pharmacies of the facilities were fairly well stocked. It was difficult for us to assess, however, the extent of the support in this regard in view of the fact that we could not determine what was in the stores before the intervention. But some of the stakeholder partners interviewed said the out-of-stock syndrome used to be the order of the day in their hospitals and Clinics but with the intervention of the BHF project, quality drugs were now available at prices lower than those in the open market and private hospitals.[91] From our investigations the DRF scheme worked well in all the hospitals and Clinics but the D & E

Plate IX: A Renovated Theatre Block at NKST Hospital Mbaakon, Vandeikya LGA.

Plate X: A 4x4 Jeep Ambulance Donated to NKST Hospital Mbaakon, Vandeikya LGA.

Plate XI: An Incinerator Constructed at General Hospital Gboko.

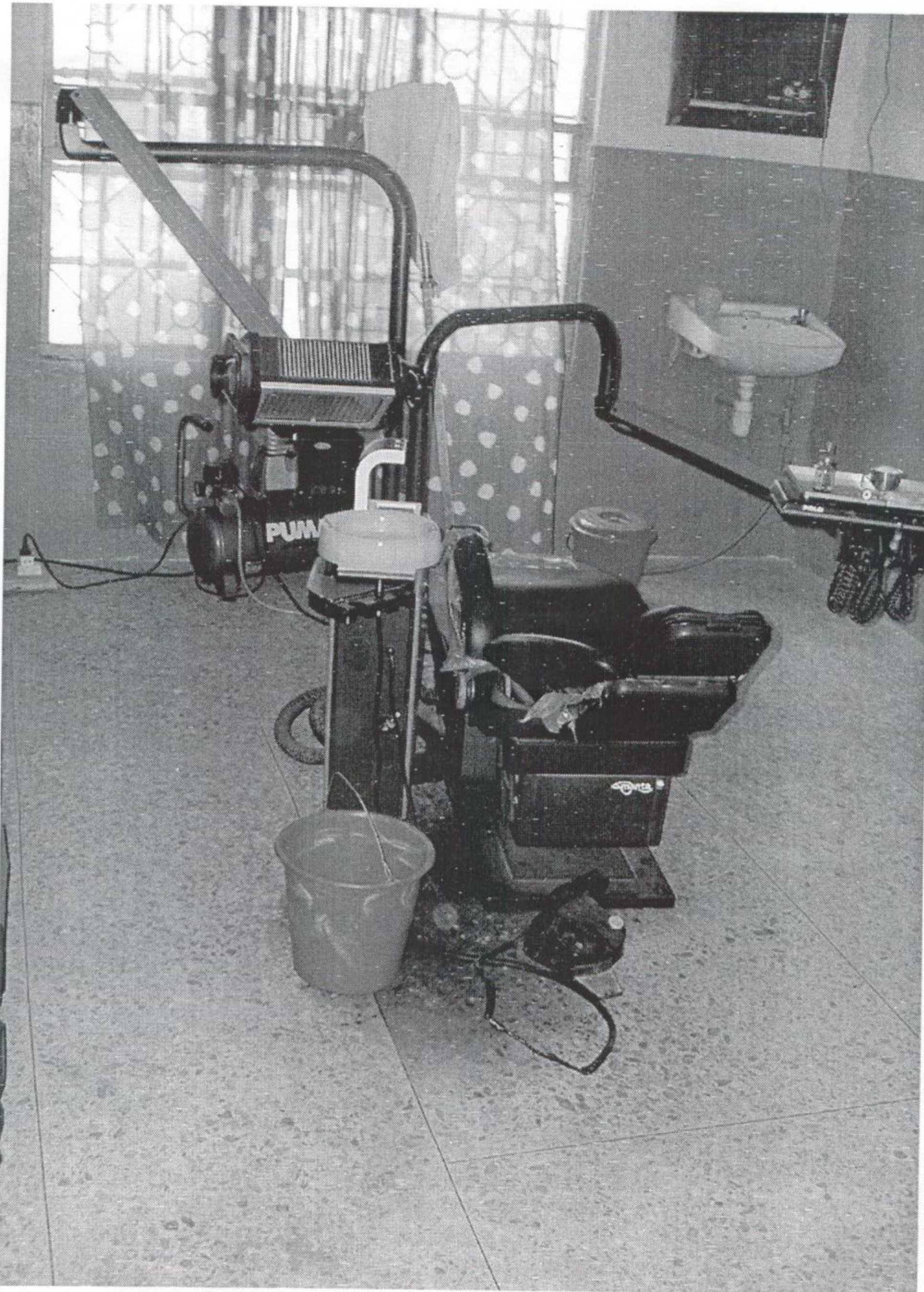

Plate XII: A New Dental Chair Bought for General Hospital Gboko.

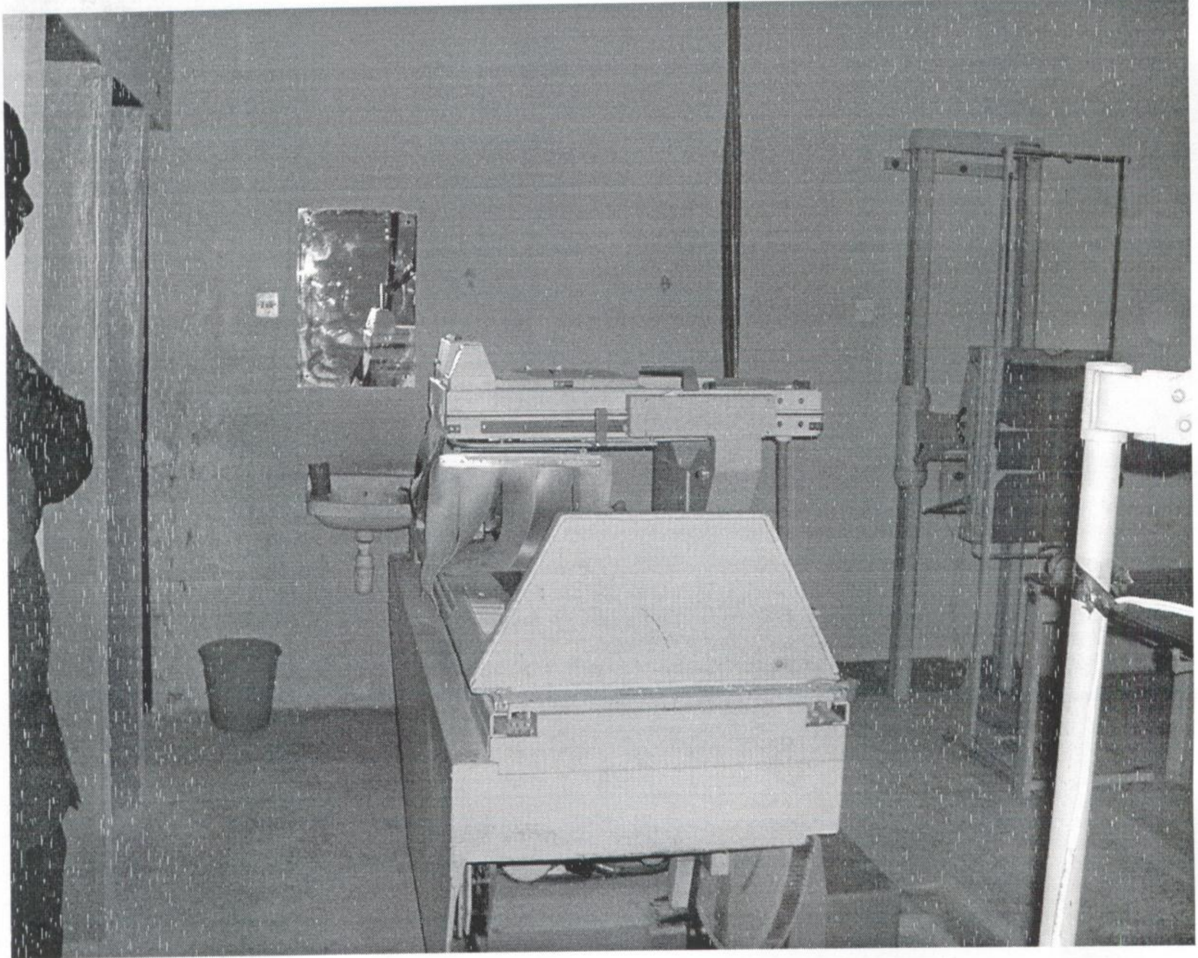

Plate XIII: A Refurbished Operation Table at General Hospital Katsina-Ala.

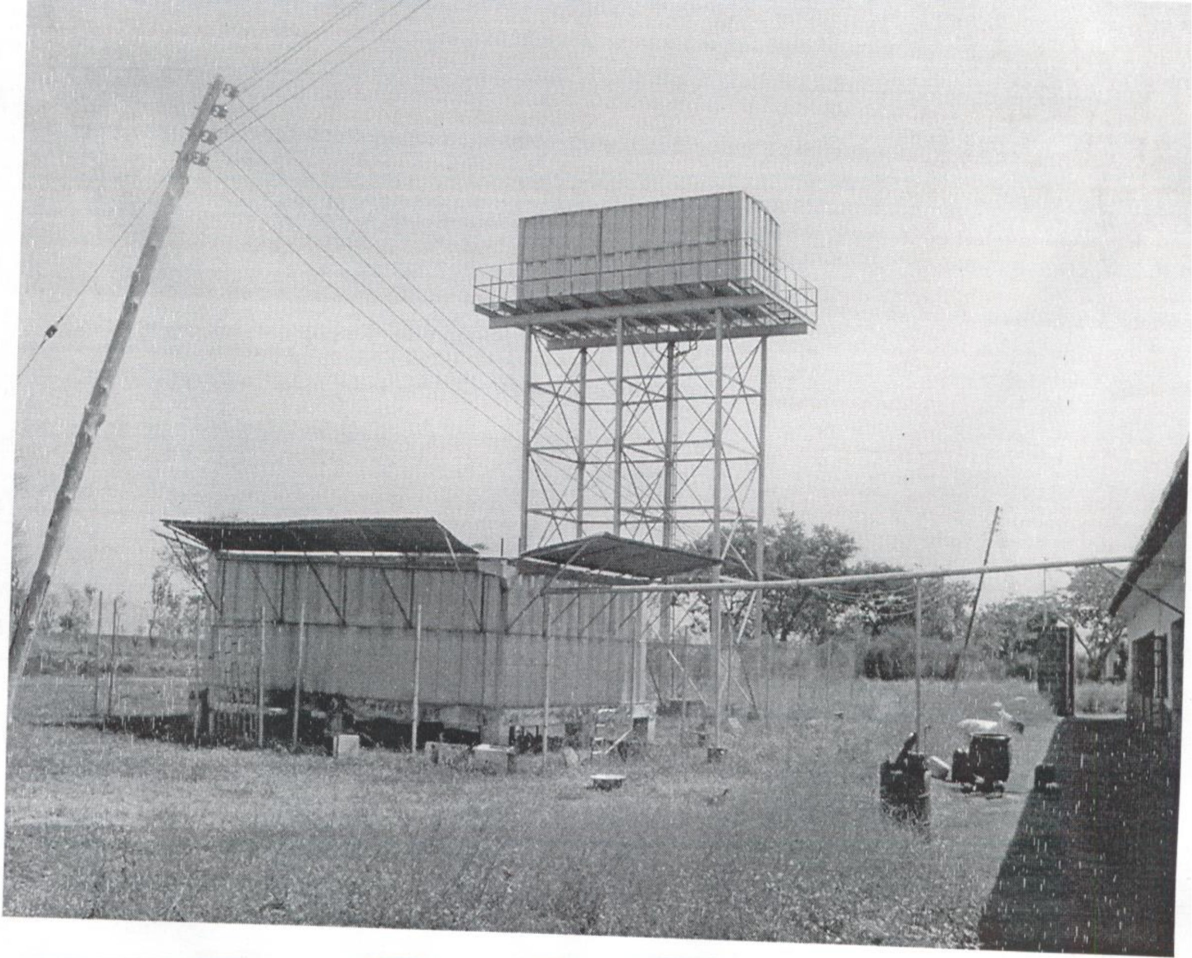

Plate XIV: A Solar Water Scheme at General Hospital Otukpo.

Plate XV: A Power Generator Set Bought for General Hospital Oju.

Plate XVI: A Renovated PHC Clinic at Tyemimongo, Vandeikya LGA.

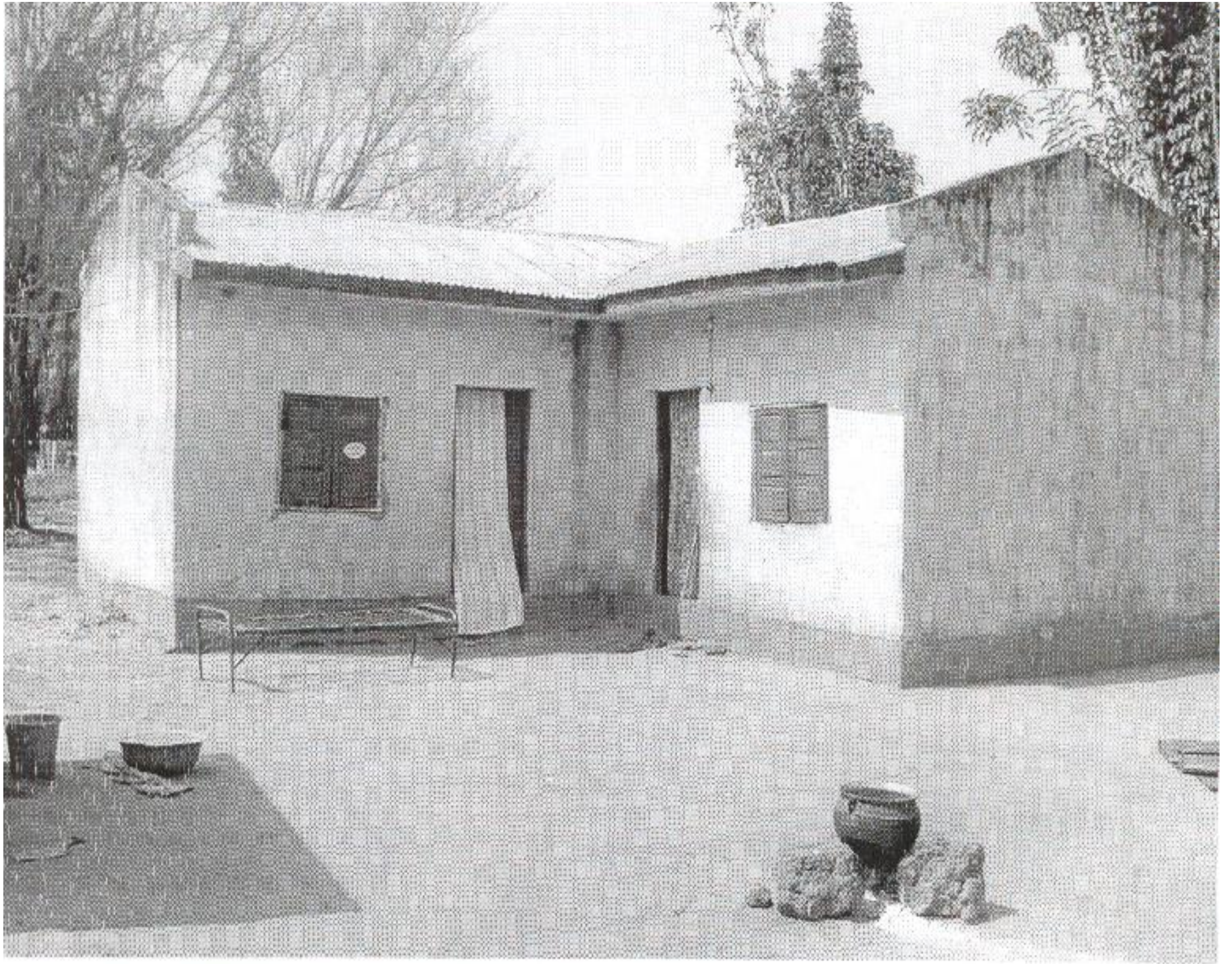

Plate XVII: PHC Clinic Staff Quarters Constructed at Opa-Adoka, Otukpo LGA.

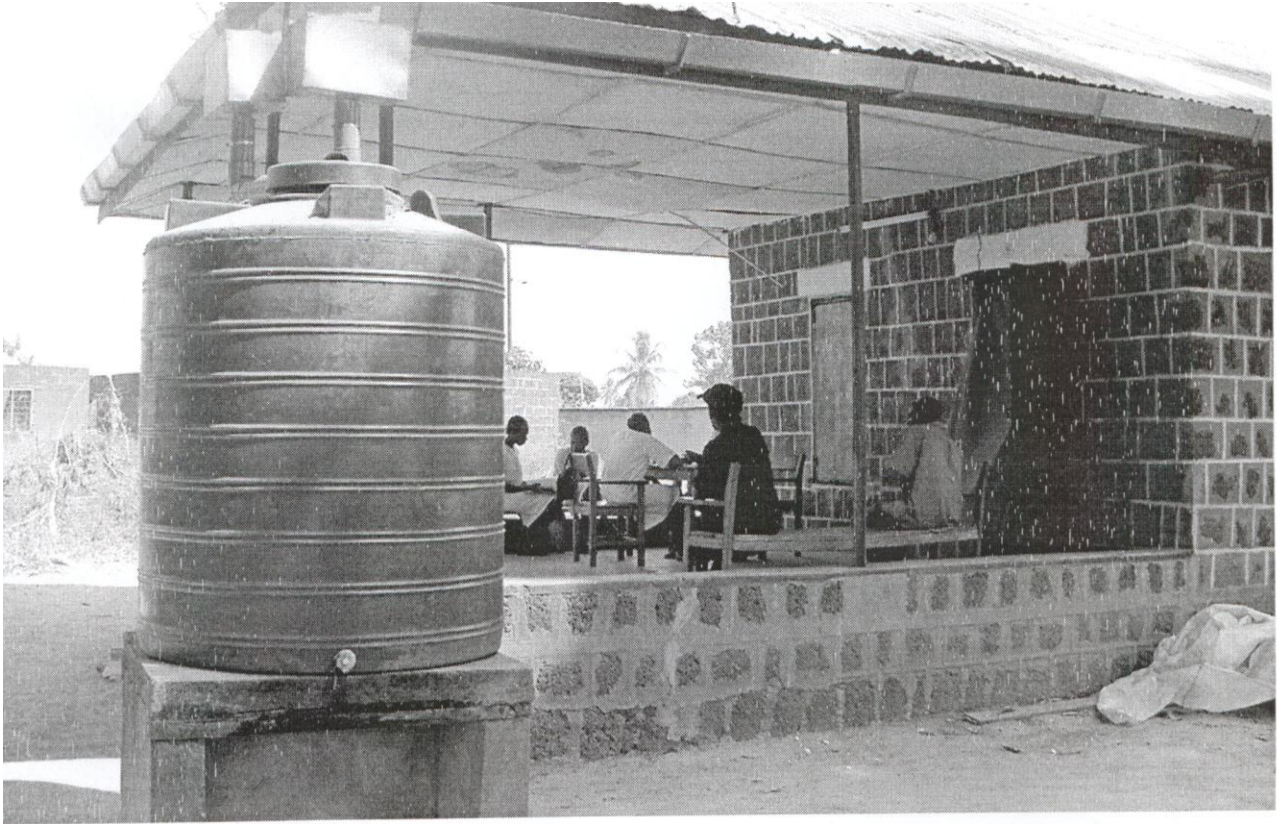

Plate XVIII: A Rainwater Harvester Scheme at the PHC Clinic Onyangede, Ohimini LGA.

Plate XIX: A Solar Refrigerator Bought for the PHC Department Annune, Tarka LGA.

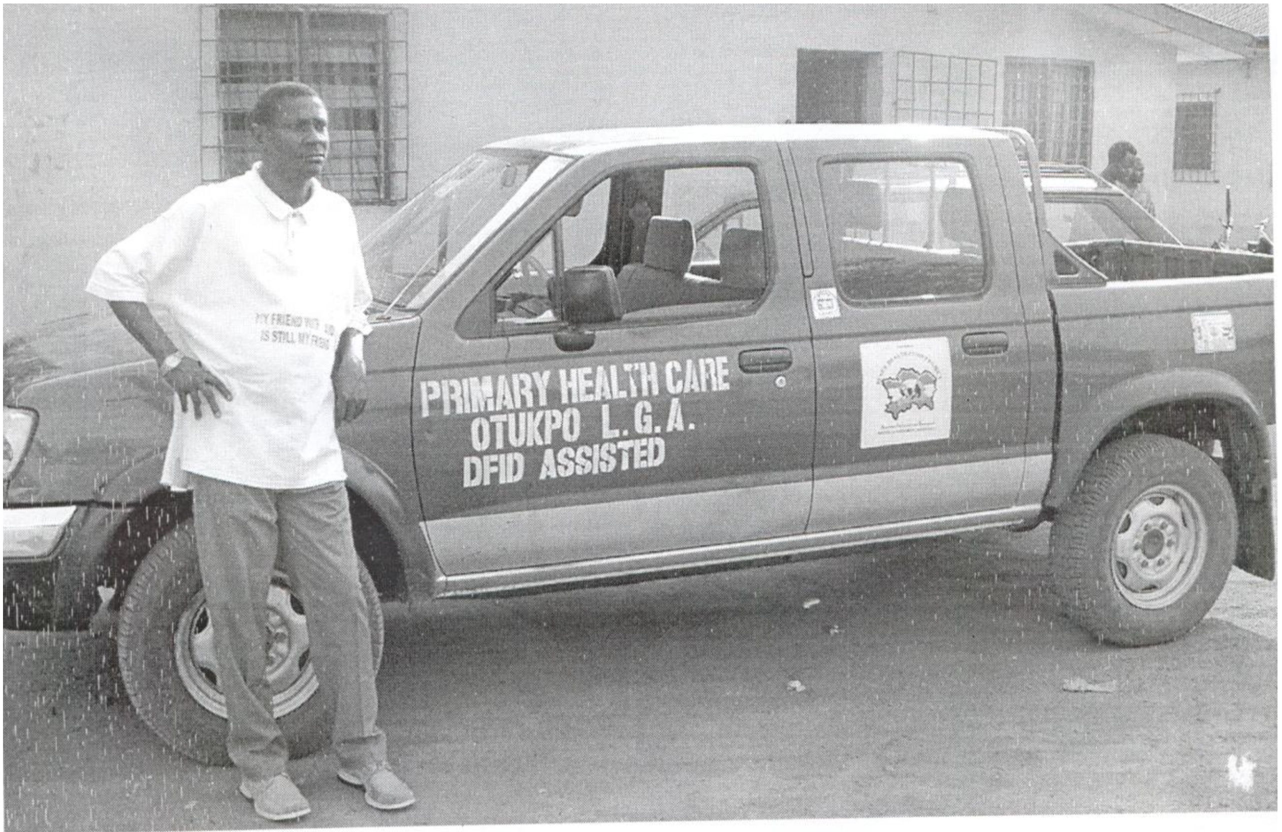

Plate XX: A 4x4 Nissan Jeep Bought for Otukpo LGA PHC Department.

Plate XX: A 4x4 Nissan Jeep Bought for Otukpo LGA PHC Department.

scheme failed in some of the hospitals and in the PHC Clinics the system did not work for long. For instance, at the NKST Hospital Mbaakon the D & E account was de-capitalized while at the general hospitals at Oju and Gboko recovery of funds was very difficult and frustrating.[92]

At the PHC level the D & E could not work for similar reasons. One of the people interviewed said the BHF project did not address the issue of staff welfare in its support, so the slightest opportunity people had to embezzle project funds was cashed in. He said, for instance, that at the time the project came, several staff in both PHC and SHC facilities were owed salaries for several months, making them vulnerable to pilfering. He wondered how D & E funds could have been left alone.[93]

On quality of care our investigations showed that although the hospitals and Clinics were renovated and provided with equipment, drugs and other medical consumables, as shown on Plates XXI and XXII, pages 261 and 262, the attitudes of services providers were yet to change drastically. For instance, the Community Liaison Officer (CLO) for General Hospital Gboko stated that clients were still complaining of unnecessary delays in the hospitals. In some of the PHC Clinics no OICs were available at all. This underscores the need for prolonged and persistent capacity building that will change the attitudes of the people. The provision of drugs and equipment alone may not suffice since the hood, they say, does not make the monk. However, the OICs we met admitted that they were guided by the protocols developed by the project in the treatment of common diseases such as malaria, dysentery, STIs and so on. We also discovered that hospitals made efforts to remind service providers to observe QoC as shown on Plate XXIII page 263. This poster adorned the walls of General Hospital Gboko. On the whole, it was difficult for us to

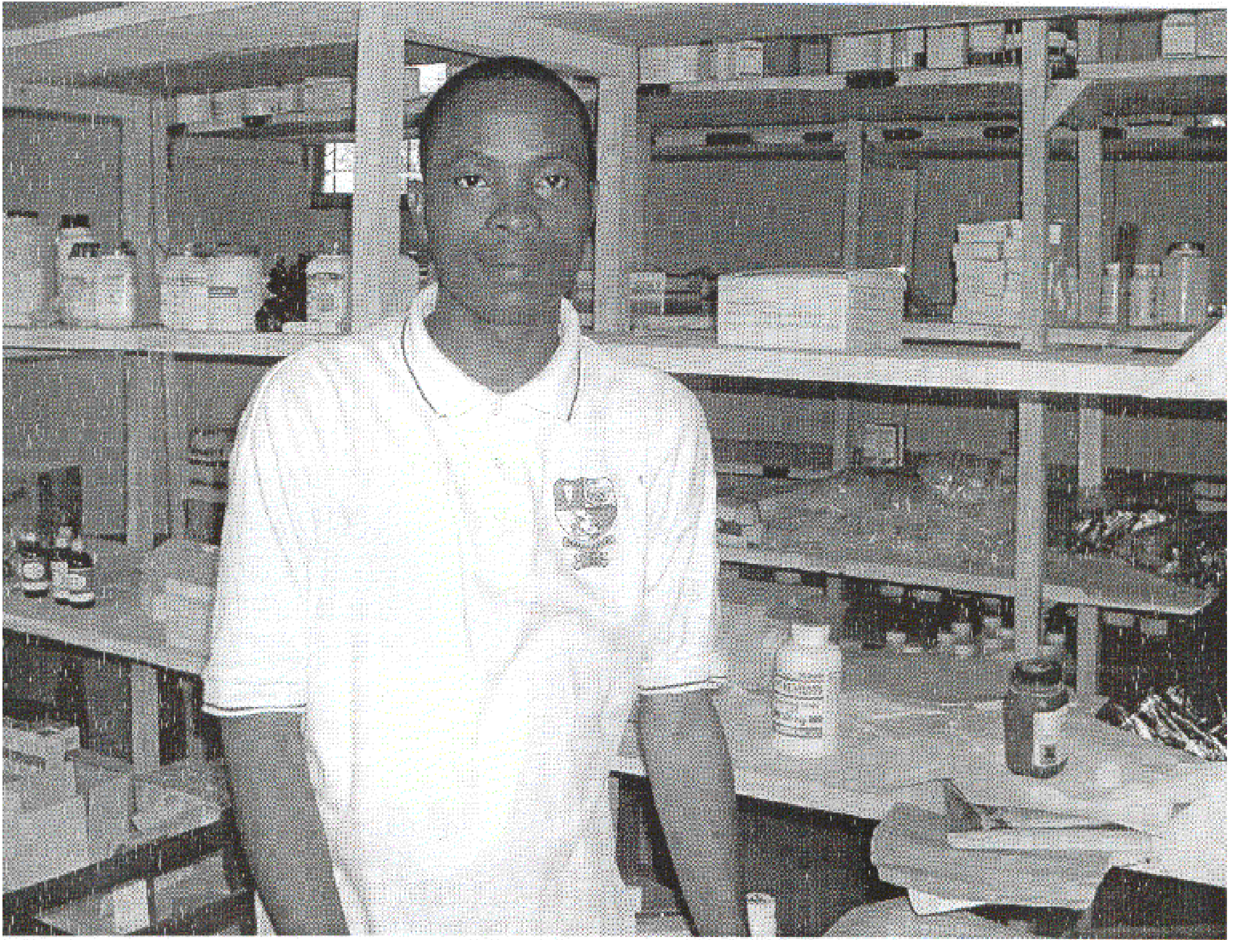

Plate XXI: A Typical Drug Stock in a SHC Facility Drugstore Donated by BHF Project

Plate XXII: A Typical Drug Stock in a PHC Facility Drugstore Donated by BHF Project

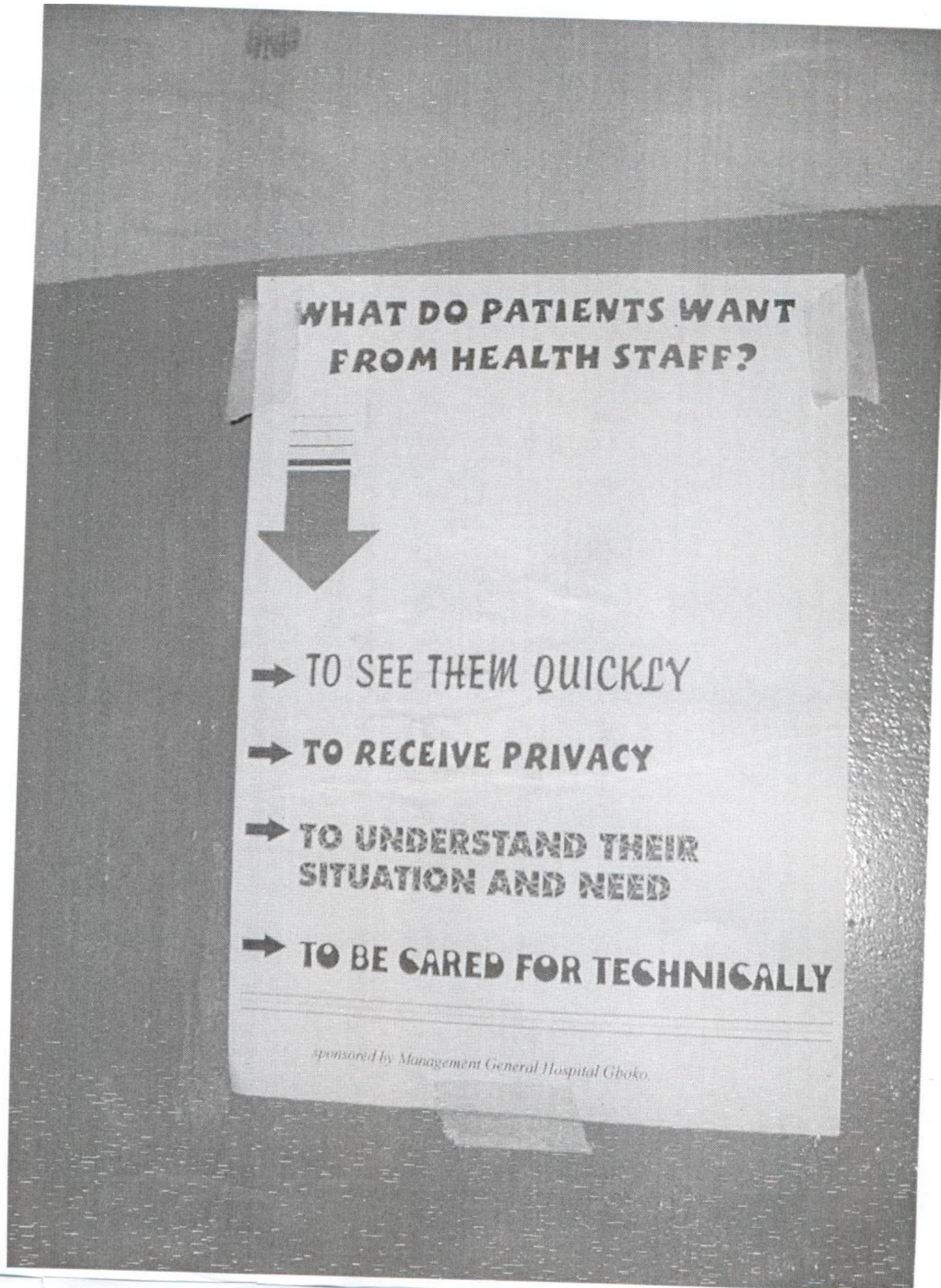

Plate XXIII: A Poster to Remind Service Providers of QoC

adequately measure the impact of the project on QoC, even though service providers felt they were on course.

5.5.4 Micro-Enterprise for Health and Community –Based Organizations

The tour of focal communities took us to Tyemimongo and Tsar in Vandeikya LGA, Tyogbenda Udende and Abaji Kpav in Kastina-Ala LGA, Iwerndyer, Ugondozua and Abeda in Logo LGA and Ukazo and Abetse in Gboko LGA. Others included Annune, Asukunya and Akpa in Tarka LGA, Otukpo-Nobi and Opa-Adoka in Otukpo LGA, and Onyangede in Ohimini LGA. In these LGAs we were able to sample the efforts of the BHF project in MEH and CBOs. It was discovered that apart from Tarka LGA, which did not have an MEH project, the rest had. The reason(s) for the absence of MEH projects in Tarka LGA were not very clear but according to a source, which preferred anonymity, Tarka people wanted the projects free. According to this source they felt that since the Governor of the State was from this place, with or without BHF the facilities were going to be provided. Some of the indigenes interviewed simply said the communities could not be mobilized early enough to request for the projects.[94] Many of the MEH projects performed well. A particular case that deserves mention was the corn processing mill in support of Kasev Mbanor Association, a widows' association at Iwerndyer, Logo LGA. They were able to generate revenue from the mill enough to assist their members and also built an annex to the PHC Clinic in the community as shown on Plate XXIV page 266. The Treasurer of the association who is also a widow informed us that the installation of the machine alleviated their sufferings in a tremendous way. According to her they used to trek five kilometer to access the nearest grinding mill but that the situation was different now. She said further that all widows ground at the mill without payment. She lamented that during the season when pounded yams were eaten over and above corn food, they recorded low patronage at the mill.[95] As a

matter of fact this was a general complaint in the Tiv-speaking communities where corn milling and gari processing machines were installed. Another complaint was that poverty usually drove people in rice producing zones to sell their rice unprocessed.[96] Some of the communities had more than one machine. Whereas others had both corn milling and gari processing machines others had both rice and corn milling machines, depending on their need and their ability to pay the counterpart funds for them.

While some of the MEH projects worked well and generated funds to cater for both the health and socio-economic needs of the poor and vulnerable among them, others did not work well due to several reasons. For instance, the corn-milling machine installed at Abaji-Kpav in Kastina-Ala LGA did not function well due to prolonged intra-communal clashes that set the people against one another. The secretary of Kpav women Development Association who granted us an interview said two factors militated against their progress since the machine was installed. The first was the prolonged communal feud already mentioned, and the unfaithfulness of the operators.[97] The communal clashes factor underscores the point made in chapter three that incessant conflicts slow down community and national development. The Iwerndyer community also suffered this fate. The Tiv-Jukun crisis of 2000/2001 sent them packing from their villages, which are on the borderline between Benue and Taraba states.

The issue of the unfaithfulness of machine operators featured in many communities. For instance, Ugondozua community's MEH project suffered this fate. In an interview with the Secretary of Uke-Uke Youths, the CBO that owned the project, and the

Plate XXIV: A New Clinic Block (adjacent to the old one) Built by Kasev
Mbanor Association from Proceeds of a Corn Processing Machine

operator of the rice-milling machine, it was discovered that the revenue realized was embezzled by the operator.[98] Apart from this, the community which is cosmopolitan lacked unity of purpose for concerted efforts to ensure that the project succeeded. Eventually, the machine was abandoned. Plate XXV page 268 pictures the case of Ugondozua, while Plate XXVI on page 269 shows an example of an MEH project at work. In some communities the story was neither that of communal crisis, nor lack of unity, nor even the unfaithfulness of operators, but that of faulty machines and lack of operators. For example, the gari processing machine at Onyangede, rather than generate revenue, drained the resources of the Onyangede Widows Association, owners of the machine. According to the chairperson of the CBO, the machine was installed with a mechanical defect that made it work epileptically, and drained resources. She informed us that the machine was up for sale so that whatever could be realized from the sale would be added to some other monies to enable them purchase a new one. The case of Otukpo-Nobi was that of lack of an operator for the corn milling/gari processing machine. Therefore, the machine laid fallow at the time we visited the community.[99]

Apart from supporting the communities with MEH projects, the BHF project also supported communities in the construction of roads and culverts that had hindered them from accessing health care facilities due to inaccessibly, especially during the rainy seasons. For instance the project built culverts and rehabilitated a 15-Kilometer road from AMaafu to Tyogbenda-Udende, an eigth- kilometer road from Otukpo to Otukpo-Nobi and ten kilometer road from Tyemimongo to Mbaduku, to mention only a few. Our visits to these roads and culverts proved that if well maintained the people would continue to have unmitigated access to health care facilities as shown on Plates XXVII and XXVIII, pages

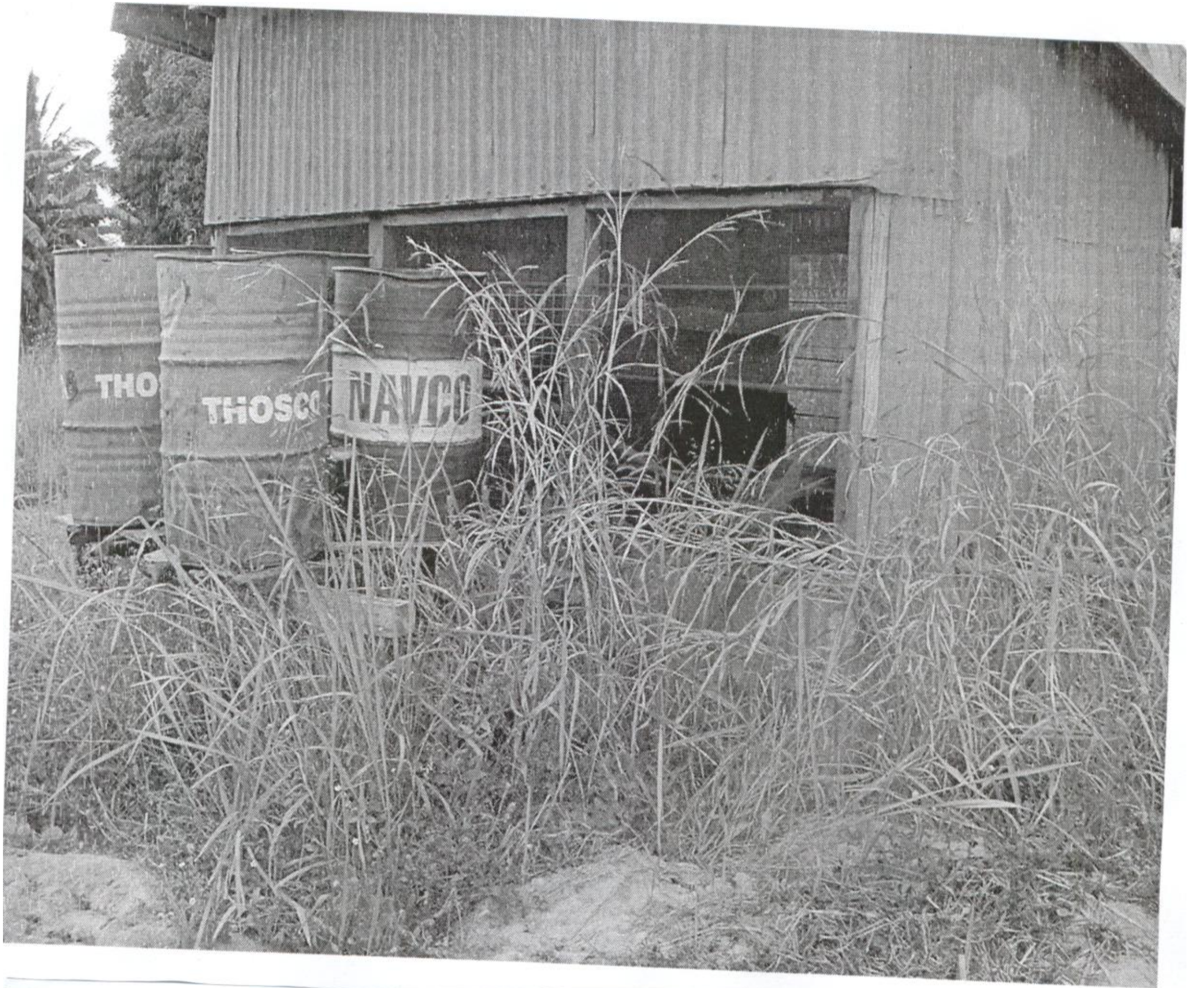

Plate XXV: An Abandoned Rice Milling Machine at Ugondozua Community, Logo LGA.

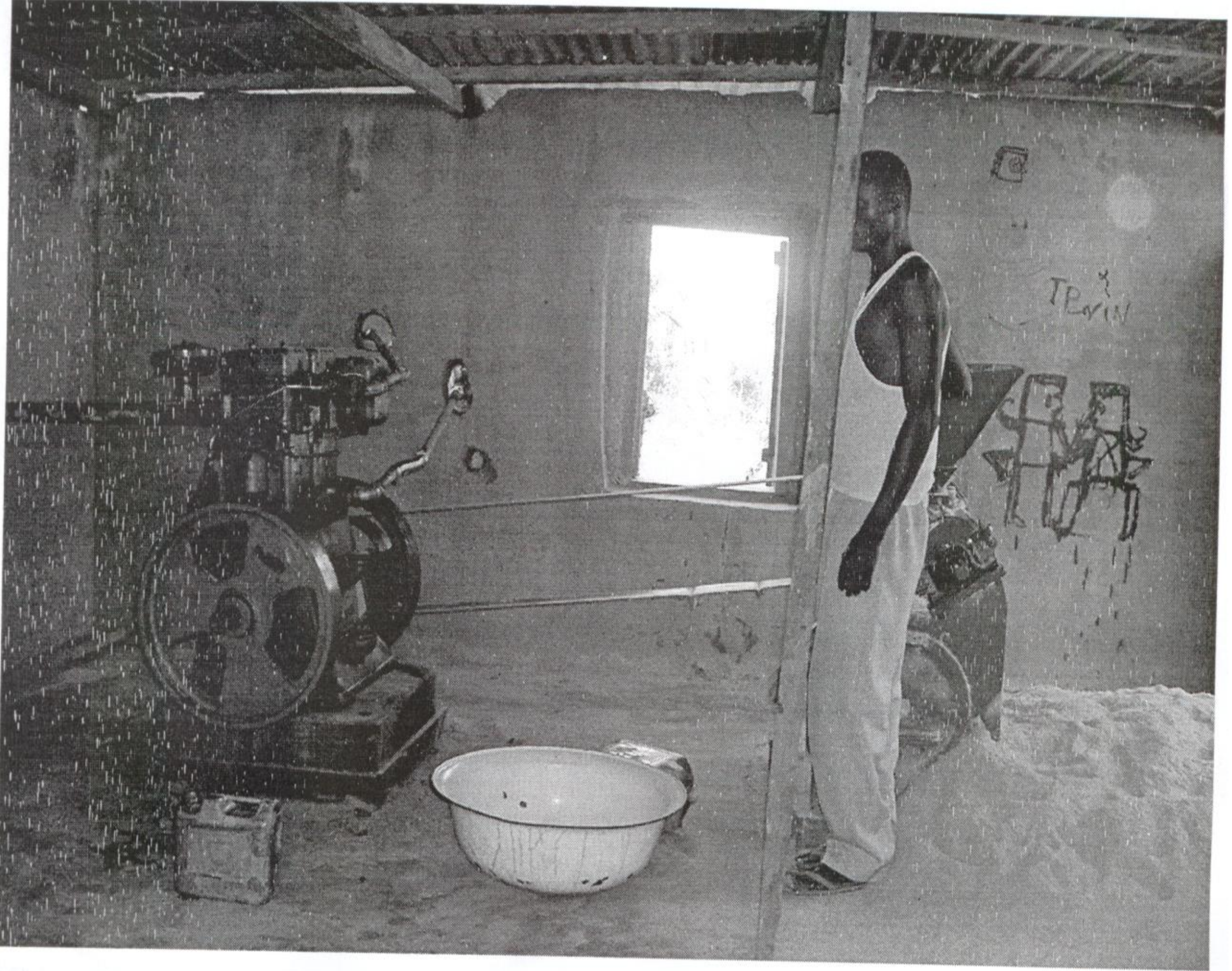

Plate XXVI: An MEH Machine Operator at work at Ukazo, Gboko LGA.

271 and 272. In Abetse community in Gboko LGA, the BHF project did not only install corn milling and gari processing machines for the widows, it also built a youth centre for the.

community. Built under the auspices of Mbategy youths, the centre has office facilities and a basketball court as shown on Plate XXIX, page 273

As at the time of our visit the centre was turned into an administrative block of the Mbategh community college, an initiative of the youths. In an interview with the Principal of the college who is also a youth leader, he expressed gratitude to the BHF project for its development efforts in the community.[100]

On CBOs our findings showed that the BHF made quite some efforts. Several CBOs sprang up in the focal communities with different kinds of names. Most of the CBOs formed were at the instance of BHF project, for the purpose of supporting them with MEH projects. A preponderance of the CBOs was formed by women, especially widows. It was discovered, however, that many of these CBOs were only active and functional as long as the project lasted. With the closure of BHF many of them went into a State of inactivity even though they still existed in name. This, again, brings us to the point emphasized a couple of times that many of the BHF project's initiatives required prolonged capacity building and orientation for them to succeed. The CBO project was a noble are but it required good time for maturation. They were formed hurriedly and they seemed to be declining in a hurry.

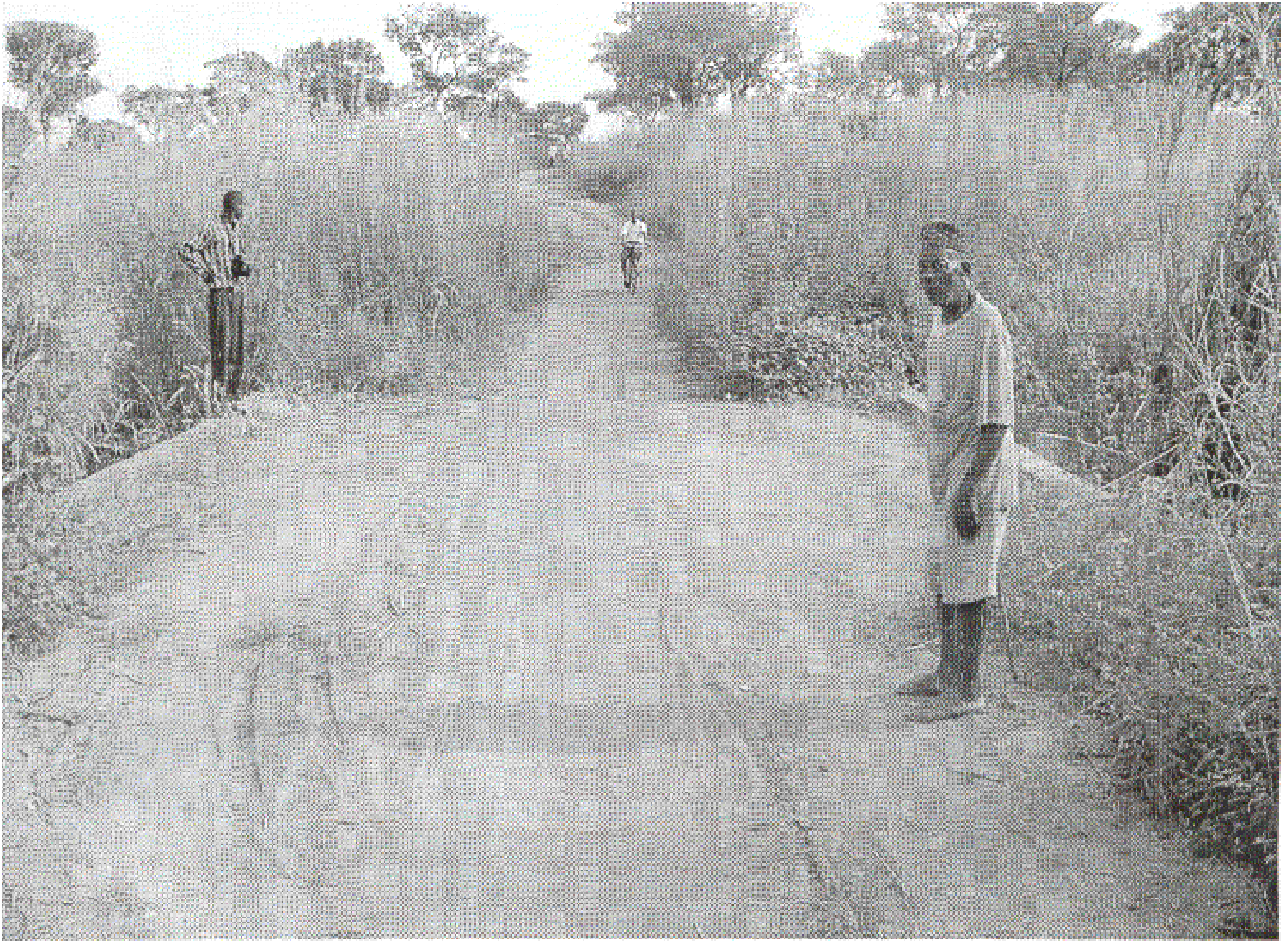

Plate XXVII: A Rehabilitated Road by the BHF Project at Tyemimiogo, Vandeikya LGA.

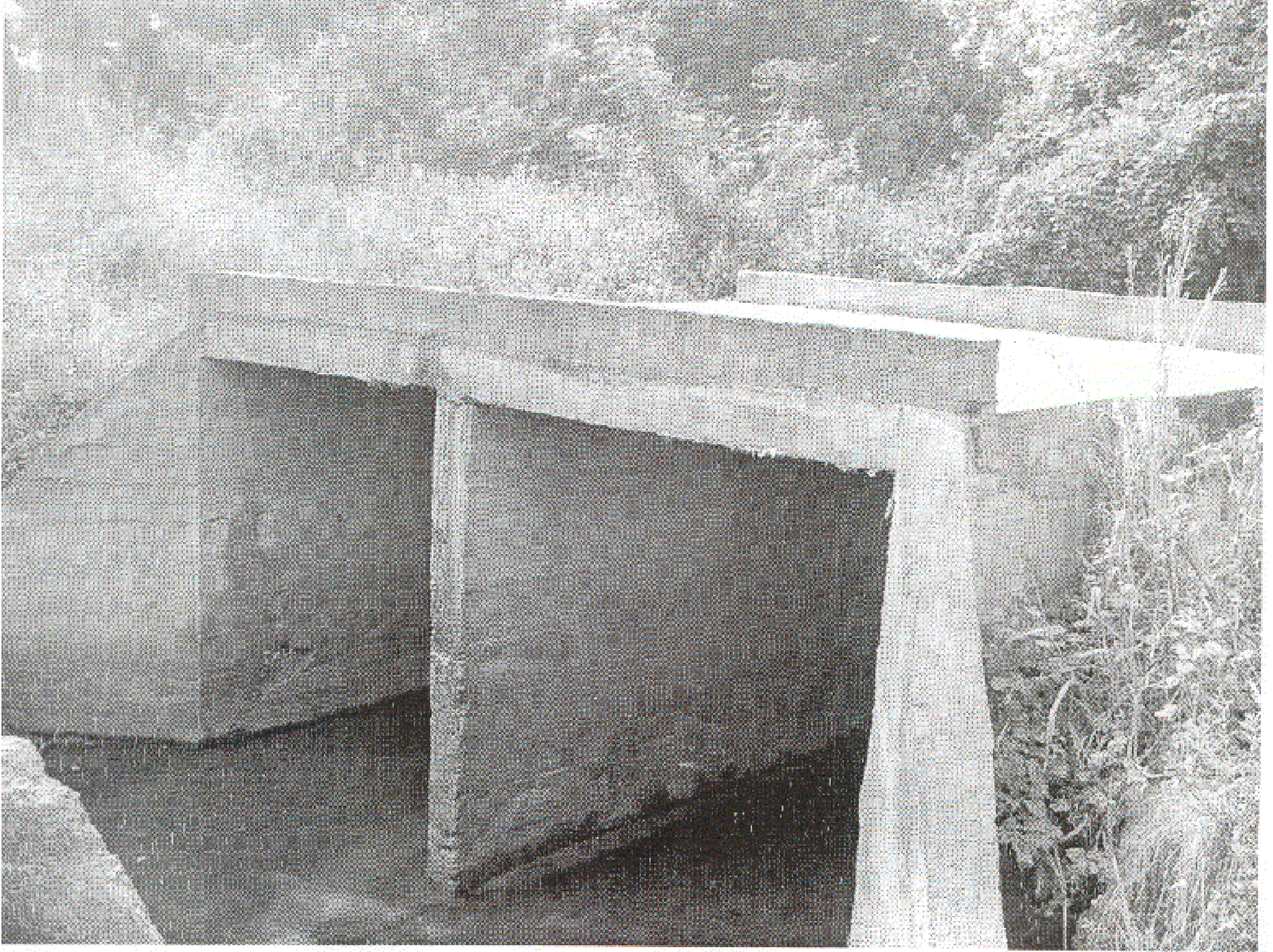

Plate XXVIII: A Road Culvert Built by the BHE Project at Otukpo-Nobi, Otukpo LGA

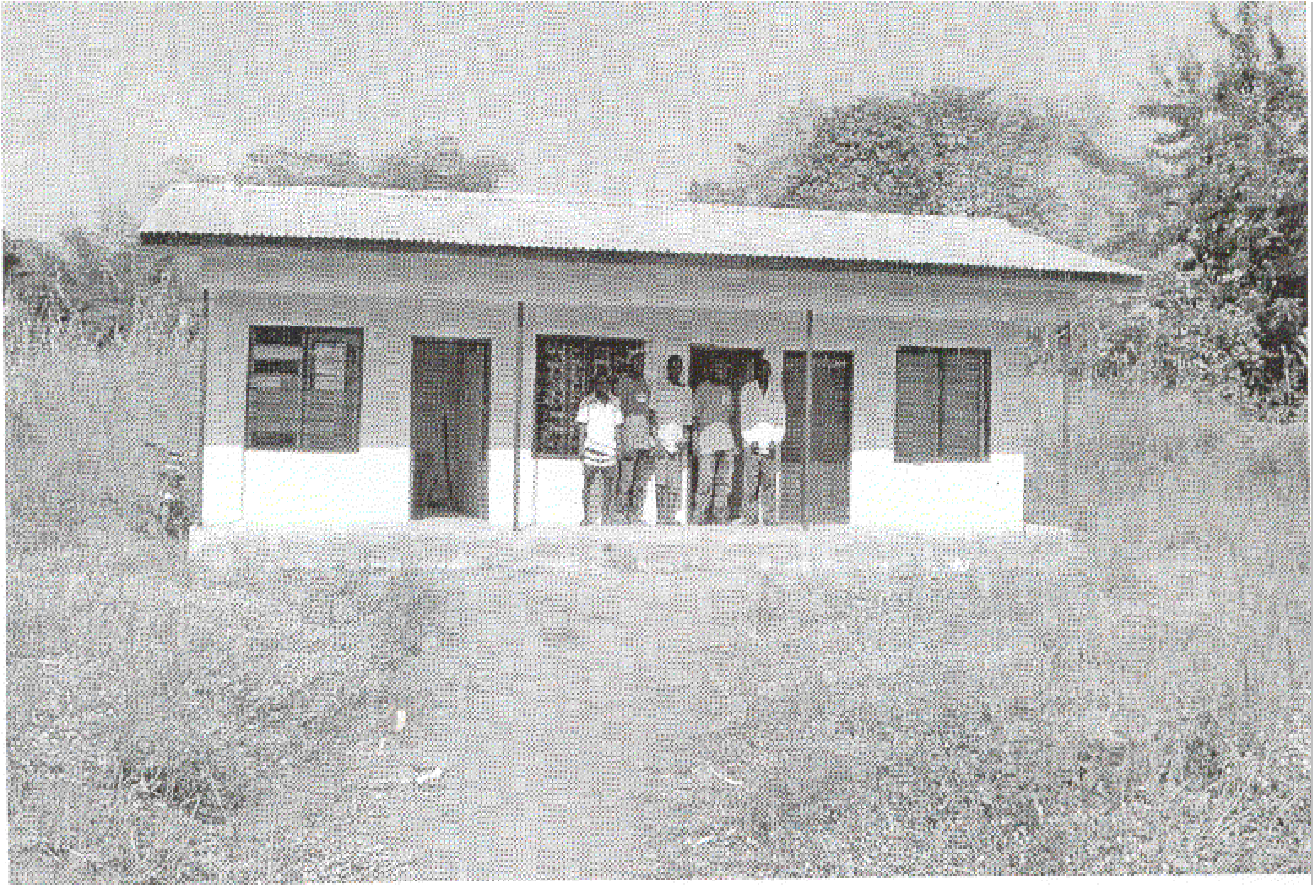

Plate XXIX: A Youth Center Built by BHF for Mbategh Youths Abetse, Gboko LGA.

5.5.5 Gender

It was discovered that, the project addressed the issue of gender in it's activities as enshrined in its logical framework. For instance, all the committees had fair women representation. Moreover, the MEH projects favoured women above the men. And from our investigations the women said the project empowered them enough to enable them have access to healthcare. Majority them testified that the men were not oppressing and lording it over them during committee meetings and with respect to the MEH projects. The men also said they had come to respect the worth and role of women in their communities more than before. This indicates that gender awareness, if monitored properly, could lead to the emancipation and empowerment of women in Benue communities, at least in those supported by the project.

5.5.6 Accountability and Financial Management

Although the BHF project did its modest best in building capacity in financial management and accountability, and also standardized the accounting system in both the PHC and SHC facilities, as well as at the HMB, our investigations relealed that not much impact was produced. Some informants testified that even under the eagle eyes of the project management, some people entrusted with project monies cut corners to enrich themselves.[101] To further validate this point the Director, Health Services in the State MOH said categorically that people entrusted with funds in the state generally, and in the ministry particularly, still lacked transparency in financial management. [102] This was also an area that required rigorous and prolonged capacity building efforts and orientation necessary for attitude change. On the whole the DFID spent a total of N628, 209,076.85 (£4, 188,060.51) on the BHF project, excluding personnel costs. [103] According to the State Director of Health

Services in the MOH this figure was quite substantial, when compared with what the state Government spent on health services within the same period.[104]

ENDNOTES/ REFERENCES FOR CHAPTER FIVE

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2 DFID. Benue Health Fund Project Extension. West and North Africa Department of the DFID, October 1999, pp.13. One of the earliest documents on the project produced by ODA in 1994 is titled Benue State Health Services Project.

3 Ibid. p.5.

4 Ibid. p.5. For poverty headcount of 1996, see FOS. Poverty Profile for Nigeria, 1980-1999… Op.Cit. pp. 24-27. From these figures Benue poverty was 64.2% and not 66% as claimed by DFID.

5 Ibid. p.5

6 BHF. Briefs on BHF Support to Communities and Primary Health Care in Selected L.G.As in Benue State. February 2002, p.1

7 Ibid. p.1

8 BHF. Benue Health Fund: Who We Are and What We Do. n.d. p.1

9 BHF. Briefs on BHF Support to Communities … Op.Cit. p.1

10 ODA. Benue State Health Services Project, April 1994, p. 57

11 Ibid. p.58

12 Ibid. p.58

13 Ibid. p.58

14 Ibid. p.62

15 Ibid. p 62

16 Ibid. p.63 – 64

17 Ibid. p. 64

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19 Laura Hawken and Timothy Agbidye. Report on Benue State Health Profile Data Collection in April 2001 (for the Benue State Strategic Health Planning Process), March, 2002 p. 2

20 The Tables are taken from Benue State Statistical Year Book 1996 – 1999. Makurdi: Benue State Ministry of Finance and Economic Planning, August 2002, pp. 49 and 51

21 DFID Better Health for Poor People… Op.Cit. p. 6

22 ODA. British Overseas Aid….Op.Cit. pp. 8 – 10

23 ODA. Nigeria Benue Health Fund … Op.Cit. p. 2

24 Ibid p. 2

25 Ibid. p. 3

26 Ibid. pp. 2 and 3

27 BHF. Briefs on BHF Support to Communities … Op.Cit. p. 1

28 ODA. Nigeria Benue Health Fund…Op.Cit. p. 24

29 BHF. Briefs on BHF Support to Communities… Op.Cit. p. 4

30 Ibid. p. 5

31 Ibid. p.6

32 Ibid. p. 88

33 Ibid. p. 8

34 A 'night half' according to the BHF, is an evening meeting with a community. Drama and songs in vernacular which involve community members are used to pass on health messages. The messages were usually about community ownership and management of the DRF in their PHC Clinics, and the role of the VDCs. The BHF worked with the staff and students of the Benue State University's Department of Theatre Arts.

35 BHF. Briefs on BHF Support to Communities… Op.Cit. pp. 9 – 10

36 Ibid. p. 11

37 DFID. Nigeria Country Strategy Paper… Op.Cit. p. 8

38 BH. Briefs on BHF Support to Communities … Op.Cit. p. 12

39 Ibid. p. 18

40 Ibid. p. 19

41 Ibid. p. 20

42 Ibid. p. 23

43 Ibid. p. 23

44 Ibid. p. 26. This statistics/data were got from BHF's quality of care survey undertaken in July and August 2000.

45 Ibid. p.30

46 Ibid. p. 31 – 32

47 Ibid. p.43

48 Ibid. p.43

49 Ibid. p. 46

50 The communities were Ipolo, Opa-Adoka and Otukpo-Nobi in Idoma- speaking area, and Ambigir, Mbanoroki and Ukazo in Tiv- speaking area.

51 William Anyebe. et al. Poverty, Practices and Preferences in Rural Benue: Findings of an Operational Research Programme into Deferring and Exempting Payment for Health Care (A Report for BHF) April 1999.

52 BHF. Briefs on BHF Support to Communities… Op.Cit. p. 48

53 Ibid. p. 48

54 Ibid. p. 51

55 Ibid. p. 53

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59 Ruth Dul. et al. Capacity Building for Community Based Organizations (A Report Prepared for BHF by CRUDAN), December 2001, p. 1

60 BHF. Briefs on BHF Support to Communities… Op.Cit. p. 58

61 Ibid. p. 58

62 BHD. Briefs on BHF Support to Selected Secondary Health Care Facilities in Benue State, September 2001, p. 1

63 Ibid. p. 3

64 Ibid. p. 3

65 Ibid. pp. 5-6

66 Ibid. p. 8

67 BHF. Decentralization of Hospitals Management– A Reform Process: The Benue Experience. n.d. p. 2.

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71 Ibid. p. 11

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76 Ibid. p. 16

77 Ibid. p. 20

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79 Ibid. p. 21

80 William Anyebe. Something New: A Report of the Consultation Phase of the

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81 All the issues raised in this section are based on an OPR report titled BENUE HEALTH FUND OPR REPORT AUGUST 2001

82 William Anyebe (45), Executive Co-ordinator, Treeshade associates (Health and Social Development Consultants), Makurdi. Provided this opinion in an interview on 8/1/04

83 Some stakeholder officials interviewed include Edward Akuto (48), Medical Doctor and Director, Health Services, State MOH, 8/12/03; Peter Igbo (50) Medical Doctor and Executive Secretary, Health Management Board, 22/12/03; Mrs. Rachael Apuu (46) Ag. PHC Co-ordinator, Vande-Ikya LGA, 2/12/03; Mr. Azua Gbaa (38) PHC Co-ordinator, Kastina-Ala LGA, 2/12/03; Mr. Moses Num (50) PHC Co-ordinator Logo LGA 3/12/03; Mrs. Joyce Gerna (47) OHC Co-ordinator Gboko LGA, 4/12/03; Mrs. Comfort Ibu (47) Deputy PHC Co-ordinator Tarka LGA 5/10/03; Mr. Obande Uba (40) PHC Co-ordinator Otukpo LGA 17/12/03; Mr. Emmanuel Adikwu (42) PHC Co-ordinator Ohimini LGA 18/ 12/03.

84 The terminology ‘white people’ is in common use among the rural communities to describe the British Government expatriate staff in development work in the State.

85 Some of the VDC chairmen interviewed accepted that they met irregularly or never met at all. They include: Mr. Hemen Dookicha (60) VDC Chairman, Tyemimongo, Vandeikya LGA 1/12/03; Mr. Samuel Tsar (50) VDC Chairman, Tsar-Mbaduku, Vandeikya LGA 1/12/03; Mr. Chirve Aminde (65) VDC Chairman Abaji-Kpav, Kastina-Ala LGA 2/12/03; Mr. lordye Kurungu (65) VDC Chairman, Iwerndyer, Logo LGA 3/12/03; Mr. Samuel Aluka (58) VDC Chairman Ukazo Gboko LGA 24/11/03; Mr. Yange Duger (35) VDC Secretary, Asukunya, Tarka LGA 5/12/03; and Hyacinth Alike (55) VDC Chairman, Onyangede, Ohimini LGA. 18/12/03.

86 In the case of the Oju and Obi Water and sanitation Project this attitude was discouraged from the onset. Job Ominyi (39), former WaterAid programme Officer said they made the communities own the project from the early stages. He said it was the communities that fed them when they visited.

87 For full details of what the project did for hospitals, PHC Clinics, communities and institutions and the costs involved. See BHF. Summary of Works and Donations 1997 – 2002

88 We interviewed the following: Dr. Nathaniel Peter (39), Medical Director, NKST Hospital Mbaakon, Vandeikya LGA 1/12/2003; Mr. David Anga (47), Hospital Secretary, General Hospital Kastina-Ala; 2/12/2003; Dr. Joseph Kumba (40), Medical Director, General Hospital Gboko 4/12/2003; Mr. Jonah Audu (46), Hospital Secretary, General Hospital Otukpo, 17/12/2003; Mr. Jonathan Tsav (48), Hospital Administrator, St. Vincent’s Hospital Aliade, 19/12/2003; Mr. B. A. Ogar (40), Hospital Secretary, General Hospital Oju 8/1/2004; Mr. Agoho Iorshe (43), OIC, PHC Clinic Tsar-Mbaduku, Vanderkya LGA 1/12/2003; Mr. Julius Yabyi (40), Ag. OIC, PHC Clinic Tyogbenda Udende, Kastina Ala LGA 2/12/2003; Mr. David Orshi (38), OIC PHC Clinic Ukazo, Gboko LGA 24/11/2003; Mr. Peter U. Pavtar (44) OIC, PHC Clinic Abetse, Gboko LGA, 4/12/2003; Mrs. Comfort Kungwa (35) OIC, PHC Clinic Akpa, Tarka LGA, 5/12/2003; Mrs. Comfort Gile (45) OIC, Township Clinic Annune 5/12/2003; Mrs Tabitha Tyokyaa (36) OIC Mbajir community Clinic Asukunya, Mr. Ephraim Chaver (50) OIC NKST Clinic Annune 5/12/2003; Mr. Benson Agbo (45) OIC PHC Clinic Otukpo-Nobi Otukpo LGA, 17/12/2003; Mr. P. S. Owoicho (40) OIC PHC Clinic Opa-Adoka, Otukpo LGA,

18/12/2003; Mr. H. Alike (55), VDC Chairman, gave us information on behalf of the OIC PHC Clinic Onyangede, Ohimini LGA, 18/ 12/ 2003.

89 Dr. Nathaniel Peter (39)…Op.Cit.

90 Dr. Joseph Kumba (40)… Op.Cit.

91 The people interviewed with regards to this aspect were: The Executive Secretary, HMB, the Director, Health Services, MOH, the hospital secretaries and medical directors of some of the assisted hospitals, the PHC Co-ordinators of the focal LGAs and some VDCs.

92. This information is based on interviews with Mr. John Gbilin (50) Hospital Administrator, NKST Hospital Mbaakon 1/12/2003; Mr. Terumbur Orbua (32) Community Liason Officer, General Hospital Gboko 4/12/2003 and Mr. B. A. Ogar (40) Hospital Administrator, General Hospital Oju, 8/1 04.

93 Interview with David Anga (47)… Op.Cit. Mr. Ephraim Chaver (50)… Op.Cit. also holds this view.

94 Some of the indigenes interviewed included Mr. Yange Duger (35) VDC Secretary, Asukunya, 5/12/ 2003; Mrs. Comfort Ibu (47)… Op.Cit.

95 Mrs. Atovi lordye (42) Treasurer, Kasev Mbanor Association Iwerndyer 3/12/2003.

96 A Community Leader, Iorhemen Kyuekaa (75) gave this explanation while responding to the question on why the rice processing machine at Tyemimongo was underutilized.

97 Mrs. Vera Kpaakpa, (40) Secretary, Abaji-Kpav Multipurpose Co-operative Society, Katsina-Ala LGA on 2/12/ 2003

98 An interview with Mr. David Tsavnum (45), Secretary, Uke-Uke Youths and Mr. Akile Jime (30), machine operator. These facts came out on 3/12/ 2003.

99 Information based on interviews with Mrs. Fatima Idrisu (65) Chairperson, Onyangede Widows Association, Ohimini LGA 18/ 12/ 2003 and Mrs. Oikwu Ondoma (67) Chairperson, Otukpo-Nobi Widows Association, Otukpo-Nobi Otukpo LGA on 17/12/ 2003.

100 Mr. Oliver Achin (25), Youth Leader and Principal, Mbategh Community College, Abetse, Gboko LGA. He was interviewed on 4/ 12/ 2003

101 This was expressed during a discussion with two former staff of the BHF project, Mr. Ignatius Tsa (47) and Mrs. Dooshima Ako (35) on 24/ 11/ 2003.

102 Dr. E. Akuto (48)… Op.Cit.

103 BHF. Summary of Works … Op.Cit. p.28

104 Dr, E. Akuto (48)… Op.Cit.

CHAPTER SIX
THE STD/HIV MANAGEMENT PROJECT

6.1 INTRODUCTION

According to the Final Report of the Benue State HIV/AIDS Control Committee, it was estimated that about 333 million new cases of sexually transmitted diseases (STDs)[1] occurred globally. The report stated that although reliable data on STDs did not exist in Nigeria, publications from hospital-based studies estimated that STD patients were fifth among Clinic attendees in Nigeria. The report stated further that untreated STDs in either partner increased the risk, up to ten times, of contracting the Human Immune deficiency Virus (HIV), the virus responsible for the Acquired Immune Deficiency Syndrome (AIDS).[2]

The first case of AIDS in Nigeria was diagnosed in 1986, and from that period up to the present there has been a steady rise in the prevalence of the HIV/AIDS epidemic, from 1.8% in 1993, to 3.8% in 1994, to 4.5% in 1998, and to 5.4% in 1999. It was estimated that 2.6 million Nigerians were already infected, with people in the age bracket of between 19 and 24 recording the highest prevalence.[3]

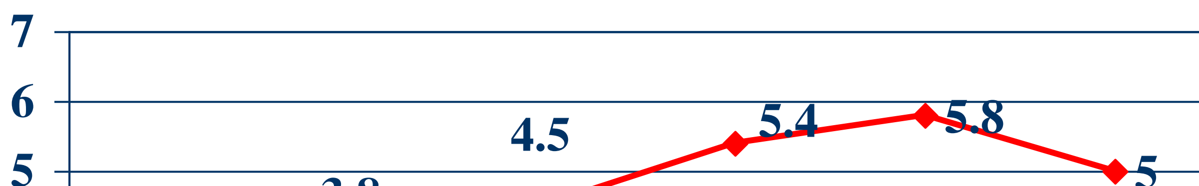
In 1994, out of the 20 states in Nigeria that recorded HIV prevalence, Benue State was the second with 11.6%. Plateau State was first with 12.6%, while Oyo State was last with 0.2%. However, the 1999 sero-prevalence survey rated Benue State as having the highest prevalence in the country with 16.8%, while back home in Benue State Otukpo LGA was singled out as having the highest HIV/AIDS prevalence rating.[4] Three years later the figures for Benue State dropped. This drop was probably due to the activities of the STD/HIV Management Project that had commenced its intervention in the State. In spite of

this drop, Benus State was still leading in prevalence rating in the federation with 13.8%. Jigawa State was last with 1.8%.[5]

These figures were disclosed by the Chairman of the National Action Committee on AIDS (N A C A), Professor Babatunde Osotimehin. He also disclosed that as at the end of December 2002, Nigeria had a sero-prevalence rate of 5.8% and warned that once a country went beyond 5%, it went into the explosive stage of the epidemic. According to him, by 2010 Nigeria was likely to have 15 million of her citizens infected, a figure he credited to the then recent survey by the US National Intelligence Council.[6] He advocated for a multi-sectoral approach to the pandemic, involving all stakeholders, faith-based organizations and schools, among others.

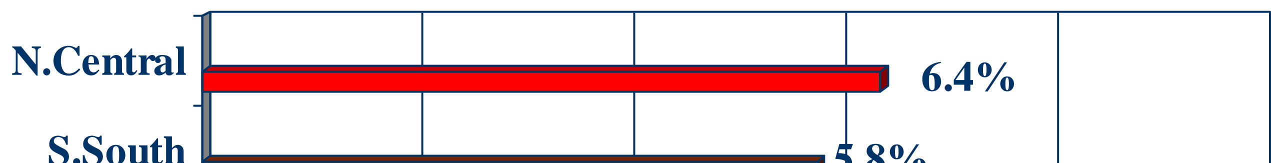
According to the Federal Ministry of Health, even though there was a decrease in the national prevalence of HIV, the trend was not consistent in all the states of the Federation. For instance, the 2003 survey showed that between 1999 and 2003, Benue, Akwa-Ibom, Nasarawa, Ebonyi, Edo and Imo States showed a decline while other states such as Yobe, Jigawa, Abia, Sokoto and Cross-River showed increasing prevalence rate. The figures published showed that although Benue State prevalence rate dropped from 13.5% in 2001 to 9.3% in 2003, the State recorded the second highest prevalence rate in the country with Cross-River State taking the first position. Benue State was adjudged to have the highest prevalence rate in the North Central Zone of the country.[7] Figures 6 to 8 on pages 285 to 287 best describes the HIV prevalence situation in Nigeria and Benue State.

Figure 6: Median National HIV Prevalence Increase: 1992 - 2003



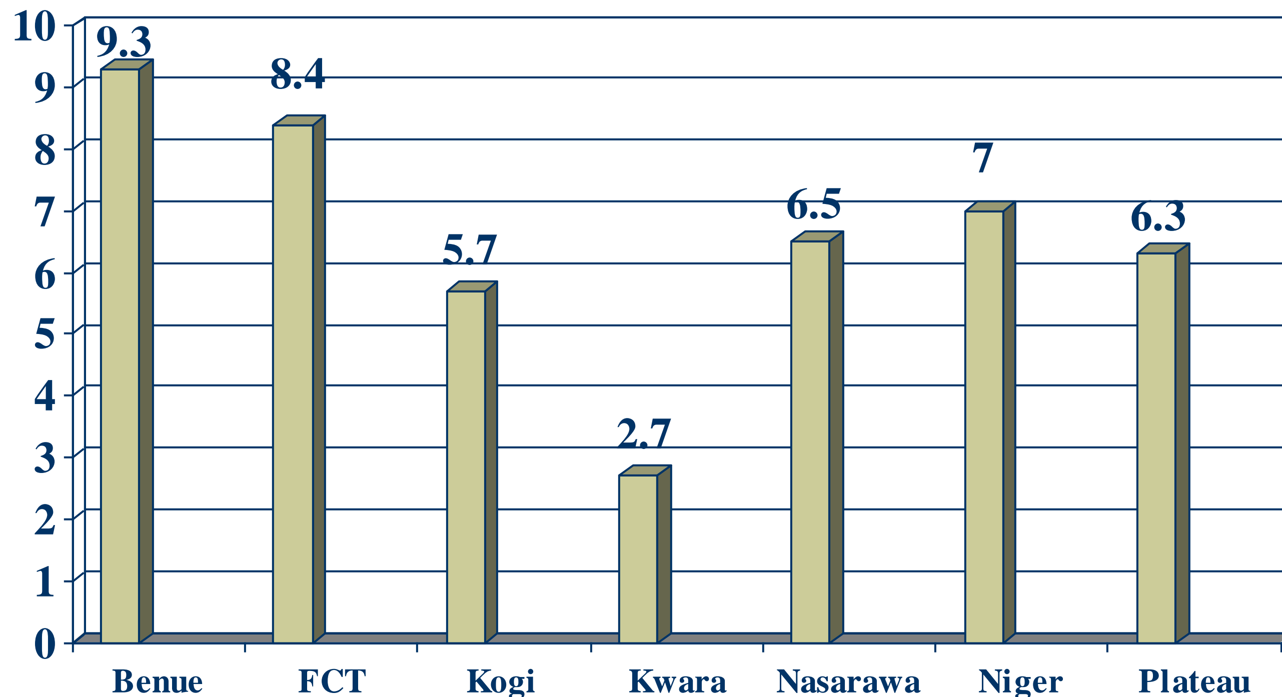
Source: National Action Committee on AIDS

Figure 7: Median HIV Prevalence by zone: 2003



Source: National Action Committee on AIDS

Figure 8: HIV Prevalence in North Central Zone: 2003



Source: National Action Committee on AIDS

The DFID had been working in the area of STD/HIV management in Nigeria since 1991. However, in 1996 a project design team surveyed the possibility of establishing STD/HIV management project in Nigeria that would integrate both Clinical and community-

based approaches to STD/HIV control and management The target of this project was high-risk and vulnerable groups. This innovative but complex project took off in May 1997. The project was situated at two sites, Otukpo in Benue State and Sagamu in Ogun State. Originally, the project was scheduled to end in November 1999, but was extended by three years based on the recommendations of an OPR report.[8]

The STD/HIV Management Project was funded by DFID but contracted to Liverpool Associates in Tropical Health (LATH), a subsidiary of the Liverpool School of Tropical Medicine, Leeds, UK. LATH sub-contracted the project to Pathfinder International, a UK-based NGO, for management but this arrangement existed only up to the end of the first phase of the project. The project office was situated in Lagos and was headed by a project field manager while the Otukpo and Sagamu offices were referred to as project sites and headed by field coordinators. Although, the STD/HIV Management Project located at Otukpo and Sagamu were considered as one and the same project, sharing the same logical frameworks and other project documents, our study will cover only aspects of the project work in Benue, as Ogun State is not included in the scope of this study.

It is not very clear why Otukpo was selected as a project site for the STD/HIV Management Project in Benue State. Even though by the 1999 sentinel survey, the LGA had the highest HIV/AIDS prevalence in the State, by 1997 when the field offices were set up the LGA had not yet been discovered as a HIV/AIDS endemic area. Therefore the choice of Otukpo could possibly have been informed by prevalence ratings from previous surveys that were carried out in 1993, 1994 and 1996. Another possibility could be the fact that Otukpo town was noted for out-migration, much of which was associated with sex work, also known in local parlance as prostitution.

The STD/HIV Management Project (hereinafter referred to as the LATH project or simply as LATH), had six secondary stakeholders in Benue, namely, Otukpo General Hospital (OGH) St. Vincents Hospital Aliade (SVHA) St. Joseph's Rural Health Center Ogobia (SJRHCO), the Otukpo LGA PHC Department, the Planned Parenthood Federation of Nigeria (PPFN), Otukpo and the Otukpo branch of the Society for Women and AIDS in Africa, Nigeria Chapter (SWAAN).[9] The SJRHC Ogobia withdrew from the LATH project, after the first phase. The circumstance surrounding this withdrawal will be discussed in due course.

Apart from the key issues of STD/HIV/AIDS which were in focus, the SVHA partnered with LATH in view of its outstanding efforts in the control of tuberculosis (TB), one of the diseases easily associated with AIDS. The primary stakeholders in the LATH project included sex workers, in and out-of-school adolescents, youths, cyclists, motor park user, police, prisoners and prison staff, people living with HIV/AIDS (PLWHA), people affected by HIV/AIDS (PABA) and communities.

The goal of the LATH project, as captured by the initial log frame, revised in February 1999, was to "reduce the prevalence, incidence and impact of sexually transmitted infections, including HIV, in Nigeria". The purpose of the project was to "create optimal access to health and information services for persons vulnerable to, and affected by, STD/HIV/AIDS in Sagamu, Otukpo and Aliade". However, after the first OPR, the goal and purpose of the project was modified slightly. The modified goal was "to support and inform the development and implementation of a comprehensive, effective, evidence-based and appropriately researched national HIV strategy in Nigeria." The purpose was now to "improve the access of high-risk and specific vulnerable groups to quality HIV/STD and TB

health, and support interventions in Benue and Ogun States."[10] Reasons for these slight modifications will be highlighted in the next section (6.2).

In order to achieve the goal and purpose for this project, LATH built a body of knowledge on ways of working with high-risk groups, which were essentially the primary stakeholders in the project, and developed models for providing care and support to PLWHA.

As we did in our study of the first two DFID projects in Benue State, we shall now consider the efforts of the Benue State Government in addressing the HIV/AIDS crisis in the State before the DFID intervention.

As it were, there is no evidence to show that previous government in Benue State took decisive steps to address the HIV/AIDS question in the State, in spite of the fact that the epidemic had generated so much concern globally and nationally. As stated earlier, Benue State was second in prevalence rating in 1994, out of the 20 States surveyed. Even then the Benue State Government did not adopt any measures to stem the spread of the epidemic. It was about four years after the British Government's intervention in the State that the democratic government of Mr. Goerge Akume, which came into office in May 1999, took some steps to address this crisis.

On March 20, 2000 Governor George Akume constituted the Benue State HIV/AIDS Control Committee (BEN-SHACC) with the following Terms of Reference (ToR):

i) To develop a strategic plan for HIV/AIDS control for Benue State covering both short and long term measures.

ii) To look into the claims of HIV/AIDS cure, monitor the efficacy of such claims (drugs?) and suggest steps to be taken for the implementation/application of effective ones.

iii) To propose measures to link up with the national HIV/AIDS control programme under the presidency and other reputable organizations working with the goal of controlling the HIV/AIDS scourge.

iv) To examine and propose any measures of controlling the HIV/ scourge in the State.[11]

By the end of its assignment in August 2001, the committee made the following recommendations, among others:

i) To launch a Benue Initiative on HIV/AIDS

ii) Carry out a HIV sero-prevalence survey for Benue State.

iii) To provide a functional resource centre for HIV/AIDS and STDs in the State

iv) To build capacity of health workers and strengthen the applications of the universal precautions for infection prevention in all health facilities in the State.

v) Identifying HIV/AIDS core support groups and promoting their networking activities on a zonal basis.

vi) Encouraging and facilitating the formation of HIV/AIDS control committees at the LGA levels.

vii) Government to make substantial annual budgetary allocations for a multi-sectoral approach to HIV/AIDS control in the State.

viii) Government should act in line with national policy on claims of HIV/AIDS cure in view of the huge costs involved in investigating such claims.[12]

BEN-SHACC claimed that during the period of its assignment, it linked up the State with NACA. Consequently, NACA supplied the committee with useful resource materials to ensure that the State's activities were in line with national strategies. The committee also developed protocols for Clinical evaluation of anti-retroviral drugs and alternative therapy.

Moreover, the committee claimed to have identified core HIV/AIDS support groups in the State and a two-day forum workshop was organized for them.[13]

BEN-SHACC was dissolved in September 2001 and was replaced by a 29-member committee known as the Benue State Action Committee on AIDS (BEN-SACA), Actually, after the establishment of NACA, states were directed to replicate the structure at their levels. It was NACA's belief that HIV/AIDS could better be tackled through multi-sectoral approaches, thus the need for States to take a cue from the Federal Government. In Benue State, several ministries and organizations were represented on SACA. Some representatives of Agriculture, Education and Health ministries on the committee underwent training. Moreover, the State Government also established a state HIV/AIDS Programme Development Project and appointed a substantive project manager for it. In February 2003 the World Bank gave the State a grant of 2.3 million dollars for the fight against the deadly disease.[14] According to the programme manager, the grant was used to take the HIV/AIDS campaign to the grassroots.

Another step towards addressing the HIV/AIDS crisis which could be credited to the State Government was taken when the State, with the assistance from the BHF project, set out to support the development of a strategic health plan that would take care of the health needs of the people. This plan, known as the Benue State Strategic Health Planning Process (SHPP), was necessitated by the realization that although donor activities in this area helped to address certain problems, their activities have highlighted some major challenges that still existed. The realization by the Benue State Government that these deep-seated problems which required far reaching strategic changes and reforms ought to be seriously addressed, initiated a process of strategic analysis of services at all levels. Core health needs and problems were examined, priorities identified and future directions considered. Seven key

health sectors/issues were examined by seven different committees, among which was the committee on HIV/AIDS. This committee was charged with the responsibility of carrying out a study with a view to describing the HIV/AIDS situation in Benue State, identifying and discussing the factors responsible for the rapid spread of the infection in Benue State. Also, the study was to highlight key issues in HIV/AIDS transmission and control in Benue State and propose implementation policy options for the control of the disease.[15]

The findings of the HIV/AIDS committee, briefly stated, showed that there was a good knowledge of the HIV/AIDS epidemic among Benue communities to the extent that they had local names for the disease. The communities were aware of the symptoms of the infection and knew their members who were infected. The study also showed that the people knew fairly well about the factors that encouraged infection such as transfusion of infected blood, sharing contaminated sharp objects and through unprotected sexual intercourse with infected person(s). Also, though there was considerable awareness of HIV/AIDS, and STDs, the people had some misconceptions about HIV/AIDS transmission. For instance, from the BHF and LATH survey cited by this committee, some people believed that the disease could be contacted through sharing toilets and rooms with infected persons, witchcraft, persistent illness, and so on. This misconception consequently brought about stigmatization of PLWHA in Benue communities. On the knowledge of ways to prevent and cure HIV/AIDS, the committee found that the people were fairly aware that safe sex practices, use of sterilized objects, use of screened blood and use of condoms were preventive measures, while some suggested prayers, herbs and Dr. Abalaka’s remedies as curative measures. However, according to the committee’s report, some said the disease had no cure.[16]

The weakness of this committee's work was that in spite of its beautiful attempt at discovering much about the HIV/AIDS situation in Benue State, it made no recommendations to the government to guide it on policy options for fighting the epidemic.

Without being judgmental, it is our opinion that the response of the Benue State Government to the HIV/AIDS pandemic was rather belated, considering the 1994 and 1999 alarming sero-prevalence survey reports. Even presently the efforts being made by the State HIV/AIDS Programme Development Project are not aggressive enough to tackle a hydra-headed epidemic of STDs, HIV/AIDS and TB. This notwithstanding, the present efforts seemed to be modest and potentially viable, justifying the dictum that half bread is better than none.

6.2 PROJECT CONCEPTION

As we observed in chapter five, the STD/HIV/AIDS as an issue of concern to the international community in general, and Britain in particular, featured in an ODA publication of 1994.[17] To put it more pungently, the HIV/AIDS and TB control agenda of the British Government was, and has been, considered under a general and broad-based health programme of the government. We may be over flogging the issue and risking repetition here since much of what we said in the last two chapters under project conception is applicable to this section. However a few salient points on HIV/AIDS may be relevant to add more emphasis to the conception of the LATH project in Benue State.

The British Prime Minister, Tony Blair, Who came to office in 1997, re-iterated Britain's commitment to the fight against HIV/AIDS. In a foreward to the White Paper on International Development titled <u>Eliminating World Poverty: Making Globalization Work For the Poor</u> he said that the spread of health pandemics such as HIV/AIDS were caused or

exacerbated by poverty. He looked at HIV/AIDS as part of the threats to global peace and security. To him, the elimination of such pandemic will be a sure solution to the problem of world poverty.[18] In the same publication, a grave picture of the impact of HIV/AIDS, globally, was painted. For instance, the White Paper maintained that HIV/AIDS was both a human and development tragedy since around 22million people have died of the epidemic with 16,000 new HIV infections every day! Out of these figures the developing nations recorded 90% with 70% coming to sub-Saharan Africa (Nigeria inclusive). In sub-Saharan Africa, the White Paper reported that life expectancy had fallen by 20 years while the cost of treatment and care for PLWHA has impoverished many families and communities. For example, potential wage earners were forced to stay at home to care for infected relations. Girls, particularly, missed studies for the same reasons. Valuable family assets were sold to pay for medical bills, etc. Moreover, the paper speculated that within the next five years there could be as many as 40 million maternal orphans in sub-Saharan Africa. Moreover, the cost of HIV/AIDS was massive. This was so because, according to the White Paper, health budgets had to be increased at the expense of other sectors. Also, death and absenteeism reduced labour supply and productivity. In countries with a high prevalence rate, like Nigeria, workforce was likely to be more than 17% smaller by 2015 than it would have been without HIV/AIDS. For example, Zambia lost 1,300 teachers from AIDS in the first 10 months of 1998, more than two-thirds of the number of new teachers trained that year.[19]

Addressing the health situation in Nigeria and the HIV/AIDS condition in particular, the DFID in its Country Strategy Paper for Nigeria stated that Nigeria's health system was dilapidated to the extent that health systems were failing to deliver the most basic services which had caused a steady decline in life expectancy. Moreover, infant and under-5 mortality rates were among the highest in the world, while maternal mortality rates were

dreadful. According to the Strategy Paper, although access to reproductive health services had improved through social marketing, limited access to contraception implied that women could not choose to have children when they wanted them. Thus, the total fertility rate in the country was high.

The paper maintained that TB and malaria were still leading causes of death due to poor access to quick and accurate diagnosis and treatment. While Nigeria, according to this publication, remained a reservoir of infections such as polio and guinea worm, the cost of the drugs for TB treatment was beyond the reach of the poor and vulnerable groups.[20]

On HIV/AIDS, the Country Strategy Paper stated as following:

> HIV media prevalence levels among women attending ante-natal Clinics have reached 5.4% (rising to 21% in one state and with average levels of 8.4% among the 20-24 age group). Without adequate intervention, once the 5% threshold is crossed there is likely to be rapid increase in HIV prevalence, and by 2003 Nigeria will have the largest number of people infected of any country in Africa.[21]

The consequences of this scenario as explained by this publication tallies with those explained in the White Paper in reference. The strategy paper concluded its comments on the HIV/AIDS condition in Nigeria with a call on all for concerted action to slow the pace of the epidemic and reduce its impact on the nation.

Perhaps, to underscore the importance the British Government attached to its determination to fight HIV/AIDS in developing countries and in Nigeria, particularly, the DFID published a strategy paper on HIV/AIDS in Nigeria. Titled Nigeria: HIV/AIDS Strategy, the publication, among many other issues, outlined a policy response to HIV/AIDS. The DFID's policy framework included the reduction of poverty which exacerbates HIV/AIDS and tackling HIV/AIDS as a key development issue. The DFID's response to HIV/AIDS in Nigeria included networking with global partners such as UNAIDS, national partners and the development of new knowledge and technologies. This

was to involve working with other donors to improve affordability of current and future drugs and other technologies for preventing HIV transmission and the care for PLWHA. Also, the response was to develop effective vaccines for Nigeria and other developing countries. Furthermore, DFID intended to support awareness programmes on HIV/AIDS and reproductive health as well as commission strategic research on key issues that would guide policy formulation and best practices ob HIV/AIDS prevention such as the multi-sectoral strategies in tackling the epidemic and behaviour change interventions.[22]

Although, the LATH project in Benue State commenced before the publication of this strategy paper, it is evident that it was a follow-up to the ODA agenda published in 1994 and also a follow-up to the UK Government's policy published in 1997. As a matter of fact, the strategy paper made elaborate reference to the 1997 White Paper.[23]

The LATH project had a project framework that was initially prepared, revised and used during the first phase of the project. There was yet another one, which was a modification of the first, during the extension period. For details on the logframes, refer to the project documents titled STD/HIV Management Project, Nigeria, Revised Logframe, February 1999 and STD/HIV Management Project Extension, Nigeria, November 1999.

In the introduction to this chapter we mentioned that the goal and purpose of the LATH project as contained in the initial log frame was modified during extension phase. This became necessary because, according to LATH, the extension phase sought to strengthen and consolidate the progress recorded, through the provision and testing of STD/HIV prevention, care and support interventions which were responsive to the expressed need of both primary and secondary stakeholders. This was going to help in the development of a national strategy for working with high-risk and vulnerable groups. To this extent, the LATH project management took another look at the initial log frame with a view to making

some changes that were going to enhance the project's success.[24] For instance, the LATH project felt that the original goal of the project was rather narrow. To reduce the prevalence, incidence and impact of STDs including HIV in Nigeria was good but to assist Nigeria to develop a national HIV strategy was definitely better. Therefore, this goal was modified. There was also a change of emphasis at the purpose level. According to LATH this change was to encompass a more attainable objective than was originally envisaged. The initial purpose was "to create optimal access to health and information service for persons vulnerable to, and affected by STD/HIV/AIDS in Sagamu, Otukpo and Aliade" while the later one was "to improve access of high-risk and specific vulnerable groups to quality HIV/STD/TB health and support interventions in Benue and Ogun States. This revision was based on a number of factors. One of these factors included the impossibility of arriving at a workable consensus among primary and secondary stakeholders on "optimal access". Another factor was the need to help both primary and secondary stakeholders to realize, more than ever before, that they were not merely passive receivers of services but active members of the process, with LATH as only support providers. Thus, there was need to add the phrase "support interventions" in the extension log frame.[25]

The point we intend to emphasize here is that the extension log frame was a product of the original one and that the changes were made in order to ensure the overall success of the LATH project. As a matter of fact, these changes occurred, not only at goal and purpose levels, but also at many other levels of the log frame.

6.3 PROJECT IMPLEMENTATION

Jean Lennock, then Deputy Health and Population Field Manager in the British High Commission in Nigeria admitted, in 1999, that the LATH project faced several difficulties

during the implementation process. These difficulties, according to him, included conflicts within the communities, conflicts among stakeholder, delays in project funding, complex management arrangements and delayed research activities. In spite of these difficulties, Lennock said LATH was still able to make impressive achievements.

With the difficulties expressed above it is not very clear if the implementation process was ordered as planned in the log frame. In any case, the order of implementation did not have to follow a hard-and-fast approach, provided all the activities in the log frame were carried out, in the final analysis. Records at our disposal show that the LATH project was implemented under nine major components in focus. These components included peer education, community education, advocacy and policy engagement, counseling/home-based care and support groups. Others included TB management and control, and Clinical services, participatory monitoring and evaluation (PM&E), gender issues, and project management.[27]

6.3.1 Peer Education

According to LATH, at the inception of the project the creation of awareness of HIV/AIDS was carried out largely by government and that there was no recognition of peer education as a technique for promoting behaviour change. Therefore the LATH project had some initial difficulties in recruiting peer educators. But with the passage of time and with prolonged advocacy, the peer education programme became accepted within the communities to the extent that people demanded to be trained as peer educators.

Peer education as a technique for STD/HIV/AIDS awareness required people of the same social status or in the same age bracket talking to each other about STD, HIV and AIDS. In this approach the LATH project targeted groups engaged in high risk behaviours, namely, cyclists, youths and sex workers. For instance, peer education promoted debates on

behaviour change with the introduction of “no condom no sex” policies in brothels in Otukpo and other target communities with such facilities.[28] Also, the peer education technique helped in the reduction of stigma as well as greater awareness and demand for information by primary stakeholders and communities. LATH trained these peer educators and supported them in skills acquisition to enable them communicate knowledge on STD, HIV/AIDS to the target groups and communities. Some of the peer educators were also trained to be able to provide counseling services at the community level.

The LATH project assisted stakeholders, through advocacy, to overcome cultural and religious barriers to gain acceptability for peer education as a technique with application for groups other than youths and sex workers. For instance, the PPFN used the technique with inmates of Otukpo prison with considerable success. All the departments in the Otukpo LGA office had peer educators while some institutions such as the Benue State University established peer education groups.[29]

The peer education programme recorded some achievements. These included an increased demand for condoms by the youths, reduction of other risky behaviours such as sharing of sharp objects, transfusion of unscreened blood, etc. Other achievements included a reduction in stigmatization and rejection of PLWHA, increased disclosure of HIV status, more positive attitudes to life and improved availability of accurate and relevant information. Moreover, LATH trained peer educators among the youths, in Otukpo prison, in target communities and in schools. Also, LATH trained peer educators among PLWHA, LGA workers, among sex workers and among cyclists.[30]

These achievements notwithstanding, stakeholders had problems concerning shortage of up-to-date information, education and communication (IEC) materials in local languages even though the local radio station did its best in translating messages into Tiv

and Idoma. Other challenges the LATH project faced were the high mobility of youth peer educators and loss of HIV positive peer educators, and securing the co-operation of brothel and hotel managers in order for the peer educators to assist sex workers negotiate condom use with clients. Moreover, lack of funds for follow-up activities and sustainability as well as religious, cultural and gender diversity/barriers were identified as some of the challenges encountered by the LATH project in its peer education programme. The problem of incentives by way of financial remunerations to Peer Educators also arose.

The LATH project identified the following priorities for the future of peer education:

i) Continuous recruitment of and retraining of peer educators.

ii) Need for strong record keeping and monitoring and evaluation. (M&E)

iii) Developing links with other agencies to source for funds

iv) Mainstreaming peer education techniques into government activities.[31]

6.3.2 Community Education

Between 1999 and 2000 LATH and the BHF project supported studies that identified sexual health needs of young people in Benue communities. As a follow up to this, the communities expressed the desire for their young people, parents and community leaders to be trained as an important step towards addressing these sexual health needs. Therefore, in March 2000 secondary stakeholders from LATH and BHF agreed that a new curriculum tailored specifically to the Benue context be developed with a view to addressing HIV prevention and sexual health issues at the community level with the youths as target group. Consequently, two manuals were produced. The first was titled Working Together: A Training Manual for Community-Based Education in Sexual Health and STI/HIV Prevention while the second was titled Working Together: A Training of Trainers' Manual

for Community-Based Education in Sexual Health and STI/HIV Prevention. The first manual was reviewed in 2001 and the key concepts translated into Tiv and Idoma languages in 2002.

The objective of LATH'S community education programme were to improve community awareness and knowledge of HIV/AIDS leading to community level responses; and to improve intergenerational communication on sexual reproductive issues.[32] According to LATH, it was imperative to pursue these objectives because some Benue communities experienced problems such as those listed below, among others:

i) High prevalence of STDS and unwanted pregnancies, especially among the youths.

ii) Dearth of appropriate information and communication about sexual health matters at the disposal of the youths

iii) Poor communication between the youths and their parents due to cultural and religious inhibitions.

iv) Non participation of the female gender in community-based activities due to gender roles and relations.

v) Lack of a comprehensive curriculum for training and for providing information to the different age groups among the in-school youths.

vi) Absence of youth friendly service providers and facilities.

vii) Poverty leading to sex work.[33]

As a result of the problems cited above, coupled with the devastating impact of HIV/AIDS in the State, the LATH project, in collaboration with the BHF project, selected six communities in four LGAs for the community-based education programme. These communities included Iwendyer in Logo LGA, Abetse in Gboko LGA, Ullam in Gwer LGA and Opa-Adoka, Otada and Otobi in Otukpo LGA. The six communities were mobilized for

the programme. This was a continuous activity during the project's life-span. Essentially, the community education activities involved a detailed explanation of the programme to the communities with a view to getting them to pledge their support, commitment and involvement. Thereafter, the communities were briefed on the criteria for selecting community representatives to the training of trainers (ToT) event. One of the major criteria was specific attention to equitable representation of all the important sub-divisions within each community. For instance, young men and young women were selected as well as older men and women. Educated and uneducated members of the community were also selected.

The community-based education took place in four pilot and six focal communities, namely, Gboragayo, Abenga, Otukpo-Nobi and Otukpo-Icho. Others included Abetse, Iwerndyer, Ullam, Opa-Adoka, Otobi and Otada. Thirty two persons in each of the four piloted communities participated in the ToT trainings using the ToT manual already referred to, while community-level trainings which were carried out by the trainers took place in the six focal communities using the training manuals, also referred to earlier. These levels of trainings produced 128 peer educators between 2001 and 2002, while in 2002 alone 185 of them were produced in the communities. The mandate of the trained peer educators was to train more peer educator in their respective local governments in the use of drama, advocacy and other media of communication for passing on sexual health and HIV/AIDS messages.

It is imperative for us to briefly examine LATH's activities with specific respect to youths, as part of community education. The devastating effect of HIV/AIDS on the youths can only be imagined than described. For instance 6,000 young people aged 15-24 worldwide are infected with the virus every day! In other words, one every 15 seconds. It is no wonder then that one of the International Development Targets is to achieve a reduction

in the infection rate of youths in worst affected nations by the year 2005.[34] In Nigeria, the infection of youths by the virus is exacerbated by cultural inhibitions which we made reference to earlier. It is a situation whereby frank discussions between parents and their children on sexual matters are prohibited, thus resulting in ignorance on STD's and HIV issues. LATH's youth-focused interventions using sensitization, advocacy, peer education and training worked with in-school clubs and out-of-school activities. LATH also adopted youth-friendly approaches to health service and condom provision and counseling.[35]

The SWAAN worked with five secondary schools with a total student population of 7,250 (3,830 boys 3,420 girls), 54 peer educators and 20 trained teacher counselors. The SWAAN also involved parents-teacher associations and school principals in the campaign. The PPFN in Otukpo worked with out-of-school youths. It gave refresher training to 60 peer educators while 30 replacement peer educators received basic training. It was reported that increased numbers of young women were volunteering as PPFN peer educators. The concerted efforts of LATH and the stakeholders to mitigate the infection rate of HIV in Benue State was in order to beat the projection that by 2015 close to 40% of under 15 years olds will be orphans in the State.[36]

The community education initiative is said to have recorded achievements in Benue State such as improved awareness and knowledge of HIV/AIDS and sexual health issues. The programme also supported rural communities to act as change agents by challenging and overcoming cultural inhibitions about discussing sexual health matters. The LATH project was particular about the freedom of women and young people in discussing sexual issues in community-based forum and within marriage, made possible by the project's community training and education initiative. Moreover, LATH believed that findings from the participatory M&E showed that communities were now aware of the gender aspects of

HIV/AIDS such as sexual violence, rape, wife inheritance, etc. Also, that community and religious leadership in Benue State were encouraged to participate in HIV prevention, care and support for PLWHA.

Furthermore, the LATH project indicated that training manuals developed in Benue State and translated into Tiv and Idoma were being adopted for use in other States in Nigeria, e.g. Enugu, and in some organizations, e.g. Nigeria Fellowship of Evangelical Students (NIFES). Apart from the adoption of these manuals by some states and organizations, some aspects of it were used for other work with some vulnerable groups. For instance, they were used for peer education and community awareness activities. The community education initiative was so well received by the communities that the state and LGA officials got involved in it and plans were in the pipeline to incorporate elements of the programme into the state's sexual education curriculum by the State Commissioner of Educaation.[37] This was yet to be implemented by the State Government.

In spite of the achievements recorded, the community-based education initiative experienced some setback. For instance, the issue of financial incentives for community members who participated in the programme became a thorny issue for the project. Some of the participants actually sought financial gains from LATH. This situation affected the degree of support and involvement of communities in the initiative. Also, the LATH project did not get the required support of the State and LGA officials sufficient enough to drive the community education programme to expected limits. This was not surprising, however, considering their antecedents of poor support for the development sector.

Furthermore, LATH encountered problem in the area of supporting trainers to deliver sensitive information, and technical and theoretical concepts to a diverse crop of learners of different backgrounds, different literacy levels, attitudes and expectations.

Similarly, the translation of key concepts in the manuals into Tiv and Idoma was difficult, in view of the fact that some of the concepts and technical terms that were used in English do not exist in Tiv and Idoma. To compound this problem, Tiv and Idoma languages have some variations that are peculiar to some communities.

Finally, LATH admitted that community-based education was time consuming and capital/resource intensive. For example, delivering training that may challenge and dislodge deeply entrenched religious and cultural attitudes and practices required sustained efforts and money. Unfortunately the project had to work within a limited time frame and the resources were not inexhaustible.[38]

6.3.3 Advocacy, and Policy Engagement

The DFID'S LATH project recognized multi-sectoral approaches to tackling HIV/AIDS as an underlying tenet. This is because HIV/AIDS is not just a health problem. It affects all facets of society and development. This multi-sectoral approach promoted a more comprehensive, integrated and holistic responses to HIV/AIDS. This involved participatory approaches by all sectors, public and private as well as donors, civil society organization, etc, to achieve consensus on priorities for action on HIV/AIDS prevention and impact mitigation.[39] Therefore, the LATH project, to that extent, supported the establishment of a functional Local Action Committee on AIDS (LACA) in Otukpo LGA and worked closely with the BEN-SACA. Although formed in 2000, it was in 2002 that Otukpo LACA became functional. It had a broad composition of stakeholders and met regularly. LACA had produced a two-year HIV plan and was involved in counseling, training and community education. It once received a grant from the State HIV project.[40]

According to LATH, Otukpo LACA recorded some major achievements. For example, LACA trained 17 members from line departments, CBOs, NGOs, traditional leaders and traditional healers in HIV/AIDS prevention. It also mainstreamed HIV/AIDS across sectors of the LGA machinery and monitored HIV/AIDS activities with special focus on quality, technical support and capacity building. In spite of these achievements, LACA faced some challenges such as lack of a budget line for it, frequent changes in political leadership, inability of the LGA chairman to attend LACA meetings regularly, etc.[41]

In the area of policy input LATH claimed that it influenced policy in a number of ways. For instance, stakeholders contributed to policy formulation within their own institutions and through the wider networks they were linked to such as the Catholic Dioceses, BEN-SACA and Benue PLWHA network. Also, LATH's efforts supported some general practice guidelines with curriculum and protocols adopted by other LGAs and stakeholders. The Benue State University also requested stakeholders to assist it with advice and data on STDs, HIV and AIDS. Moreover, LATH's linkages with BEN-SACA and other agencies influenced State policies in some areas e.g. TB pilot. Finally, LATH believed that it was responsible for lobbying the Federal Government to include SVH Aliade and OGH in the national anti-retroviral scheme.[42]

6.3.4 Counseling, Care and Support Groups

One of the key objectives of the LATH project was to strengthen the quality and delivery of counseling and care services and to also improve access of vulnerable groups to these services. According to LATH, by 1997, when the project started, there was a high level of stigmatization, rejection and discrimination of PLWHA by health workers, relatives and the community in general. PLWHA were referred to, derogatorily, as 'AIDS Victims.'

Therefore PLWHA were unwilling to declare their status while many people declined to go for voluntary testing. People who underwent routine testing, e.g. pregnant women, pre-surgery patients and blood donors were tested without their consent. So the results were not released to them.[42]

The LATH project, in response to this state of affairs established high quality counseling services in Otukpo and Aliade. LATH trained over 200 counselors and improved infrastructural facilities necessary for effective counseling. LATH also supported the institutionalization of counseling services within stakeholder organizations. Moreover, LATH supported the development, field-testing, collation and dissemination of a set of essential counseling related resources. These resources include: HIV/AIDS Care and Counseling: A Training Curriculum for Community Volunteers, HIV/AIDS Care and Counseling: A Training Curriculum for Health Care Professionals, and Caring Together: A Home Care Handbook for People Living with HIV and AIDS, Their Families and Other Careers. Others include HIV/AIDS Care and Counseling: Good Practice Guidelines and HIV/AIDS Care and Counseling: Monitoring, Evaluation and Recordkeeping Tools. According to LATH, stakeholders have used these materials and tools to make inputs into the national voluntary counseling and testing (VCT) curriculum.

Counseling, in the context of the LATH project was the professional relationship between a trained counselor and a client designed to assist clients express their feelings and also understand their situations better with a view to making well-informed choices about how to resolve their problems and improve their lives. The counselor was expected to be non-judgmental and respect the principle of confidentiality. Counseling, according to LATH was a core element in the holistic approach to HIV/AIDS management.[43] With respect to VCT, LATH said it was an optimal and client-oriented relationship with the counselor

involving pre-test counseling, HIV antibody test, post-test counseling and optimal follow up. VCT, according to LATH was an entry point to prevention and care services.[44]

Care and support for PLWHA incorporated a wide range of services, combining both care and prevention. This approach too was holistic. While caring for PLWHA by way of spiritual, emotional, social and physical needs, with a view to reducing their pain, there was need for family members, community members and health care professionals to be protected from infection.[45] Detailed guidelines for counseling, VCT and home-based care were provided by LATH in the resource materials earlier referred to. The only snag to these materials was the fact that unlike the community education training manuals, they were not translated into Tiv and Idoma languages.

The LATH project supported the provision of counseling and HIV screening facilities at OGH and SVH Aliade. The Otukpo LGA PHC department also ran similar services. The other stakeholders, PPFN and SWAAN, only ran counseling service together with other services such as peer education. They referred cases to the two supported hospitals as the needs arose. Home-based care teams existed at Ogobia and Aliade but with the conflict that engulfed Ogobia in year 2000, LATH was forced to withdraw, leaving only the one in Aliade functioning. The team at the SVH Aliade, made up of about 50 members, provided services to 90 PLWHA and 410 family members. They also engaged in creating awareness on HIV/AIDS, and in confronting stigmatization and discrimination by promoting the acceptance of PLWHA.[46]

The LATH project recorded some achievement in counseling, VCT and home-based care. It built capacity by training counselors and providing stakeholders with M&E skills. Moreover, the project established and utilized VCT services leading to improved health status of PLWHA, greater acceptance of positive living and less denial of status. Also, the

project developed and applied training curriculum and guidelines, put in place core teams for counseling and support, and provided laboratory equipment like microscopes and reagents for HIV testing, to OGH and SVH.[47]

Nevertheless, LATH admitted experiencing major constraints in the implementation of this component of the project. For instance, the number of counselors trained by LATH was very infinitesimal when compared to the target population. Also, poverty continued to be a barrier to the prevention of STDs and HIV, considering the fact that several girls indulge in transactional sex work to elk a living for themselves and their family members. In fact, some parents encourage this risky behaviour. Moreover, LATH lamented that some of the people trained as counselors were inappropriate, since they did not live up to expectation. Furthermore, LATH admitted that in spite of awareness created by the project, many HIV- positive clients still denied their status. LATH also noted that orphans who lost their parents to AIDS were not properly cared for.

In the area of home-based care and support, LATH believed that the project succeeded in the establishment of support groups in Otukpo and Gwer LGAs and capacity building for PLWHA, their relations who are also known as people affected by AIDS (PABA), health workers and community members. This, to LATH, brought about improved care and attitude change towards PLWHA as well as improved networking and collaboration amongst PLWHA and other stakeholders.[48]

6.3.5 Benue TB Control and Management

The LATH project claimed that TB is the largest cause of premature death due to a single cause (pathogen), globally. While TB-related mortality and morbidity has steadily increased in Nigeria, the Benue situation was described as worse, due to some contributing

factors. These included lack of funding and drugs, poor case management, high community HIV prevalence as well as a high poverty profile. LATH claimed further that with this situation, HIV-related illnesses, particularly TB, accounted for over 30% in-patients in Benue State. Moreover, LATH indicated that before the start of the project in 1997, TB control activities in Benue were largely uncoordinated and at variance with the national guidelines. There were neither smear microscopy nor TB treatment in PHC while smear microscopy was available only in two out of the four focal LGAs, one in OGH and the other in SVHA. Apart from these major deficiencies TB drugs were said to be costly while treatment lacked supervision and outcome data.[49]

To address this problem of TB control and management in the state, LATH piloted the Benue TB control using the Directly Observed Treatment Strategy (DOTS), a strategy widely regarded as the most cost effective and advocated by the WHO for TB control. The LATH project, in collaboration with the BHF project and the State MOH, developed a proposal for a DOTS pilot TB control project in 1999 covering four LGAs, namely, Gwer, Otukpo, Ohimini and Gboko. The strategy, according to LATH, involved the decentralization of TB management from hospital-based diagnosis and treatment to integration within the PHC system without distorting the international best practice.

It also involved sputum smear microscopy as the main diagnostic and screening tool for TB patients. This, according to LATH, provided the most specific way of ascertaining cases that posed infectious risks to others. The observation of each dose of TB treatment by health workers, especially in the first two months of therapy, which was usually intensive, is internationally advocated. This was adhered to by LATH. LATH also supported the establishment of treatment centres in 20 PHC centres, supported the establishment of four diagnostic laboratories in secondary health care centres (including a mission hospital), and

involved private practitioners as case finders with supervision carried out by the PHC supervisors.[50]

Within a period of 16 months, after the implementation of the smear microscopy, LATH confirmed that it detected 479 smear positive cases and 337 smear negative ones. The LATH project believed this was a great achievement when considered against the backdrop of unrests and strikes in the State.[51] Another achievement of this component was that the TB pilot was fully integrated into the PHC system with the staff having a strong sense of ownership of the TB control activities and organized their work according to pilot guidelines. Moreover, as PHC health providers witnessed the cure of TB cases, hitherto considered impossible, their morale was boosted. Moreover, the relationship between TB and HIV was better understood by health providers. For instance, health workers knew that TB was an 'opportunistic infection' of one already infected by HIV, while the infection of a TB patient by HIV aggravated the patient's condition. LATH also succeeded in reducing the incidence of cross-infection and created awareness for implementation of universal precautions. LATH also claimed that the pilot project in Benue State had significant impact on national TB plans. For instance, the Benue pilot guidelines and training modules informed the national TB manual.[52]

These achievements notwithstanding, the TB control pilot component faced major challenges in the implementation process. One of these challenges was inadequate human resources and infrastructure. For example, medical stores, both of the State and LGA levels, poorly stocked, while insufficient trained health personnel was going to frustrate the progress of the entire TB control programme in the State. Another challenge was the delay in the release of counterpart funds by government, as well as irregular payment of salaries resulting in labour disputes in the LGAs.

Furthermore, since the DOTS strategy required that patients take their drugs under supervision by health workers, many clients had to travel long distances to access treatment. This was difficult especially that much of Benue rural roads were only seasonally accessible. Finally, stakeholders were left with the challenge of maintaining continuous supplies of drugs and equipment and also in keeping their technology and knowledge up to date.

6.3.6 Clinical Services

When the project commenced, the range of services in the supported health facilities were then very limited with poor infrastructure. Communities were not targeted; and hospitals did not provide counseling services. Also, the laboratories were ill-equipped while 'opportunistic infections' (OIs) were poorly managed. Furthermore, due to low awareness, diagnosis of HIV tended to be at the terminal stage. Moreover stigma in health facilities was very high while stakeholders worked independently without networking, collaboration and referral. Another problem on ground then, according to LATH, was poor practice of universal precautions. For example, TB patients were admitted in general wards while the linkage between TB and HIV was poorly understood. Finally, LATH said the health facilities operated weak record-keeping, data monitoring and evaluation system.[53]

However, LATH was able to reverse the trend by strengthening the infrastructure and human capacity of stakeholder institutions to enable them deliver Clinical services in the areas of TB, OIs and STD care. According to the project, it also improved networking and collaboration between the stakeholders as well as encouraged the referral system to the extent that, for example, referrals to OGH for HIV confirmatory tests became common practice. Also, quality of care improved, record keeping and financial management also

improved, while training manuals such as those on syndromic management of STDs and standard operating procedures for laboratories were produced.

Syndromic management of STDs is, essentially, the diagnosis and treatment of STDs based on physical conditions or symptoms indicating an infection, without necessarily carrying out laboratory tests. Syndromic management of STDs has a capacity to reduce costs, since laboratory tests are excluded. Apart from these, LATH trained and re-trained some health providers who, as a result of the training, became increasingly aware of STDs and HIV, and imbibed adherence to universal practices and precautions in STD/HIV management. This helped stakeholders to improve nursing and medical care for PLWHA and increased demand for STD/HIV testing. With a large number of clients turning up to be tested, there was increased utilization of the laboratories.

On antiretroviral therapy (ART), the LATH project claimed that even though it did not supply stakeholders with the antiretrovirals, it assisted in lobbying for SVHA and OGH to be included in the national antiretroviral scheme.

The Clinical services component of the LATH project, just like other components, experienced some set backs. Firstly, the laboratory staffs were resistant to changes and improvements. In other words, there was the attitude of “this is not how we used to do it”. Secondly, lack of existing Federal Government guidelines and policies on laboratory procedures and syndromic management of STDs flow charts to complement project efforts hampered progress in this regard. Thirdly, while stakeholder health facilities insisted that blood was screened before transfusion, private practitioners continued to transfuse unscreened blood, thus undermining the efforts of the LATH project. Furthermore, the cost and availability of antiretrovirals were beyond the reach of several vulnerable and poor primary stakeholders. Finally, LATH encountered the problem of insufficient or complete

absence of quality test kits and reagents in several health facilities. Those provided by the project did not meet up with client demands.

6.3.7 Participatory Monitoring and Evaluation (PM&E)

The participation of primary stakeholders in shaping and managing activities to mitigate the impact of HIV/AIDS was in line with the call for greater civil society involvement in the fight against the epidemic by the Nigerian National Emergency Action Plan on HIV/AIDS (HEAP). There was need for HIV/AIDS activities to become sustainable community-based interventions. Therefore, the PM&E was the method used by the LATH project to promote the participatory approaches advocated by HEAP.

Briefly stated, PM&E transferred the key questions of "who measures results" and "who defines success" to primary stakeholders.[54] The main idea of PM&E was the value it placed on the contributions of all stakeholders. The approach was also sensitive to gender and other aspect of the society. The PM&E approach encompassed five general functions:

i) Impact assessment,

ii) Project management and planning.

iii) Organizational strengthening and institutional learning.

iv) Understanding and negotiating stakeholder perspectives.

v) Public accountability.[55]

Focus group discussions, community mappings, ranking exercises and so on, were some of the tools used in PM&E to arrive at assessments that reflected both the needs of clients and service providers. People in the community, especially those directly affected by HIV/AIDS made inputs into the project cycle (identification, planning, implementation,

monitoring and evaluation, post-project assessment and dissemination of experiences and lessons learned).

According to LATH, since 1997 primary and secondary stakeholders were involved in operational research activities and were now in a position to take advantage of the opportunities to participate in all the stages of the project. Although primary stakeholder participation in the first phase of the project was largely limited to passive reception of activities, the second phase witnessed greater participation of stakeholders. Research activities were not integrated into the project structure in the first phase because the project was tardy in undertaking a baseline survey. But the second phase kicked off with a baseline survey which was carried out between July 2000 and March 2001. The primary stakeholders who participated in the research performed roles such as data collection and analysis, dissemination of findings, information, education and communication (IEC) review, etc. The following statement by one of the stakeholders summarized the ethos of PM&E: “we used to work for the community; now we work with the community”.[56]

6.3.8 Gender Issues

One of the principles of DFID’s global strategic response to HIV/AIDS is the assessment of the gender inequalities which exacerbates the epidemic. In the same way, Nigeria’s response to the epidemic adopted a rights-based approach. This meant that the rights of the citizens (including those of women) were taken into consideration. Since women and girls face unique physical, social and economic vulnerabilities, the LATH project developed a gender-sensitive body of evidence-based and action-oriented knowledge based on data to be used in response to HIV/AIDS. The project also mainstreamed gender into project activities.[57]

To underscore the degree of vulnerability of women in the HIV/AIDS epidemic, it is important to highlight a few facts as presented by LATH. According to LATH, gender inequalities in Nigeria have made it difficult for women and girls to protect themselves from infection and to escape stigmatization. This is because Nigerian traditional societies have no respect for women's sexual and reproductive rights. For instance, whereas women are punished for having multiple sex partners, the men are excused. Also, females are not permitted to openly discuss sexual matters, thus keeping them ignorant of health information and services. Moreover, women and girl's physiological make-up exposes them to HIV infection more than the men. For example STDs, which are ready vehicles for HIV infection, are more often asymptomatic in women than in the men. Furthermore, LATH estimated that six women are infected with HIV for every four men worldwide. In Nigeria AIDS is often described as "women's disease" with women blamed for infection, and suffer more stigmatization than the men.

Finally, the poverty conditions in Nigeria described in chapter three, which we argued put the women on the lower rungs of the socio-economic ladder, has also aggravated the incidence of HIV infection in women. According to LATH, poverty 'forced' several women and girls into transactional sex work. Moreover, it is often the women and girls who would abandon economic activities and schooling respectively, to look after a family member who went down with AIDS. This deprived them of economic benefits and education, respectively.[58]

The LATH project's gender mainstreaming efforts were sustained throughout the duration of the project with all stakeholders getting involved. According to LATH, these effort yielded the following dividends:

i) Communities were able to link the negative aspects of gender issues to the transmission of STDs and HIV

ii) The issue of access to land as inheritance for widows and orphans was taken up in the communities and currently receiving attention

iii) Involvement of women in decision-making on project activities at community levels. Also, females sat with males at meetings to discuss and take decisions on issues affecting them.

iv) Introduction of sanctions by community members against people involved in gender violence against women such as rape.

v) Reduction in high bride price to encourage marriage and avoid promiscuity.

It was the hope of LATH that these gains would be sustained after the close of the project.[59]

6.3.9 Project Management

Initially, the management arrangement put in place for the LATH project were cumbersome, to say the least. Whereas the DFID awarded the contract for the project to LATH, the project was sub-contracted for in-country management to Pathfinder International. Therefore, several problems arose with reporting systems and line management being unclear. Staffs were divided between two management groups while there was lack of specific job descriptions and Terms of Reference. This confusion slowed down project activities.

However, during the second phase LATH managed the project alone and the conflicts were removed. LATH was responsible for recruiting and managing its own staff and providing technical and administrative support. It was the responsibility of DFID to

provide funds and resources for the project and to monitor progress of work on a quarterly basis through DFID's Deputy Heath and Population Field Manager.[60]

6.4 PROJECT'S SELF-ASSESSMENT

Just like in the case of the BHF project, the report of the first OPR of the LATH project, which took place from the 5th to 12th July, 1999 could not be accessed. However, other documents such as the Pre-OPR report of February 1999; the implementation documents; the second OPR and other project papers have reduced the impact of the inaccessibility of the first OPR report.

The Pre-OPR exercise of February 1999 was headed by Liz Tayler, DFID Health and Population Adviser while the second OPR Team was headed by Claire Moran, DFID HIV/AIDS Co-ordinator. The second OPR took place from the 4th to 8th March 2002. Other members of the two teams are listed in the following documents: Review of STD/HIV Management Project, February 1999, and STD/HIV Management Project, Nigeria Phase II: 1st April 2000-31st March 2003 OUTPUT-TO-PURPOSE REVIEW REPORT. 4-8 March 2002. The issues raised by DFID assessors are also based on these two documents. These two review teams approached the reviews in a more holistic manner than the OPRs we considered in the Oju and Obi WAS project and the BHF project. For instance, whereas the LATH project OPRs examined issues thematically (covering components of the project) the first two projects examined issues by looking at one output, with all its activities, after the other. Therefore, our study of the LATH output reviews will also adopt the thematic approach.

6.4.1 The First Phase

In section 6.3 we examined in details LATH's project implementation activities with particular emphasis on the support to the various target groups and communities. These services came under the scrutiny of the DFID, which hired LATH to do the job, during the review exercises.

Services Provided to Target Groups

Generally speaking, LATH was commended for doing a fairly good job during the first and second phases of the project. However, the reports indicate that the first phase was more problematic than the second. For instance, the pre-OPR report of February 1999 rated the first phase three (3) over five (5) and indicated that the purpose of the project was partially achieved.[61] The report noted that severe poverty in Benue had negative impact on the success of the LATH project. It was also discovered that the views or input of primary stakeholders on project development, implementation and plans appeared somewhat limited. The review team recommended the introduction of monthly meetings of stakeholders and project management to facilitate more information sharing and problem solving related to common issues. In Ogobia and Aliade, the team observed that there were regular meeting of the home-based care teams with the vulnerable groups which gave opportunity for feedback. Similarly, the adolescent peer educators that worked with PPFN felt they were given the opportunity to participate in regular meetings with the project staff. Apart from these, the involvement of other stakeholders in influencing the project was unclear.[62] This raises a fundamental question which the review team either overlooked or forgot to ask: Why should some stakeholders be given opportunities to influence the project while others were denied the opportunity?

Furthermore, the review team noted with concern the little noticeable impact on health facility utilization, but was impressed by the fact that PLWHA were receiving home care. Many of them later died while the number receiving home care declined considerably. The review team said there were considerable potentials for expanding home-based care services. The difficulty in achieving this, according to the team, was the particularly high levels of poverty among PLWHA in Benue State. To further compound this problem was the project's inability to assist with the people's basic needs of food and free drugs (e.g. for TB).

In terms of counseling services, the pre-OPR team noted with satisfaction an expansion in the delivery of counseling services both in health facilities, through SWAAN, and through the home-based care programme. On information gathering and research, the team commended the effective documentation of sex workers' activities in registered hotels but agitated for an expansion of the information gathering to include sex worker's in non-registered hotels and sex hawkers so that health seeking behaviours and other risk factors could be compared. The team also expressed worry over the insufficient use of data collected to inform project implementation.[64]

Training

In terms of training which was a key aspect of the LATH project, the review team observed that about 1000 people from different stakeholder groups were trained in syndromic management, counseling, home-based care, peer educator training and advocacy training. In some stakeholder groups some step-down training events were significant (e.g. SVHA) while in others it was negligible (e.g. OGH). The team noted that the trainings provided were based on training needs assessment carried out by each stakeholder group. It meant that training modules were responsive to the needs of the trainees. However, the team could not evaluate the impact of the training due to lack of formal mechanism for carrying

out the evaluation. Even though Pathfinder International (PI) claimed that all training events were evaluated after six months, this appeared to the team as informal and insufficient. The team recommended the review of the training in syndromic management of STDs and its impact on the practices of health care providers.

Still on training, the review team suggested that selection criteria for training be reviewed to include necessary interpersonal skills as well as the appropriate background and current position of prospective trainees. Also, the team called for a downward review of financial incentives for attendance at training events. The advice of the BHF project was to be sought about this. Moreover, the review team agitated for consolidating evaluation of training and its impact before further training were carried out. Follow-up training were to be given, should the need arose, while the capacity of stakeholders to supervise trainees after the training and evaluate impact was to be strengthened. Finally, the team noted with satisfaction the conversion of four, out of the nine technical co-operation training (TCT) health sector support awards into in-country training. By this conversion 25 participants were trained. Out of the five remaining awards, one was trained in UK in reproductive health; one in an HIV training course in Thailand while three went on a study tour to the Midmay Centre in Uganda. Before this time three people had been sent to the UK for training. The team said it appeared that the trained personnel and the project benefited from these traning.[65]

Social Development Issues

A few major social issues were appraised during the first phase of the project. One of such issues was the need to get hotel directors and managers to keep sex workers infection-free. The modus operandi for this was to be set in place through operational research during the second phase. The second issue was on female gender and HIV infection, which we

examined in detail in section 6.3. While we do not intend to risk repetition, it is pertinent to note that the review team recommended good governance, civil society and rights-based approaches in solving the problem of the impact of HIV on the female gender.

Project Activities: Matters Arising

Just before we begin to look at the OPR report on the extension phase of the LATH project, we would like to draw attention to some of the critical and burning issues that almost marred the LATH project's progress in the first phase. These issues are contained in a document titled Output-to-purpose Review of STD/HIV Management Project, Nigeria. 5-12 July 1999: Issue papers for the Review Team's Considerations. These issue papers were compiled following consultations between all six secondary stakeholder organizations involved in the project and PI/LATH.

The first issue had to do with compensation of volunteers, particularly those who cared for PLWHA. For a better understanding of this issue, a brief background is imperative. It will be recalled that in section 6.1 we said all the six secondary stakeholders in the LATH project in Benue State were in existence and working with their primary stakeholders before the commencement of LATH. However, with the coming of the LATH project, the project decided to work in partnership with all the stakeholders, as a strategy to reach the goal and purpose of the project in the State. It was therefore necessary for the capacities of the stakeholders to be built to enhance project performance. It was after they were trained and began to work more efficiently with the target groups that the volunteers began to demand for incentives. They demanded the project to pay them "incentives", "compensations" or put them on "pay roll" to maintain initial interest and commitment or to be compensated for taking their time off from their jobs, or because they were unemployed. This problem was compounded by the fact that some of the support group leaders were being paid stipends and

"white people" were seen in the communities which, to them, was an indication that a lot of money was going into the project and they were not getting their own share of the 'cake'. To solve this problem, it was suggested that these agitations be ignored while incentives of less monetary nature could be provided.[66]

An issue which was similar to the first one was about increased demands on stakeholders' staff time and honoraria. True, staff of stakeholder organizations directly involved in project activities were full time employees and therefore taking on additional responsibilities for LATH. Therefore, they were paid some honoraria based on a percentage of their time spent outside their main jobs. Sooner or later there were complaints from different stakeholder staff that they were spending more time on LATH, than on their own employers and should be paid double honoraria. This brought about the question of who owns the project?. It was feared that this matter would cripple the project's sustainability measures which were being worked out. It was suggested that more volunteers be utilized rather than engaging more stakeholder staff on secondment. It was also suggested that the issue of honoraria be re-negotiated with stakeholders.[67]

A third issue was how to improve quality of service in the private sector, considering the fact that the LATH project's secondary stakeholders were mainly public and not-for-profit sectors. Otukpo LGA reported (and it was confirmed through preliminary research findings) that vulnerable groups sought treatment for, and information on HIV/AIDS from the private sector especially from patent medicine stores. The private sector, on its part, indicated interest to participate in syndromic management trainings, and also attended seminars organized by LATH consultants. It was feared that since private sector health services were unregulated and their information irregular and inadequate, they could contaminate the efforts of LATH. It was therefore suggested that the private sector be

allowed to participate at LATH seminars thus maintaining closer links, and that the collaboration with Society for Family Health (SFH) be strengthened. The rationale for this suggestion was that SFH sought to strengthen the private sector for condom distribution.[68]

The issue of how to manage the difference in views between religious groups and the project on condom use was another thorny one. The small Muslim community group in Otukpo LGA, SJRHC Ogobia and SVHA, both Catholic hospitals, were resistant to condom use, on the basis of religious beliefs. But the LATH project felt that since proper use of condom was recognized as a means of preventing HIV/AIDS and STDs, and since not all Catholics worldwide were against condom use, it was proper to educate the people to use them. Moreover, a 50% increase in condom distribution was LATH's output target as contained in output 7 of the project's log frame. This issue was not easy to resolve in view of the fact that some religious organizations, apart from Catholics, 'voted' against condom use with the excuse that it encouraged promiscuity. It was resolved that condoms be distributed to those who would use them while advocacy, IEC and other measures were intensified to enlighten the communities and other target groups.[69]

Two other issues, which we intend to consider together, bordered on how to improve the quality of life of PLWHA, and how to secure regular and reliable local supply of quality reagents for project-supported STD/HIV diagnostic laboratories. Considering the critical issue of poverty in Benue State in general and the project's stakeholder organizations in particular, this was a disturbing issue. The expectations of many were that LATH had enough money, which LATH did not have, to meet such needs.

It was suggested that while LATH continued to subsidize the cost of taking care of PLWHA and PABAs, as well as providing medical consumables and other equipment, communities should be mobilized to assist in supporting income generating activities for

PLWHA, orphans, etc. Stakeholder organizations and the new democratic government in the State was advised to look inwards and procure reagents to complement LATH's efforts in this regard.[70]

6.4.2 The Extension Phase

The OPR for the second (extension) phase took place two years into the three-year extension. The report of the review will also be studied thematically, as earlier stated.

Findings:

The overall assessment of the OPR team was that the purpose of the project which was "to improve access of high risk and specific vulnerable groups to quality STD/HIV/TB health and support interventions in Benue State" was likely to be partially achieved by March 2003. The team scored the project three (3) out of five (5) and was impressed with the way and manner the project management team and the stakeholders were carrying on with project activities. However, the team observed that in the absence of disaggregated data on access to services by different target populations and high-risk groups, equity issues, client satisfaction and other vital poverty monitoring indicators, it was difficult to evaluate the two main purpose level indicators which addressed access by high-risk groups to quality HIV/STD/TB services.[71]

The OPR team also noted with some disappointment the fact that after five years of the project, secondary stakeholders were still struggling to substantively include the primary stakeholders in the full range of decisions that affected them. This attitude, according to the team, negatively affected the project, in the sense that some of the activities undertaken did not meet the needs of the target population. The team hoped that the secondary stakeholders

would change this attitude before the close of the project. This notwithstanding, the team highlighted notable achievements of the project over its lifetime as follows:

i) Hard work, commitment and enthusiasm exhibited by stakeholder groups.

ii) Broadening community response to the epidemic as demonstrated by greater acceptance of PLWHA, stigma reduction, attitudinal change and a more multi-sectoral approach.

iii) Creation and capacity strengthening in counseling and home-based care for effective support groups working with PLWHA.

iv) Strengthened capacity of secondary stakeholders to manage community-based interventions.

v) Effective team work and collaborative efforts by stakeholders (e.g. the counseling core team).

vi) Greater ownership spirit by stakeholders and increased understanding on participatory approaches.[72]

The OPR team suggested that the following areas were to be given greater attention:

i) A better understanding of primary stakeholders' needs and levels of satisfaction.

ii) Production of better quality and more timely data and information.

iii) Revising and redefining the targeting of vulnerable groups

iv) Expanding opportunities for advocacy, policy influencing and information sharing beyond Otukpo.[73]

The OPR team recommended the following priorities for the remaining part of the project (March 2002 to March 2003):

i) A continuation of the good efforts by the secondary stakeholders with special focus on key competences and areas of expertise while consolidating on the gains already recorded.

ii) Strengthened networking and communication amongst secondary stakeholders

iii) Improved communication between secondary stakeholders and their LACA and SACA

iv) Time and resources to be set aside for documenting lessons learnt and for an active dissemination strategy.

v) Greater emphasis on advocacy and impact on policy.

vi) Enhanced LATH technical and management capacity to enable it maximize the projects impact over an intensive final year.

vii) Sustainability strategies developed.[74]

Cross-Cutting Issues:

These were issues that the OPR team considered critical to the long term sustainability of the interventions managed by the stakeholders, and suggested that they be addressed in the remaining year. These issues included gender, PM&E, project input into policy, multi-sectoral approaches, civil society and sustainability. We shall not risk repetition here since all these issues, except sustainability, were discussed in detail in section 6.3. Moreover, the issues raised by the OPR team were already incorporated in the briefing papers, which we used extensively, when we discussed these cross-cutting issues in section 6.3.

On the issue of sustainability, the review team encouraged stakeholders to ensure that activities supported by LATH did not stop with the end of project funding. The team also announced that DFID was going to continue to support Benue State in its new

HIV/AIDS programme, but not in its current form. The stakeholders were also told that DFID was still considering which initiatives to be included in the new programme and how local partners were going to be selected.[75]

Focal Areas:

The review team reviewed the projects activities in areas considered as focal to the LATH project. These area included peer education, Clinical services (including TB pilot), counseling, community education and support groups and home-based care. These areas too were discussed in section 6.3. We relied heavily on information from the briefing papers which were, in turn, inputted by the extension phase OPR report.[76]

Project Management:

The review team observed that project management was strengthened during the second phase but also observed that reporting was a problem. According to the team, quarterly reports came in late while reports tended to emphasise the good news and ignored difficulties within the project including poor performance. In addition, the team observed that the log frame was still very unwieldy, in spite of previous revisions, and it remained an ineffective tool for adequately assessing the project. The team did not elaborate further but said it was not worth the efforts revising it any further.[77]

Conclusion:

In concluding the review, the OPR team observed that the project was on course and was capable of making further impact during the remaining year, especially as steps were being taken to ensure that valuable interventions were sustainable. Also, that critical skills such as counseling was making dramatic improvements in quality while LATH and stakeholders were becoming more realistic about their skills and limitations. The team

expressed satisfaction that the wealth and knowledge and experience accumulated by the LATH project since 1997 were going to become valuable source for several new DFID programmes and other donors. The team suggested that these experiences be documented and disseminated so that both the State and national response could feed from.[78]

6.4.3 The Ogobia Conflict

Earlier, in the course of writing this chapter we mentioned that the SJRHC Ogobia, one of the six secondary stakeholders in the LATH project in Benue State withdrew at the commencement of the extension phase. We did promise to take up the issue in due course. Actually, the Ogobia episode represents a typical case of community-level conflict and HIV/AIDS. A policy brief titled COMMUNITY LEVEL CONFLICT AND HIV/AIDS prepared for the OPR team in February 2002 captured the story adequately.[79] The purpose for bringing in the story is two-fold. First, we needed to explain why one of the stakeholders withdrew from the project activities, and secondly there were lessons to be learnt from the conflict.

The SJRHC Ogobia is a Catholic facility run by Daughters of Charity. In 1997 when the LATH project commenced, the health centre was involved as a secondary stakeholder and its project activities centered on home-based care of PLWHA, outreach and Clinic-based care. According to the brief, by 1998 72 PLWHA support Group members engaged in community outreach and by the end of 1999 had developed a well organized home-based care. A major achievement of the group was greater acceptance of PLWHA.

However, in early 2000 a Nigeria Television Authority (NTA) sensationalized documentary on the impact of the HIV/AIDS epidemic in the Otukpo area portrayed Ogobia as the most affected by HIV/AIDS in Nigeria. Although Ogobia is outside the reception area

of the NTA, Ogobians in the diaspora, as it were, picked the news and relayed it home with a high degree of exaggeration. Tension began to mount, coupled with already existing misunderstandings between the village on one hand and SJRHC management and the support group on the other hand, over perceived LATH's favouritism to the health center and apparent financial gain for the support group. These misunderstandings became worse because the health center management and local project staff were involved in the documentary. Tension in Ogobia built steadily until in May 2000 when SJRHC was forced to end its HIV/AIDS related activities. The Daughters of Charity were threatened with death while the support group was forced to disband.

In June 2000, LATH contracted Academic Associates Peace Works, an NGO to attempt conflict resolution to enable SJRHC resume its project activities. Between June and November 2000 three conflict resolution missions were undertaken. The SJRHC did not wait to see the end of the conflict resolution efforts before it decided to withdraw from LATH in late 2000.

With the withdrawal of SJRHC from the LATH project, Ogobians who were previously receiving home-based and Clinic care and counseling experienced significant hardship. Also, broader HIV/AIDS IEC activities also ceased, given rise to renewed stigmatization within the community.

The main lesson learnt from the Ogobia episode is that community expectations of what the project will deliver should be discussed and common understanding reached. Financial matters, more than any other factor, fuelled the Ogobia crisis. According to the brief, financial incentives given to members of SJRHC and the task teams from the project were resented by some in the community who felt excluded from a share, especially as the

amounts were exaggerated. This provoked jealousies of those who did not benefit. The NTA documentary was only the last straw that broke the camel's back.

6.5 ASSESSMENT OF PROJECT'S IMPACT

In this section we shall attempt, as usual, a descriptive assessment of what we saw, physically, on the ground during our field visits to the project areas. The LATH project, unlike the first two studied, did not put physical infrastructures such as boreholes, wells, hospital buildings, and machines on ground which could be seen. Rather, what we saw when we visited secondary stakeholders and some communities were more of programmes. We intend to highlight our findings under three broad segments, namely, rural community-based activities, city-based activities and health facility-based activities.

6.5.1 Rural Community-Based Activities

One common feature we observed in some of the rural communities visited, namely, Iwerndyer, Abetse, Otukpo-Nobi and Opa-Adoka, was the people's awareness on STDs, HIV and AIDS. For instance, in Iwendyer a 13-year old school girl demonstrated to us how a female should clean up her anus after defeacation.[80] For a rural community, the boldness and freedom with which the girl talked with us on STDs and HIV showed that LATH'S community education made some impact. Two other females interviewed in the same village admitted that there was considerable awareness on STDS/HIV/AIDS. They testified that condoms were being used.[81] Also, one of Iwerndyer's community peer educators who talked with us said 32 of them were trained (16 males and 16 females each) for the purpose of mobilizing the Iwerndyer community and the surrounding communities for STDs and HIV prevention. According to them, they did this through drama and other IEC measures such as early morning 'cries'.[82]

Moreover, in Otukpo-Nobi we saw a great sense of awareness among the people. For instance, two young people interviewed expressed satisfaction with the level of STDs/HIV/AIDS awareness and testified that there used to be rampant cases of the epidemic in the village but that the cases were now reduced as a result of the efforts of LATH and Otukpo LGA LACA. One of the informants went into his room and brought some condoms and showed us, to underscore the fact that they were aware of STDs and HIV and were taking precautions.[83] They also testified that peer group leaders in the community were trained on HIV/AIDS awareness.

The situation was the same in Abetse where the people interviewed admitted that LATH did a lot in the area of community education. About 32 peer educators were trained in Abetse. According to our informants, awareness exercise was carried out in Abetse up to five times. They also said IEC activities brought about a reduction in sexual promiscuity in the village.[84] However, on this point two female college girls interviewed disagreed. According to them, even though there was awareness on HIV/AIDS, people were not taking the facts seriously. For instance, one of them admitted sleeping with boys without the use of condoms.[85] We tried to find out from some of the boys interviewed why they never used condoms. Some of them said they trusted their sex partners while others said condoms never gave them sexual satisfaction. [86] This was an indication that the awareness in that community was either low or some of the members of the community were obstinate about STDs and HIV preventive measures. From a comment made by a 35-years old widow interviewed, it is clear that some members of the community were simply obstinate. According to her, while some people were benefiting from the IEC programme of LATH, others vowed to “die in battle” In other words, to such people sexual activity and enjoyment was a battle they were prepared to fight and die in, irrespective of the consequences. She

said stigmatization of PLWHA was a thing of the past, and that in the PHC Clinic in Abetse, only disposable syringes were being used.[87]

At Opa-Adoka, we discovered that the community was aware and mobilized against STDs/HIV and AIDS. Here too, 32 peer educators were trained. According to our informant, awareness was created in other adjoining settlements such as Okpeje and Adoka center. They raised a drama group and performed during the 2002 World AIDS Day. He said their drama sketches were performed in Idoma language.[88]

In spite of the indications in the communities visited that there was good awareness and education, we discovered some problem areas. For instance, it was a general complaint that the LGA LACAs were not supporting community education activities, financially, after the close of the LATH project. Except for Abetse where it was reported that the Gboko LGA LACA supported HIV/AIDS awareness efforts with two bicycles and a megaphone, no other LACA extended such gesture. Consequently, community education and awareness had virtually come to a stand still in all the communities visited. Another problem we discovered was the non-replacement of many of the peer educators trained for the communities who either died, married (in the case of young ladies) and/or relocated. Similar to this problem was the case of lack of re-training for trained peer educators. This re-training would have been necessary for refreshing purposes. Fresh trainings were also necessary for those who were yet to be trained.

Furthermore, the problems of lack of incentives for peer educators, after the project closed, had discouraged many. According to the peer educators in the communities, the LACAs were doing nothing in this regard. Therefore all of them had gone to find ways to make a living for themselves. For instance, the day we visited Abetse, the leader of the peer

educators in the village was said to have gone to the Gboko rice mill where he found a means for sustaining himself.

6.5.2 City-Based Activities

On this aspect we intend to examine the impact of LATH activities on secondary stakeholders in Otukpo town. These stakeholders include Otukpo LGA LACA, the PPFN and SWAAN.

Otukpo LGA LACA:

We interviewed the Otukpo LGA HIV/AIDS coordinator on various aspects of the LATH project activities. According to him, LATH built capacity for the LGA LACA in various areas such as in counseling, ToTs and step-down community education trainings, financial management, laboratory training, etc. He said LATH equipped their laboratory and procured reagents, partially renovated the family planning Clinic and supported the establishment of care and support associations in the LGA. In addition, it was the LATH project that assisted in the establishment of Otukpo LACA, and also provided a television set and video player for it. LATH also supplied LACA with condoms for distribution and paid monies into LACA account on quarterly basis. According to the coordinator, LATH also provided LACA with a megaphone. We asked to know what LACA on its own had done in the communities. In response to this, the coordinator said LACA sponsored the 2002 World AIDS Day in the LGA and provided grains for PLWHA.

On the impact of LATH on the LGA, our informant said communities in the LGA were aware of the causes and prevention of STDs, HIV and AIDS. He said the impact of

LATH'S project activities were tremendous. For instance, he said HIV/AIDS sentinel report on Otukpo in 2001 dropped. He could not, however, provide the percentage in drop. This was an indication of lack of adequate data in the LACA office. The Otukpo HIV/AIDS coordinator complained of lack of funding for his unit by the LGA chairman. He said this situation had slowed down the pace of activities since the closure of the LATH project, in March 2003.[89]

The PPFN:

According to the PPFN project manager on STDs/HIV/AIDS, the outfit was a family planning (reproductive health) NGO that managed some of the conditions that result to HIV/AID/STDs. According to him they had been working in PPFN's focal communities of Otukpo-Cho, Otada, Asa, and Otukpo Federal Prisons before DFID interventions. He said with the coming of the LATH project the PPFN received support by way of training (capacity building), equipment for Clinical activities and furnishing. According to him, the support PPFN got from LATH, especially on training, enabled them to train 250 peer educators, for the PPFN focal communities. The provision of free condoms, megaphones and other resources promoted their work in their communities tremendously. Apart from training peer educators the project manager said LATH's support also enabled them to train TBAs and prison warders on HIV/AIDS prevention. According to him, LATH also assisted in facilitating the access of PPFN peer educators to the Internet, while the monies paid into the PPFN account by LATH helped to stabilize the account which still existed.

On the impact the PPFN has made on its focal communities, the project manager said there was behaviour change among the people towards PLWHA and on STD/HIV

preventions. He said that generally, LATH's assistance helped PPFN to improve its services to clients and the volume of clients also increased. For example, PPFN conducted advocacy work with parents to facilitate sexuality education for youths in and out-of-school. The organization also mounted a programme of STD/HIV IEC and support to warders and inmates at the Otukpo prison. A warders/inmate weekly IEC forum held while young inmates were held separately, in order to protect the young from sexual and physical violence. On the whole, the programme manager praised DFID's efforts in Otukpo LGA.[90]

The SWAAN:

Like the PPFN, the SWAAN was in place before the DIFD intervention in STD/HIV management in the State. According to Rose Adejoh, the SWAAN secretary, the organization was inaugurated in Otukpo in 1996 and that since then they worked with sex workers, in-school youths, the police, communities (Asa and Otukpo) and cyclists, popularly known as 'okada riders'. However, according to her, when SWAAN experienced dwindling financial resources they were forced to shed off some of their primary stakeholders. She said their strategy was advocacy, training, distribution of IEC materials and peer education.

With the coming of LATH, the SWAAN accepted to participate in project activities as one of the secondary stakeholders. With this present status, LATH built SWAAN's capacity. She indicated that before their capacity was built they did so many things wrongly. For instance, they gave out wrong information on HIV/AIDS. Apart from capacity building, she said the LATH project constructed a counseling room at the SWAAN health information post located at the Otukpo main motor park, as shown on Plate XXX, page 343. LATH also supported SWAAN projects with finances. Moreover, LATH donated furniture, public address system and a computer to SWAAN. Furthermore, two of the SWAAN members in Otukpo went abroad on a TCT training award.

On the impact of LATH/SWAAN activities in the LGA, Adejoh said SWAAN's activities, coupled with its networking with OGH, PPFN, SVHA, and the LGA PHC department helped to bring down the incidence of HIV/AIDS in the LGA. The SWAAN also carried out sensitization and peer education training for the Police Force in Otukpo to facilitate their knowledge of HIV/AIDS and risk behaviour and to support their work with sex workers. Also, the society has trained cyclists in Otukpo as peer educators, and has opened a counseling and information post at the Otukpo main motor park for commercial drivers.

Commenting on SWAAN'S present challenges, she said lack of financial support for the society was crippling its activities and functions. According to her, the membership of the society dwindled from 40, when LATH supported SWAAN, to 20, when no support came. She said presently SWAAN was only engaged in counseling, information sharing at the SWAAN office and social marketing of condoms. Like many other stakeholders the SWAAN is waiting for another donor initiative. [91]

6.5.3 Health Facility-Based Activities

Essentially, we shall be assessing the impact of LATH'S activities on the hospitals supported by the project, as perceived by the stakeholders themselves. With the SJRHC Ogobia out, we are only left with OGH and SVHA.

The OGH:

The OGH administrator claimed that as a health facility stakeholder in the LATH project, the hospital was supported considerably. He said several staff of the hospital

benefited from capacity building strategy of the project. He said many have been trained in and outside the country on syndromic management of STDs, laboratory techniques, TB

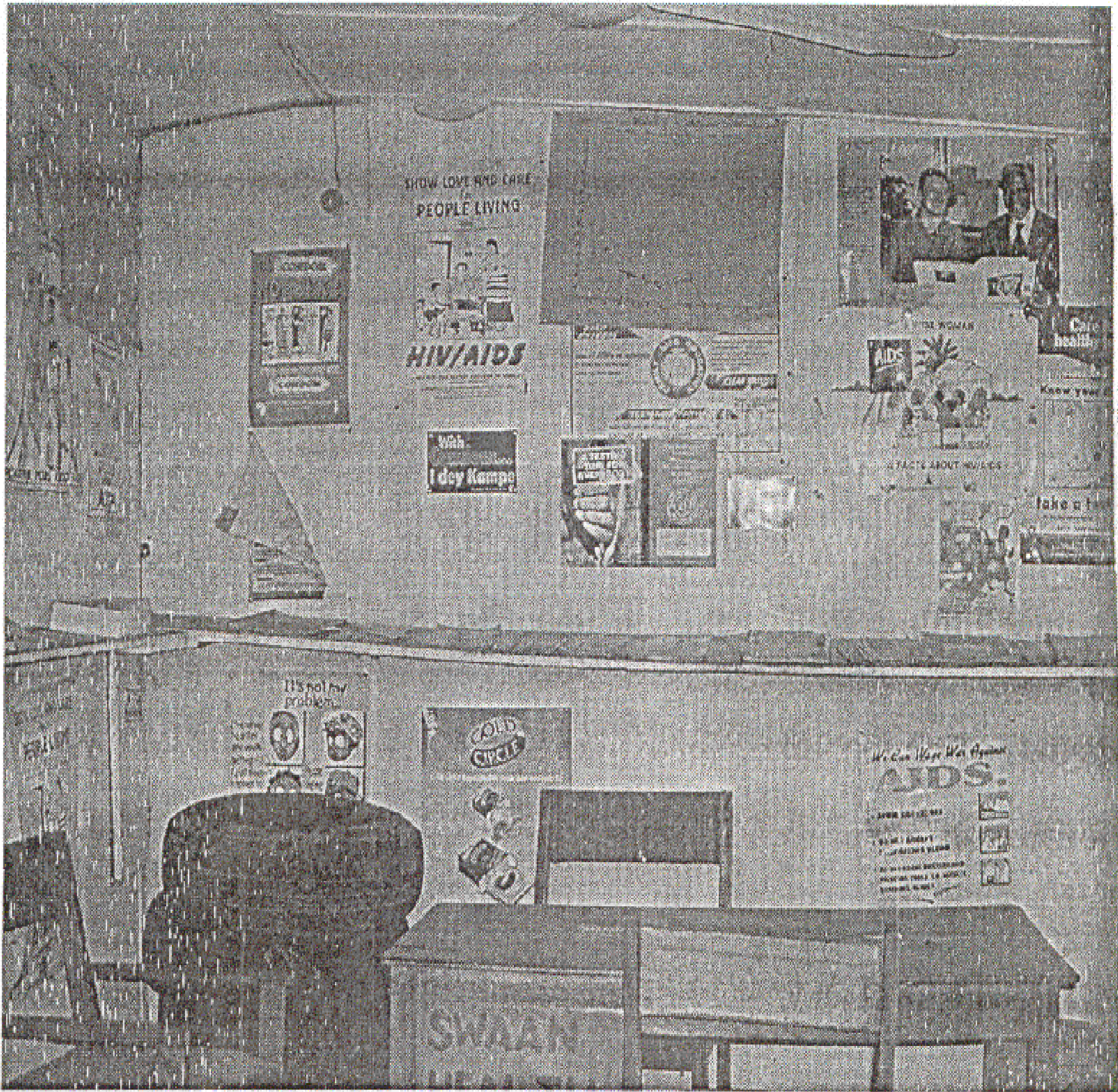


Plate XXX: A SWAAN Health Information Centre on HIV/AIDS at the Otukpo Main Motor Park.

management, etc. He stated further that apart from equipping the OGH laboratory to meet the challenges of the HIV/AIDS epidemic, the LATH project also supplied other equipment such as a television set, video player, and so on. The project also supported the hospital financially, on quarterly basis. According to him, DFID assistance in this area was quite substantial and should be applauded. [92]

Voluntary Counseling and Testing (VCT) activities have increased at OGH. The hospital's HIV/AIDS consultant counselor claimed that over 4,000 clients were counseled at the hospital between 1999 and 2003. He said the way and manner people were coming for VCT showed that stigmatization had reduced. According to him, counseling tools, such as client satisfaction form and counselor's self evaluation form, developed by LATH made counseling easy and interesting. According to the consultant, OGH's active participation in project activities brought it to the limelight. This enabled the hospital to be involved in the national sentinel survey of 2001. He stated further that OGH provided referral services for other stakeholder organizations in Otukpo LGA because these stakeholders had no capacity to treat opportunistic infections such as TB. OGH also provided antiretroviral treatment for clients.[93]

The SVHA:

This hospital was another stakeholder in the LATH project that benefited considerably from project activities. According to the administrator of the hospital, LATH did a lot for the hospital and for the Benue community in general. He said the DOTS scheme worked well in the hospital with patients taking TB drugs free of charge for eight months.

He stated further that LATH built capacity for SVHA similar to what the project did at OGH. But in addition, LATH supported them in the management and evaluation of its Care AIDS Team for caring for PLWHA and TB patients. Moreover, LATH built a HIV laboratory with the kits and also donated four motor cycles for monitoring and visitation. Furthermore, the administrator said the hospital had a trained HIV coordinator who was in charge of the VCT unit. On the whole he said he was very impressed. [94]

6.5.4 Summary

The LATH project was yet another attempt by the DFID to support interventions in the Benue State health and social sector. Although the project had its own share of flaws common with most development projects, it was nonetheless a noble attempt. Even though the DFID itself did not claim that the project was a huge success, the benefiting communities and stakeholders felt the impact of the project activities and admitted so. Throughout our interactions with the rural communities and stakeholders it was discovered that they were visibly impressed with the little that the 'white man' did for them. This has continued to prove the point that our governments have not yet adopted the development paradigm being advocated by the UN and the world over. Our governments have not yet substantially improved the health and social welfare of the people. There is, therefore, no wonder that when donors did a little for the people it became much to them. For instance, the DFID spent a total of £1,782,882 (₦ 267, 432, 300.00) on the LATH project. But strangely, Benue State's total expenditures on health for three years (1997 - 1999) totaling ₦258, 777, 787.21 was not up to this amount.[95]

Although it is difficult to adequately assess the long-term impact of the project on the benefiting communities and the State in general, due to lack of disaggregated data, it is

clear from what we saw on ground that the impact could not be sustained. For instance, barely after one year of the closure of the LATH project all the stakeholders in the project have complained about a lull in activities, as a result of lack of funds from either the State or LGA authorities. What we would like to learn from this state of affairs is that the capacity of all the stakeholders was not build on a sustained basis for a good length of time. Next time, the DFID, as a matter of strategy, space capacity building for at least a period of ten years or so, to enable the capacity of the people to be built gradually so that within this period there could be some degree of attitude change among the people. Another lesson we would like to learn is the fact that our governments have a dependency syndrome. When donors come in to assist, both the State and Local Governments stand aloof to merely watch, and if possible derive personal benefits from donor funds. It is suggested that both Local and State Governments wishing to partner with donors in development projects should pay counterpart funds up-front, as a mark of commitment, before commencement of project activities.

Meanwhile, it is our candid opinion that if the multi-sectoral approaches to tackling HIV/AIDS must succeed in Benue State, both the State and Local Governments must pick the mantle from where LATH stopped, or else we may have to give up the fight against the deadly pandemic and the revolution of rising expectations created by the DFID LATH project may turn to a revolution of rising frustrations with cataclysmic consequences.

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CHAPTER SEVEN

ISSUES IN BRITISH GOVERNMENT DEVELOPMENT ASSISTANCE IN BENUE STATE

7.1 INTRODUCTION

In this chapter we shall be discussing two key issues in the British development aid in Benue State. The first issue under consideration shall be the issue of sustainability. Here, we intend to examine measures which were put in place by the DFID and the stakeholders in the three development projects, in order to ensure that the projects executed were sustained, and to assess the overall sustainability of the DFID efforts in the State. The rationale for this exercise is to enable us draw some conclusions, in chapter eight, on the desirability or otherwise of the donor initiatives of the British Government in Benue State.

The second and, perhaps, the most important of the issues we shall be considering in this chapter is the diplomatic and/or political undertones of British foreign aid in Benue State, and by extension to Nigeria. This section is very important to us because it is an aspect of the study that seeks to highlight the remote and immediate factors responsible for the transfer of human and material resources and cash flows to Benue State and Nigeria, by way of development assistance. It is from this section that we intend to provide a clue to what the British Government stood to gain from providing development assistance to Nigeria generally, and Benue State, specifically. It is an aspect of the research that researchers have rarely inquired into.

7.2 SUSTAINABILITY OF DFID PROJECTS IN BENUE STATE

One of the key issues in development assistance is sustainability. It is unusual for the UN, its agencies and other donor agencies to discuss development assistance to needy countries without emphasizing sustainability. ‘Sustainable development’ has almost become household words in many bilateral and multilateral development assistance discourses. This is not surprising because development assistance ought to, necessarily, be sustainable otherwise it will be like the case of giving somebody fish rather than teaching one how to

fish. In the first case the person will need to come often, cap in hand, asking for fish, whereas in the second case the one in need of fish would have known sufficiently the techniques of fishing to go for it unaided.

Broadly speaking, sustainable human development, according to the UNDP is an emerging concept of development. It is development that is human centred, equitable and socially, culturally, politically and environmentally sustainable. The strategy advocates the ability of people and their society to mobilize and manage themselves and resources available to them in order to produce sustainable and equitably distributed improvements in their quality of life that is consistent with their own aspirations and with the capacity of their physical environment. The strategy of sustainable development sees participation as a proactive as well as reactive involvement whereby people at all levels of the society are able to identify their own problems, proffer solution to them and make tangible contribution to the implementation of the development programmes.[1]

To advance peoples participation in development, sustainable development embodies a number of basic principles:

i) Development evolves from a self-reliant understanding of local needs and resources

ii) Action must grow from a combination of trickle-up and trickle-down programming in which communities, governments and donors/experts are engaged in policy dialogues on development policies.[2]

In the case of Benue projects, these two basics principles of sustainable development were not in tandem. While the first principle was absence in people's popular consciousness, the second basic principle was being thrust down their throats.

In the 1980s sustainability was seen from the angle of the possibility of the benefits of a programme or project continuing to be available to beneficiaries/recipients, in the

complete absence of external funding.[31] Sustainability in this angle was from the perspective of the donors. There has been a shift, however, in the way sustainability is now looked at. In the 1990s sustainability was defined as the capacity of a development project or programme to function effectively over time with minimum external input.[4] Although defined with particular reference to water supply, sustainability is viewed by Havey and Reed as a situation whereby the "benefits of a project or programme continue to be realized by all users over a prolong period of time, and the service delivery process demonstrates a cost effective use of resources that can be replicated."[5] The Benue Health Fund Project defined sustainability, in relation to its activities, as "simply the ability of what the project is doing in the State to continue without maximum external input…"[6]. It is on the basis of, and upon the framework of the above definition that we shall examine the sustainability of the DFID projects in Benue State.

Of all the projects executed by the DFID in the State, the Oju and Obi WAS project demonstrated the greatest sustainability, comparatively. From our investigations, three factors were responsible for this. The first of these was the entrenchment of very strong community participation strategy in the project's design of activities. The Project target communities were made to understand, from the onset, that the water and sanitation facilities were theirs and that it was their duty to contribute to the building of the infrastructures and the maintenance of the same. To rub in this fact more thoroughly, WaterAid (a British NGO which had accumulated experience in water and sanitation management over the years) which managed the Oju and Obi WAS project, deliberately avoided creating an impression in the communities that there was money for the communities to share. WA was prudent in payment of allowances and honoraria to community members who underwent series of capacity building trainings. Moreover, WA as a deliberate policy, was not directly involved

in WAS project activities. It provided technical guidance to the WASU but never got involved in the physical implementation activities. Furthermore, WA insisted that benefiting communities provided accommodation and feeding for project officials whenever they visited them or were on site. As stated in chapter five, this was somehow a departure from what the BHF did in the communities they assisted. In the case of the BHF we discovered that the communities were overindulged, thereby giving communities the impression that the 'white people' came to "do for them" rather than assist them "to do for themselves" what was beneficial to them.

In actual fact, community participation has been found to be a very viable tool for sustainability. Studies carried out by Bagade in India and Olatunji in Nigeria give credence to this. According to Bagade, active community participation in a rural water programme in Dhavalpuri village in India brought about "a substantial increase in groundwater recharge component". According to him, the village used to face water scarcity during summer months every year, but when the villagers were mobilized to actively participate in the demand management of groundwater resources, the situation changed for the better.[7] Also, the study by Olatunji underscores the importance of community participation in sustainability. His experiences in Ilorin and Sokoto, both in Nigeria showed that active village participation was crucial to the working and sustainability of a rural water supply project. He drew the following conclusion, based on his research:

> Technology however appropriate is not enough to ensure that safe water is provided for all who need them. Participation of the local community is vital. The higher the level of community participation in establishing a service, in maintaining it, the more sustained the service.[8]

Olatunji's conclusion summarizes the experience of Oju and Obi WAS project which, as we said earlier, experienced a relatively good community participation. Moreover, the communities did not only passively receive facilities, but contributed in terms of finances

and physical labour in water and sanitation infrastructural building. They were also trained to maintain and repair the facilities, should they break down. However, the fact that water and sanitation seeking behaviour is slightly different from health seeking behaviour should be stressed. For instance, whereas latrines were owned by individuals within the communities, health facilities were owned by larger communities. Also, whereas water has no substitute, communities had the choice of either patronizing orthodox health facilities or traditional health institutions. Be that as it may, the Oju and Obi WAS project should be commended for its high community participation strategy.

The second factor for the sustainability of the Oju and Obi WAS project was the successful reintegration of the WASUs in the mainstream of the local governments' administrative structure after the closure of the project. In other words, the WASUs in the two project LGAs that worked with WA in the project were made to understand that their roles were going to continue long after the DFID funding was discontinued. Therefore, some of the training given to them were tailored towards this goal. For instance, the WASUs were trained to maintain a close link with the local government systems while working with WA on the project. They were made to understand that they were primarily staff of their various local government administrations and secondarily project staff. Similarly, WA emphasized the fact that the honoraria and other financial incentives the WASUs enjoyed were temporary. This emphasis was to help them adjust to the meager pay in the local governments, at the end of the project funding. As at the time of our visits to the two LGAs, the WASUs had settled down to the realities of the local government system but were still much involved in water and sanitation activities. Even though funding neither came from donors nor from the local governments, the WASUs officials indicated that they have continued to work to assist individual communities who were interested in establishing their

water and sanitation facilities. They also provided assistance to communities in the maintenance and sustainability of existing facilities.

The third and very important factor in the sustainability of the Oju and Obi WAS project was the minimum assistance which WA continued to provide at the end of project funding, free of charge to the two LGAs. It may be necessary to explain that WA as an NGO continued to work in partnership with some Benue communities after its contract with DFID ended. WA is still very much in Benue State and has continued to provide the minimum assistance, necessary for sustainability, to the two LGAs. This minimum assistance, though no longer the initiative of DFID, has enhanced sustainability of the project. According to the WASU staff in the two LGAs, the minimum assistance by way of technical advice provided by WA, was of tremendous benefits to them in their efforts.

The BHF project also enjoyed a measure of sustainability. It was, probably, the next project after the Oju and Obi WAS project that enjoyed this status, even though the project's gains declined rapidly shortly after it closed. However, in fairness to the BHF project, measures to ensure sustainability were put in place before the project eventually closed. These measures were contained in a document titled BHF's WAY TOWARDS SUSTAINABILITY OF ITS EFFORTS. The sustainability strategies outlined in the document included, among other things, the creation and strengthening of the communities' demand for quality primary and secondary health care services, improving the income generating capacities of communities to enable them finance health and social development services and collaborating and cooperating with the local and state governments in project activities. Other strategies included capacity building, by way of training, to properly position the stakeholders for project sustainability, the piloting of D&E schemes in selected communities and health facilities as well as the implementation of DRFs with community

ownership. The BHF also did its best in ensuring that it did not set up any parallel system but deliberately carried out project activities using existing local and state government structures. It was intended that this strategy would bring about replication of models in other LGAs and elsewhere. Furthermore, the BHF constantly reminded government staff on the project that they would assume the BHF responsibilities in future. Finally, as a strategy, the BHF project gradually withdrew the salary subsidy paid to government staff who worked on the project, to underscore the point that they needed to get used to the meager pay offered by government, when DFID withdrew funding for the project.[9]

However, the BHF project did not enjoy commensurate sustainability, in spite of the laudable strategies put in place to ensure it. To us, three factors account for this state of affairs. Firstly, the project did not make provision for minimum external assistance at the close of project funding. If we recall our definitions of sustainability one would be able to appreciate the role of "minimum external support" for development projects. Even though project funding came to an end, the DFID ought to have provided some kind of peripheral technical support to the stakeholders to drive home the gains of the project, if at all sustainability was going to be achieved. For instance, we saw that the minimum assistance provided by WA for the Oju and Obi WAS project contributed to the sustainability of the project. This minimum assistance was more imperative in view of the point we have continued to emphasize that for our rural people and governments to experience sustainable development, there was need for attitudinal change. A five-year project was too short to actualize this change especially that capacity building strategies were crash programmed. It would require at least ten years of consistent, rigorous and sustained training to achieve the kind of attitudinal change required for project sustainability. Although we are aware that

development projects/programmes have definite time frames, development partners could adjust this to fit into their target outputs.

Secondly, the BHF spent the most part of the project's life-span rehabilitating and putting in place PHC and SHC infrastructures in target communities and left very important aspect of strengthening community participation, through the establishment of micro-enterprises for health (MEH) projects, towards the end of project activities. It is our estimation that this aspect of the project activities, more than anything else, would have formed the fulcrum for sustainability. However, the time allotted to this aspect was too short for adequate capacity building, awareness and the actual building of the projects. The MEH was not only a viable tool for empowering the poor and vulnerable groups, especially women, but it possessed the capacity to enhance community participation, which we admitted was necessary for sustainability of development projects.

The last of the factors have to do with project management. The BHF project passed through the hands of three different project managers (PMs) within the space of five years. This did not help continuity of policies and programmes. To add salt to injury, the changes took place under controversial circumstances. For instance, the last but one PM was accused by some project staff of poor interpersonal relationship, while the last PM who managed the project to a close was accused of high-handedness.

It may be a bit erroneous, for want of a better word, to hold the DFID wholly responsible for poor sustainability of the BHF project. The state and the target LGAs share part of the blame. It was their responsibility to see to it that assisted development projects survived. As stated earlier in chapters five and six, the M&E mechanisms in the State and LGAs crumbled as soon as the project closed. This was unfortunate because we have agreed that donor assistance never meant an abdication of governments' responsibility to provide

health and social services to its people. Therefore, if health and social services supported by the DFID were not maintained, the donor should not be hanged. In an interview with the DFID State coordinator, he re-echoed this point when he said that the DFID policy on completed projects was that stakeholders had responsibility of monitoring the projects to ensure sustainability, once they were officially closed.[10]

In summary, the BHF project, to some extent, was sustained since some of the activities have continued to date, after the project closure, as discussed in chapter five. However, some of the gains of the project were short-lived and their impact on the rural communities was momentary.

The STD/HIV Management Project (the LATH project) in Benue State was the project that experienced the greatest sustainability difficulty. This problem was so severe that LATH had to organize a stakeholder consultative workshop in July 2002 to develop strategies for the sustainability of the secondary stakeholder project related activities. This workshop became necessary because during the OPR exercise of March 2002 it was discovered that the sustainability of the LATH project was in jeopardy to the extent that, for example, Otukpo experienced condom shortages as soon as LATH stopped procuring condoms for stakeholders.[11] This was a clear case of high dependency on the project for almost everything. In the report of the consultative workshop the following sustainability measures were suggested:

i) Micro-level activities of stakeholders were to form linkages with the wider systems and structures at the macro levels such as state and federal governments, policy making arena, other donor agencies, etc. The understanding was that these macro levels, if properly harnessed, could assist stakeholders in their activities.

ii) More primary stakeholders' participation in project activities during the remaining period of the LATH project was advocated. These groups of stakeholders was the poor and vulnerable groups for whose sake the project was intended, in the first place, but were not properly integrated in the decision making processes on policies which affected them. It was to correct this that the workshop made this recommendation.

iii) The forthcoming DFID-assisted HIV/AIDS programme to take off from where the LATH project ended.[12] Actually, it was hoped that the next assistance in HIV/AIDS would be a build-up from LATH.

In spite of the sustainability measures suggested above, the LATH project's sustainability was low. It is not our intention to overflog the sustainability lapses in the LATH project since we attempted to discuss this fairly well in chapter six. However, by way of recapping this we should mention that community/primary stakeholder participation was inadequate. Of course, LATH and DFID admitted this. If it has been accepted that community participation is central in development project sustainability, then it is no wonder that the LATH project's sustainability score card was a bit poor. Furthermore, as mentioned earlier, the LATH project experienced management problems. It is obvious that when the management of a project is problematic one would not expect great performance. A development project's performance is adjudged great if it is sustainable.

Finally, the issues of lack of attitudinal change which became a cross-cutting issue affected the sustainability chances of the LATH project. The project's life-span of five years was too short to tackle, through capacity building, the poor attitude of the Benue rural communities to development projects, especially projects carried out by donor agencies.

We are by no means insinuating in this section that development projects are generally unsustainable and therefore should be discarded. Rather, in actual fact, we are alluding to the fact that if well managed, and sustainability measures adequately put in place, development projects are capable of achieving the desired goals and purposes of their being put in place. We saw, for instance, that because the Oju and Obi WAS project was well managed, and that the target communities were well mobilized for project activities, coupled with minimum external assistance from WA, the project survived over and above the other ones.

7.3 DIPLOMATIC UNDERTONES IN BRITISH DEVELOPMENT ASSISTANCE IN BENUE STATE

As stated in the introduction to this chapter, this section is essentially an analysis of some of the motives for British development assistance in Benue State. It is important to state from the onset that the analysis will be based more on reading in-between the lines of the various British Government policies on foreign aid. This is because, just as it was cautioned by Hadley Arkes, not all aid motives are written in black and white, and that if we must get such motives then we would have to search for them beyond the pages of newspapers[13]. Of course, one would scarcely find any British Government official admit publicly that the aid being channeled to Benue State, and by extension, Nigeria was for Britain's personal interest. However, it should also be accepted that no nation would use its tax payers' money without consideration of the possible gains accruing to it.

To set the tone for our discussion in this section, we shall first consider Britains' position with regards to this issue. In the foreword to the White Paper on International Development titled Eliminating World Poverty: Making Globalization Work for the Poor, British Prime Minister, Tony Blair said:

> The new millennium offers a real opportunity to eliminate World Poverty. This is the greatest moral challenge facing our generation. It is also in the UK's national interest[14]

We have underscored the last sentence of the above quotation to press home the tacit acceptance by Britain that development assistance serve not only the interest of the recipient but also those of the donor. Explaining further how development assistance serves the UK's national interest, Blair said, in part:

> If the poorest countries can be drawn into the global economy... it could lead to a rapid reduction in global poverty… But if this is not done the poorest countries will become more marginalized, and suffering and division will grow. And we will all be affected by the consequences.[15]

Actually, Blair's position only re-echoed the position propagated by the Report of the Pearson Commission, already cited in chapter one. While advocating for international development assistance as a moral imperative, the report added an interesting dimension when it argued that rich countries would benefit if the world's resources were used to the fullest capacity and international trade expanded. The Report also argued further that rich and developed countries would be more secured.[16] This is a truism. For instance if the economies of the third world countries are viable, and if political and social systems are stable, devoid of wars, coups d'etat and other upheavals, the developed countries will stand a better chance to exploit the resources of these nations. For example, whenever there was war and unrest in the Niger Delta region of Nigeria, the multinational oil companies exploiting petroleum resources there were forced to close shop until such a time when peace and stability was restored again. During such times of upheavals both Nigeria and the multinational companies, and by extension, the developed nations involved in the business lose substantial revenues. Some notable experts on British foreign policy have given strong indications that national interests were paramount in the country's aid policies. For instance,

Morrissey, Smith and Horesh stated that although British aid with developmental objectives in mind were given to the poorest LDCs in 1987, the policy of the government in power (Margaret Tatcher's) favoured economic growth in the LDCs rather than targeting the poor which, to the government, was a more effective means of poverty alleviation. These authors stated further that even development aid during this period enjoyed only reduced 'tying'.[17] In other words, some conditionalities were attached to the aid given. This position tallies with that of Eyinla who argued that the EU's (of which Britain is a key member) aid policy to sub-Sahara African countries had political conditionality which was designed to bring in the developing nations under the new international economic order. According to Eyinla, democratization, political and economic reforms, and good governance formed the bedrock of this conditionality.[18]

It is therefore no wonder that the development assistance to Nigeria and Benue State from Britain has been accompanied by assistance in the areas of good governance, reforms and justice to integrate Nigeria into the world economic system. Presently, in Benue State, the DFID's SLGP is on ground assisting the State Reform Team (SRT) to, among other things; bring about a "more democratic, accountable, transparent and responsive state and local government.[19] Also, the Access to Justice Programme has been designed to "enhance access to, and the quality of safety, security and justice for poor people".[20] The Programme's purpose is to support the development of a Nigeria – led justice sector reform.

Apart from the motive of bringing Nigeria under the globalized economic order, is the specific motive of economic development of the country which also provides immediate and long-term benefits to the donor. This shall be explained shortly. Nigeria which was a British colony has maintained a long-standing political and economic relationship with Britain and has remained one of Britain's most viable trading partners in sub-Sahara

Africa.[21]It is not an overstatement to say that when Nigeria sneezes, Britain catches cold. Strengthening of Nigeria's economy and, of course, political system will benefit Britain directly or indirectly. As a matter of fact, it is our belief that the economic viability of Nigeria is Britain business in view of the fact that the latter has monumental investments in the formers' economy. This view is further substantiated when, in the Country Strategy Paper on Nigeria the British Government said:

> Nigeria has endured more than fifteen years of military rule. Its substantial human and natural resources endowment should make it the engine for economic growth. Instead its population is one of the poorest in Africa. There are enormous challenges ahead to meet the international development targets. Success will spread benefits beyond the country's borders.[22]

It is our view that it was to accomplish this agenda of ensuring that Nigeria's wealth "spread benefits beyond the country's borders" that Benue State and three other states (Ekiti, Enugu and Jigawa) were used as 'pilot sites,' as it were, to demonstrate that economic, social and political reform can deliver practical benefits for the poor. Since there cannot be a meaningful approach to the economic development of Nigeria without streamlining the agricultural sector, the British Government assistance to Benue State also included assistance in agriculture. In the 1996 UNDP Human Development Report on Nigeria, the agency recognized agriculture as the life wire of the Nigerian economy, providing half of total employment (measured in full time equivalents) over and above other sectors such as mining, manufacturing, construction, etc. The UNDP regretted that in spite of the noble place agriculture occupies in the economy of Nigeria, the country has remained a monocultural economy with oil accounting for 96% of external earnings.[23]

Benue State of Nigeria has great potentials for providing the much needed agricultural boost to the nation's economy. Tagged the "food basket of the nation", the State has the capacity to provide enough food and cash crops for the nation, if properly

harnessed. It was with this consciousness that one of the federal universities of agriculture was established in the State with a mandate to, among other things, promote effective linkages between farmers and researches, provide training for extension personnel and produce effective materials with a view to enhancing livelihoods and sustaining agricultural productivity.[24] The British Government, equally aware and conscious of Benue's unique agricultural potentials, did not only assist in the area of health but also in the agricultural development since the two sectors are mutually complementary.

There was need for the people to be healthy in order to develop their agricultural potentialities. Consequently, between May 1997 and March 2001 the DFID assisted the State in its agricultural development. The project, named Improved Farmer Participation in Research and Extension in Benue (IFPREB), worked in collaboration with the Co-operative Extension Centre of the University of Agriculture Makurdi, in assisting rural farmers, especially women, by enhancing the capacity of agricultural support services to provide relevant, accessible and affordable information and skills. These skills were to lead, inevitably, to sustainable management of agricultural resources and an increase in productivity, against the backdrop of shortages of accessible farmlands and declining soil fertility. These consequently gave rise to reduced crop yields, limited household incomes and household food insecurity.[25]

The IFPREB project was conceived in 1994 when an ODA's Renewable Natural Resources (RNR) sector strategy for Nigeria identified Benue State as a potential focus for RNR support. In 1996 PRAs were carried out and there was a confirmation that opportunity to provide development assistance in this area existed. The degree of success and the sustainability of this project cannot be established, however, in view of the fact that it does not form part of the projects studied in this research. Nevertheless, the project underscores

the British Government's strategy of strengthening Nigeria's economic capacity through agricultural development.

Another important motive for British development assistance in Benue State has to do with issues of prestige and the creation of spheres of influence. In an interview with two British Government officials working in the area of development assistance, they expressed the view that the British Government gains nothing by assisting LDCs except the satisfaction that the country was committed to international development targets to help humanity.[26] We have certainly seen beyond this. Firstly, on the issue of prestige we can say only little since prestige is hardly measured. It has to do with high reputation which is acknowledged, in this context, by the international community. A nation has to be strong politically and economically to join the 'club' of donors. Similarly, the more the volume of aid channeled for international development, especially capital flows, the stronger, the wealthier and influential a nation is considered to be. Although this measure of strength is scarcely advertised, such nations know themselves and belong to groups which go by names such as the G8, Paris Club, OECD, etc. Secondly, during the scramble, partition and eventual collapse of the African continent, the creation of spheres of influence by the European powers was for the purpose of exploiting the resources of the subjugated peoples by force.[27] But in the new dispensations spheres of influence are created through friendships, for the purpose of peacefully and surreptitiously 'exploiting' resources in the LDCs through economic globalization. Carol Baker stressed this point further when she argued that, aid relationship is a two-way process. According to her, this means that both the donors and recipients benefit from aid. Specifically referring to aid in health, Baker said, benefits to recipients are good health infrastructures while the donors benefit by securing friendships and influence as well as commercial opportunities.[28]

In the course of writing this chapter we said in view of the fact that the world was becoming a global village was rationale for international development assistance. At this juncture we wish to comment, briefly, on this concept of globalization. In the opening remarks to the eighth forum of the Foundation for Advanced Studies on International Development (FASID), its Executive Director, Masaki Saito maintained that large waves of globalization were reaching all corners of the earth, facilitating the transfer of people, money and information across national boundaries with the information technology playing an important role in accelerating this trend. He admitted that as a result, the world has experienced both the bright and dark sides of globalization. The dark side, according to Saito, included so-called marginalization of certain regions (such as the LDCs) which felt left behind, while the bright side was characterized by the forward movement of the concept. He hoped that as the bright side develops further, global public goods may be seen more clearly.[29] In her contribution, Inge Kaul said globalization is characterized by increased openness of borders, facilitated by new technologies and increased international regime building. This include regime for removal of at-the-border controls for trade and capital flows. Globalization, to her also includes the emergence of transnational actors within civil society and the private sector, the resultant cross-border economic activities, accompanied by numerous (positive and negative) externalities; and growing systemic risks such as pressure on the global natural resources, increasing global inequity and the risk of crisis inherent in international financial market.[30] From the above views expressed by Saito and Kaul it is apparent that globalization, at the stage we are today, has benefited the developed countries more than the developing. Although Saito hoped that the dividends of globalization will reach all and sundry in due time, this was yet to be seen, especially in Nigeria. It is therefore our thinking that when the chips are down, Britain’s effort to “make

globalization work for the poor" of Nigeria will definitely benefit the rural people but the benefits accruing to the donor might be richer. Hanafi, a leading Islamic scholar articulates this common fear when he conceptualized globalization as the consolidation and extension of an exceptionally potent brand of neocolonial hegemony in which the cultures and even the wills of the colonized peoples are finally subjugated.[31] Hanafi's fears are founded to some extent because the 'train' of globalization has moved at a speed that LDCs have found difficult to catch up with. It will be recalled that when the Executive Director of FASID remarked that poorer nations were feeling marginalized because they were left behind the global 'train', he only stated the obvious. For instance, the opening up of trade barriers, the new information technological order, the emergence of transnational actors within the civil society and the private sector, etc, benefits the developed nations and their nationals more than the developing ones.

Finally, there is yet another subtle undertone to British aid which has to do with self preservation. It is the belief of the British Government, as contained in the country's White Paper on International Development titled Eliminating World Poverty: A Challenge for the 21st Century, that "violent conflicts generates social division, reverse economic progress, impedes sustainable development and frequently results in human rights violations."[32] The consequences of these are large population movements, security threat of whole regions, threat to livelihoods and displacement of persons, especially the poor. Usually, whenever there are violent national and international conflicts of a high magnitude in developing countries, refugees preferred to seek asylum and hiding places in developed countries which are relatively stable. This scenario brings about economic hardship for the host countries. It is therefore no wonder that the British Government believes that the promotion of political stability, both within and between states is necessary precondition for world peace and

stability. Conflict prevention therefore, has become crucial to the UK government's diplomacy of international development.

Coming closer home, Benue State has been known for rampant communal conflicts which we admitted in chapter three were caused by poverty. We also admitted that the consequences of the conflicts were more poverty and more ill-health. If the prescription of the British Government is anything to go by, an elimination of intra -and inter-state conflicts in Benue State and in Nigeria respectively, will go a long way in promoting stability and security. This will eventually give rise to political and economic prosperity. And as stated in the DFIDs Country Strategy Paper on Nigeria, "success will spread benefits beyond the country's borders"[33], reaching Britain as well.

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CHAPTER EIGHT
SUMMARY AND CONCLUSIONS

8.1 SUMMARY OF FINDINGS

This pioneering, multidisciplinary and innovative research attempted, in a modest way, to examine British development aid in health and social development in Benue State within a period of ten years. Although slightly deviating from conventional historical research (because it is built, as it were, on current documents and reports), the study's rationale was clearly stated in chapter one – to do a development study that responds to the call on historians to adopt the new philosophy of history, which emphasizes dynamic and pragmatic researches that are development relevant. Our choice of British aid in health and social development was deliberate. It underscored the importance of health in the overall development of an individual and the community at large. This was also clearly articulated in chapter one.

Chapter two reviewed some of the literature on the subject of our research. It was discovered that much of the literature only had indirect bearing on our research because no known work has been done in the area before now. Be that as it may, the literatures on foreign and British aid were particularly useful in giving us a basis and framework for the study. Both radical and conservative literatures were reviewed. Chapter three provided us with insight into the Benue State of our research, looking at the brief history of the State and an examination of its poverty, against the backdrop of Nigeria's poverty profile. Thus the chapter provided a rationale for British aid in the State. The chapter ended with an analysis of the origin of British assistance in health and social development in the State, setting the stage for us to discuss the three major DFID-assisted projects in the area from 1996 – 2003.

Chapters four to six actually formed the fulcrum of our research. It was in these chapters that the three DFID-funded projects, namely, the Oju and Obi WAS project, the BHF project and the LATH project were discussed, in that order. Our study of these projects revealed key findings, which have been highlighted in this chapter. Firstly, it was discovered that the British Government spent a total of N1,135,641,376.85 on the three projects. The sum of N240,000,000.00 was spent on the Oju and Obi WAS project, N628,209,076.85 on the BHF project and N267,432,300.00 on the LATH project. Secondly, it was discovered that all the target communities of these projects stakeholders praised the efforts of the DFID and admitted that the projects had tremendous impact on their poor and vulnerable people. However, our study revealed that soon after these projects closed, two out of the three, the BHF and the LATH projects, experienced low sustainability due to the fact that the DFID withdrew from the projects without traces, and without minimum assistance. Also, other sustainability measures such as community participation were not adequately entrenched. Furthermore, we found that the projects' life span was too short to build capacity that will stand the test of time, and bring about attitudinal change in the rural people's attitude towards development projects. But above all we discovered that our local and state governments have not yet imbibed the human development paradigm advocated by the UNDP, therefore they are usually reluctant in providing sufficient budget lines for community and rural development. They keep waiting for donor initiatives, forgetting the fact that development assistance ought not become a substitute for their constitutional responsibilities to the people they govern. The Oju and Obi WAS project experienced a good degree of sustainability. It was discovered that his was due to the solid foundation for community participation laid by WA, the NGO which was contracted by the DFID to manage the project. Also, after the closure of the project WA, though no more

funded by DFID, maintained minimum contacts and provided minimum + technical assistance to Oju and Obi WASUs.

Another key finding in our study of the three projects was the fact that to the best of our knowledge the models developed by the three projects were replicated only in a few places. LATH claimed that their activities in Otukpo and Aliade informed the Federal Government's policy on multi-sectoral approaches in tackling HIV/AIDS, while the Oju and Obi WAS models were being replicated in Vandeikya and Logo LGAs of Benue State by WA through partnerships with the LGAs.

Chapter seven discussed two key issues of sustainability and diplomatic undertones with British aid in Benue State. The issue of sustainability has already been adequately tackled, since it cuts across chapters four, five, six and seven. On the issue of diplomatic undertone it was discovered that although Benue State and, indeed, Nigeria stood to gain from development assistance from Britain, the donor too had much to benefit by way of globalization dividends, trade, friendship and prestige.

On the whole the research discovered that the DFID recorded modest achievements in bettering the lives of the neglected poor and vulnerable in some Benue rural communities. Even die-hard anti-aid proponents such as Hayfer, while arguing that even poverty-focused and environment friendly projects "amount, at best, to minor palliatives, which do little to counteract the overall effect of disastrous external and internal pressures and policies" admitted that "there are of course, some modest achievements".[1] To the Benue rural poor, Hayfer's "modest achievements" meant much when compared to their poverty. While it is not our primary focus in this research to engage in the seemingly unending debate on whether or not foreign aid was desirable, it is our candid opinion that development aid, especially the type advocated by the UN for international development ought to be

embraced. Frankly speaking, tied aid that has apparent crippling effects on a nation's economic and political liberties is obviously harmful and should be rejected and discouraged by the UN. Donor nations whose aid programmes are direct responses to the international development targets should be encouraged to do more for the "wretched of the earth." How much sense does it make, for instance, when we reject DFID's assistance in water and sanitation, healthcare, agriculture, education, and so on, when our state and local governments are either not willing or ill-prepared to provide them.

As we draw curtains on this section, it would be worthwhile to peep into the future of DFID development assistance in Benue State and Nigeria. Presently, there are on-going DFID projects in Benue State in the areas of health, governance, education and justice. In health, the DFID is supporting Benue State and the other focal states in a sever-year programme known as Partnership for Transforming Health Systems (PATHS). The goal of this programme is to improve the health status of the poor in Nigeria by improving and strengthening the delivery and use of effective pro-poor health services. The programme is collaborating with Nigerian partners across all sectors and developing partnerships to achieve this goal. [2] Also, in health the DFID is supporting the Insecticide Treated Mosquito Nets (ITNs) project with the goal to reduce the rate of morbidity and mortality caused by malaria in pregnant women and children under the age of five. The purpose of the ITNs project is to increase the household coverage of insecticide treated mosquito nets in the State through the demand and utilization of the commodity through advertising and direct marketing. The project is managed by Futures Group Nigeria. [3]

In the area of governance, the DFID is funding a seven year State and Local Government Programme (SLGP) which commenced in 2000 with the objective of building capacity in States and Local Governments to deliver services to the poor, and to help

establish accountable, transparent, responsive and democratic governance. With this programme in place, the capacity of the State and Local Governments will be enhanced to formulate policy, manage resources and support service delivery in the interest of the poor people. [4]

Furthermore, DFID is collaborating with the World Bank to provide support to the Federal and State governments' strategy for the Universal Basic Education (UBE). The purpose of this five-year project is the development and implementation of the State plans for UBE in 16 States, including Benue, with priority given to educationally disadvantaged areas. [5] In addition to this project is the Access to Justice Programme, a seven-year programme which has developed through extensive stakeholder consultation, including the Chief Justice of Nigeria, the Federal Attorney General, Nigeria Police Force, Nigeria Prisons Service, State Chief Judges and Attorneys General, traditional authorities, civil society organizations and other donors. The goal of the programme is to enhance access to, and the quality of safety, security and justice for the poor people. The purpose of the programme is to support the development of a Nigeria – led justice sector reform so that pro-poor policies are implemented. The programme is targeting the following reform areas:

i) Strengthening the management and operation of key government justice institutions.

ii) Development of sector-wide policy development and implementation.

iii) Improving security and policing for poor people.

iv) Promoting of fair and equitable lower court outcomes.

v) Alternative to the courts.[6]

Finally, The Rural Livelihoods Programme is a six-year DFID assisted programme with the goal of improving livelihoods and well being of the rural poor. The purpose is to enhance opportunities, greater livelihood security, and reduced conflict and vulnerability

that contribute to economic and political transformation. State structures, civil society and the private sector are partners to this programme.

Although the new HIV/AIDS programme of the DFID is yet to commence in the State, there were indications by the DFID Co-ordinator that it will soon commence. This up-coming programme is designed to support the national response to HIV/AIDS, by building capacity for HIV/AIDS intervention at the Federal level, support key foundation activities identified in the HIV/AIDS Emergency Action Plan (HEAP) of NACA. [7]

On the future of DFID assistance in Benue State and Nigeria, the State DFID Coordinator said there was going to be a fundamental shift with Country Assistance Plan (CAP) replacing the Country Strategy Paper which will end in the middle of 2004. According to him, CAP will respond directly to President Obasanjo's National Economic Empowerment and Development Strategy (NEEDS). [8] The NEEDS programme of President Obasanjo's Administration was conceived as a medium term strategy for poverty reduction, wealth creation, employment generation and value re-orientation spanning between 2003 and 2007. The NEEDS is a nationally coordinated framework of action in close collaboration with State and Local Governments and other stakeholders such as the Manufacturers Association of Nigeria (MAN), Nigeria Labour Congress (NLC), civil society organizations, etc. The NEEDS rests on four key strategies, namely, reforming the way government works, growing the private sector, implementing a social charter for the people; and a reorientation of the people with an enduring African value system. [9] The DFID response to NEEDS, according to the Benue State DFID Coordinator will be in the areas of economic growth, political change and human development. Reading through the NEEDS document, the impression we gather is that the present administration may be gradually responding positively to the campaign for human development paradigm which the UNDP

began to advocate. Since the 1990s and has continued to advocate. It is only hoped that like other poverty alleviation programmes, the NEEDS will not experience a false start. The intention of the Obasanjo Administration is that the NEEDS will give birth to State Economic Empowerment and Development Strategy (SEEDS), while SEEDS will finally give birth to Local Economic Empowerment and Development Strategy (LEEDS) at the LGA level.[10]

Apart from responding to NEEDS, the DFID State Coordinator said DFID will also respond to Nigeria, in the area of assistance, in accordance with the Millennium Development Goals for poverty reduction as agreed by the UN. As already stated, the British Government accepted Benue State as a foci for British assistance since 1992 and has continued to provide development assistance to the State since then. Therefore, the place of Benue State in British aid in Nigeria of tomorrow seems to be secured.

8.2 CONTRIBUTION TO KNOWLEDGE

This pioneering research has contributed to knowledge in a number of ways. First, this research demonstrates that history as a dynamic discipline has successfully made incursions into development studies. It will be recalled that while providing a justification for this research, in chapter one, we said development studies were not only increasingly becoming an area of interest and concern to the UN, the entire international community and individual nations, but we also said this area had been hitherto left for social scientist; but that the new philosophers of history were now calling on historians to engage in researches in the area. This research is therefore a response to this call.

Secondly, to the best of our knowledge, this is the first time in Benue State, and probably elsewhere, that activities of a donor agency will be subjected to the close scrutiny

of a researcher. This scrutiny has revealed a number of findings which have already been highlighted in section 8.1. These findings, if examined by donors and recipients of aid with a view to appropriating them for future activities of donor initiatives, it is hoped that the insights garnered and the critical issues raised wouldn't be lost.

Furthermore, the research has generated some recommendation which, if adopted by both the Benue State and the Federal Governments could bring about accelerated rural and community development to the people, and consequently reduce poverty in the country. Similarly, the recommendations, if appropriated by the DFID and other donor agencies may succeed in bringing about some changes in donor policies that could assist in development project planning implementation and sustainability.

8.3 POSSIBLE AREAS FOR FUTURE RESEARCH

It is hoped that this modest pioneering effort which this research has put up will eventually open a floodgate for other researchers in history and social sciences who may research into what bilateral and multilateral aid agencies are doing in Benue State and in other places. Specifically, it is hoped that activities of donors such as UNICEF, the WHO, World Bank and the UNDP in Benue State will be researched into. Also, sooner or later historians and social scientists in Enugu, Ekiti and Jigawa States may wish to commence enquiries into the activities of the DFID in these States with a view to either investigating in these States what our research has investigated in Benue, or exploring new horizons in the entire British aid agenda.

Moreover, the area of community development is a very vast and interesting terrain, which our research has exposed. For instance, our research only mirrowed British aid in health and social development, leaving out other areas of assistance such as in agriculture,

justice governance, etc. It is suggested that the DFID – assisted IFPREB project which lasted for five years could be studied by other interested researchers. Also, governments' efforts in community and rural development are areas which historians could pick some interests in. For example, the Benue Rural Development Agency (BERDA), BERWASSA, Benue Agricultural and Rural Development Authority (BNARDA), etc, are Benue State government outfits that have been put in place for over ten years (BNARDA has been in place for almost 20 years) without researches being carried out into their activities. Since historians are developing more interests in community and rural development, these agencies of government could be viable research areas.

8.4 CONCLUSION

A research of this nature will be a bit inconclusive if one fails to make some recommendations by way of conclusion, based on findings. Therefore, we intend, in this section, to make recommendations that may input into future aid policy as it affects the donor and the recipient. These recommendations may also guide our governments on rural and community development strategies and policy thrusts for now and in the future. However, to do this, it is our intention to lay a background, for the purpose of supporting the recommendations.

Nigeria is expected to have come of age, to have become part of donor nations, doing for poorer nations, particularly African countries, what the developed nations have been doing for her. This expectation is informed by the fact that Nigeria has enormous material and human resources that could accommodate this. Apart from Nigeria's position as the sixth largest producer of oil, placing her as one of the richest countries in the world, the country is also blessed by nature with other money-spinning mineral resources such as coal,

bauxite, limestone, tin, to mention only a few. Moreover, the country's soil is rich, producing both cash and food crops in large quantities, although largely untapped. Furthermore, Nigeria has been blessed with a cream of intellectuals and professionals in different fields and areas of endeavour, apart from several other blessing provided by the creator.[11] With this monumental wealth, Nigeria's poverty actually exists in the midst of plenty. This situation could be described as Nigeria's paradox. A few factors are responsible for this crippling poverty which has become an albatross, as it were, to many Nigerians.

Firstly, official corruption is central among these factors. The systematic entrenchment of corruption in Nigerian's body polity commenced from 1966, when the military established the first totalitarian regime in the country, even though the foundations of corruption had been laid by the first civilian Administration of Alhaji Tafawa Balewa, from 1960, when Nigeria become an independent entity. Although the first independent government in Nigeria sowed the seed of corruption (since it was toppled for reasons of corruption), it was the successive military regimes that watered the seed to full-grown maturity.[12] The history of corruption in Nigeria is a long and complete one which we do not intend to highlight in details since much has been written on this; and since it does not form the crux of our study. However, suffice it to be said that Nigeria of the past had been corrupt; and Nigeria of today is even more corrupt. For instance, apart from the various reports cited in this dissertation which have pointed to Nigeria's corruption, Transparency International, in 2001 and 2003 rated Nigeria as the second most corrupt nation in the world. Bangladesh was first. The organization stated that corruption was the major threat to a successful institutionalization of a stable and durable democracy. Transparency International accused the nation's leadership of propagating corruption. The organization stated that corruption in Nigeria was from the top to bottom, becoming a cancer, so to speak, which has

eating into every fabric of the society.[13] Also, only recently, the president of the World Bank James Wolfenhson, in a dialogue with President Obasanjo, described corruption on the African continent as “the greatest cancer you have on the continent”.[14] He urged the Nigerian leader to fight it, arguing that Nigeria possessed the potentials of being the jewel of Africa. He stated that Nigeria’s reform programmes would change the face of Africa. He pledged the support of the World Bank to President Obasanjo’s reform agenda.

The present leadership in Nigeria has also admitted that corruption was still one of the country’s major headaches. In the NEEDS document we have cited a couple of times in this chapter, the government’s admittance reads, in part:

> Corruption and abuse of positions and privileges have long been features of Nigeria’s economic and political landscape. For several years, inflation of government contracts and the whole challenge of systemic corruption, low levels of transparency and accountability have been major sources of development failure.[15]

With this tacit acceptance by government that corruption in Nigeria is real, what further proof does one need?

Another factor responsible for the poverty of the Nigerian citizens is illiteracy. Although the Federal Office of Statistics (FOS) has not updated its poverty indicators since 1996, the Federal Government of Nigeria believes that illiteracy showed little or no change during the decade of the 1990s.[16] The rate of illiteracy in Nigeria has remained high. For instance, in 1996 72.2% of heads of households were illiterates while 54.4% of Nigerian children could not be enrolled in primary schools. Fifty-two percent did not go to secondary school while 49.2 had no access to post-secondary education.[17] The negative effects of illiteracy on a community of people are very obvious and evident. For instance, illiteracy creates a situation whereby people are ignorant of their rights, privileges and responsibilities in a society. Thus, they become incapable of pursuing creative ventures that generate wealth

and sustenance. They are also unconscious of practices that promote personal and collective well-being in the society. It is no wonder that in Nigeria, most of the illiterate and ignorant rural dwellers are often 'hoodwinked' into voting for people who lack patriotism, vision and purpose, to represent them during elections, provided the vote seekers are prepared to part with stipends in form of cash and other consumable items. This situation has enabled Nigeria's rulers to rule as if there was nobody to account to. The cycle of ignorance has reduced the masses to a level of docility that they hardly demand for their rights and privileges, and are scarcely aware of basic issues pertaining to their healthcare, such as basic hygiene and sanitation practices.

Apart from illiteracy, lack of political will on the part of government has also been identified as fueling the embers of poverty in Nigeria. This is a condition whereby resources are available for the provision of essential services such as education, health, roads and other infrastructures, and so on, but the government is unwilling to put them (resources) to productive uses. For instance, a citizen of Nigeria lamented over this situation when he could not find a functional Magnetic Resonance Imaging (an orthopaedic diagnostic equipment, which costs only between ₤675,000 and ₤700,000), in any of the nation's most popular hospitals. According to him, he looked for the equipment at the National Orthopaedic Hospital, Igbobi; Lagos University Teaching Hospital, University College Hospital, Ibadan, National Hospital, Abuja, while the University of Maiduguri Teaching Hospital had only a semblance of it.[18] He concluded, in part, his lamentation:

> How much does it cost to have this machine?… It is not up to what one minister would steal under Obasanjo. It is not up to what Obasanjo would spend in one second, illegally. Yet the health of our people is being seriously ignored… What is the purpose of government if you don't look after the health of the people:[19]

Official government's neglect of the human development paradigm is translated into this lack of will to provide services for the people. This is seen not only in the area of health but also in other areas. For instance, there is actually no sector that has received sufficient attention. There is no sufficient safe water for the people, education is not on the governments' priority list, and neither is industrialization being vigorously pursued. In actual fact, this factor cannot be divorced from the factor of corruption. They are mutually compatible.

So, the people watch with dismay as the systemic decay continues unabated, hoping to find help someday while the governments go cap-in-hand soliciting for assistance from donors.

It is therefore, on the basis of the above foundational discussion that we make the following recommendations:

i) Both the Benue and Federal Government should sincerely address the problem of official corruption and cease paying lip service to the evil. Already, the government has admitted that corruption, absence of transparency and accountability are major sources of development failure. Having identified sources of development failure, the governments should take a further step to eradicate the epidemic. Development and corruption cannot, certainly, go together. Mark Bannister believes that corruption in development is "a killing virus". From studies carried out in South Africa, Bannister discovered that to improve the quality of peoples' lives, development required economic growth, equity and redistribution of that growth, poverty reduction and environmental safety. He stated further that to accomplish this, there was need for social change, institutional development, enhanced salaries for public and private workers, improved working conditions and environment, and so on.[21] Bannister recommends the South

African government's approach to tackling corruption. He indicated that this could be done through economic reforms, legal and procurement reforms, political will, etc. He warned that if corruption is not stemmed, it could give rise to distorted public spending, discourage investment and growth, undermine efficiency, undermine governance and discourage international development assistance.[22]

ii) Both the Benue and Federal Governments should, as a matter of priority invest more in the areas of health and education for accelerated development of the citizenry. Ill-health and illiteracy are twin maladies that no nation can afford to accommodate. A healthy mind and a healthy body are assets to the individual and to the nation. The UNDP has repeatedly emphasised this. The inability of the Universal Basic Education (UBE) programme of the present administration to take off fully is held suspect. The programme should be pursued with such a vigour as to generate hope for a new dawn in the educational development of the people. Also, investments in secondary and tertiary education should be increased. The governments should muster sufficient political will to do this. On health matters, the governments should show more commitment by investing more in health. For instance, a situation whereby the Benue State government is providing only 32.5% healthcare services as against the private sector with 67.5 is unacceptable. Even the 32.5% of services provided by the government are of low quality, inadequate and poorly distributed. There are five doctors to 100,000 people with most of the doctors concentrated in Gboko, Makurdi and Otukpo, while there are 41 nurses and midwives to 100,000 people with the same distribution pattern as the doctors.[23]

Furthermore, it is our standpoint that the issue of good health for the grassroots people in the overall socio-economic development of Benue State and Nigeria is not only

critical but imperative. Therefore, more proactive measures should be taken in this direction. We further recommend, consequently, that similar measures which were taken in the past by the Federal Government to address the issue of poor funding and broken down infrastructures in primary education be adopted. It will be recalled that with the near-collapse of primary education, which is constitutionally the responsibility of the LGAs to provide for the people, the Federal Government set up the National Primary Education Commission (NPEC) and also directed the states to establish the States Primary Education Boards (SPEBs) for the purposes of funding and directly monitoring primary education at the grassroots levels. These measures have since restored the glory of public schools, to a reasonable extent, across the country. it is hoped that if the NPHCDA becomes National Primary Health Care Development Commission (NPHCDC) and is given more powers, whereby monies are channeled through it for funding PHC through the States Primary Health Care Boards (SPHCBs), which we recommend should be established, the grassroots people will sigh a sigh of relieve in the nearest future. PHC facilities will be rehabilitated and salaries of health workers at the third tier of government will be paid promptly, thus boosting their morale.

iii) Future development assistance to Nigeria by the DFID and other donors should, in addition to specific areas of need, pay attention to capacity building for civil society organizations, particularly civil rights groups who are capable of coordinating pressure groups that will press governments at the various tiers to take steps to address human development needs. Experience has shown that in Nigeria, pressure on government and strikes, more than persuasion, make governments to respond to the yearnings and aspirations of the citizens. That is the more reason why civil rights groups may be more relevant in the development process, in the new dispensation.

iv) When we discussed the various DFID-assisted projects, we emphasised the fact that capacity building trainings were too short to achieve optimum impact on the trainees. Although we understand that donors operate within limited time frames, in the planning, implementation and evaluation of projects, we recommend that in future, more time be devoted to capacity building so that when projects are closed the recipients will be adequately equipped to sustain them. similarly, we recommend that development projects be spread over a period of, at least, seven years; and project management by the donor's expatriate personnel should give way, gradually, to indigenous management. During this period frequent changes of management staff be discouraged, as much as possible, to allow for continuity of policies and programmes. Furthermore, indigenous consultants and experts be used in preference of expatriates. This recommendation is informed by the fact that some Benue professionals indicated that although the DFID assistance in the State was quite substantial, much of the capital went back to expatriates in form of consultancy and contact fees, as well as through procurement of machineries such as vehicles, generators, medical equipment, etc.

v) Since we have indicated that donor initiatives are still relevant, especially in countries experiencing failed governments, we recommend, therefore, that the DFID and other donors should increase their assistance to Nigeria's rural communities in the areas of health and social development, education, agriculture, as it is being done presently. Funds for development aid be disbursed directly by donors without channelling them through the government, as is presently done. We recommend further that both expatriates and indigenous personnel working on the projects be screened with a view to having the best hands. It was discovered from our study that some Benue State indigenes who worked on some of the projects pilfered project funds and materials, at the slightest opportunity. Also, some expatriates lacked commitment, and managed the staff with some degree of

highhandedness. As a matter of fact, we recommend that faith-based NGOs could be contracted to handle some of the DFID-assisted projects since it is assumed that charity organizations may do better in this regard.

vi) We recommend that henceforth the DFID and other donors should insist on counterpart funding to be paid up-front by all tiers of governments before commencement of development projects. This will help the governments to imbibe the culture of funding grassroots projects, in particular, and development projects generally. It will also serve as their commitment to the projects.

vii) It is also our recommendation that the models developed by the DFID in Benue State be replciated in all the LGAs in the country. For instance, it will be worthwhile to replicate the Oju and Obi models for water and sanitation. This models should be entrenched as a policy for all LGAs. WASUs should be established or resuscitated, where they existed before, and budget lines be provided for their activities.

viii) Since the UN has set international development targets, the body, through the UNDP, should monitor development activities in the world, especially in developing countries with a view to sanctioning nations that fail to meet the targets. It is our view that as long as the international body has not imposed sanctions, calls for human-development will continue to fall on deaf ears. Similarly, it is our suggestion that the Federal Government should set national development targets and entrench them in the constitution so that the two tiers of government could be guided in their development efforts, especially human development Sanctions should be imposed on states and local governments that fail to meet these targets. For instance, if a state's or local government's share from the Federation Account is withdrawn or withheld for failing to meet human-development targets in a year, it is hoped that more efforts will be put in this area. Otherwise, the states and local government

executives will continue to collect revenues and develop themselves at the expense of the generality of the people.

ix) The present administrations NEEDS and SEEDS programme are vigorously pursued, as a demonstration of government's commitment to poverty eradication. Civil society organizations and other pressure groups such as the NLC and civil rights groups should be sensitized by donor agencies to keep an eagle-eye on activities of the government with a view to ensuring that the new programme does not go the way of several other laudable poverty alleviation programmes in the past.

It is our hope that if the over recommendations are implemented, Nigeria's toga as one of the "rich" poorest countries of the world will be dropped, sooner or later. Similarly, the health and social development status of Benue State will improve, sooner or later.

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Andrew Onah, 35, WASU Staff, Oju, 26/11/02

Atovi Iordye, 42, Housewife, Iwendyer, 3/12/03

Azua Gbaa, 38, Health Worker, Katsina-Ala, 2/12/03

B.A Ogar, 40, Hospital Administrator, Oju, 8/1/04

Barnabas Abaya, 21, Student, Abetse, 4/12/03

Benedict Ona, 50, Farmer, Irabi-Ito, 27/11/02

Benson Agbo, 45, Health Worker, Otukpo-Nobi, 17/12/03

Bridget Niongon, 18, Student, Abetse, 4/12/03

Chirve Aminde, 65, Farmer, Abaji-Kpav, 2/12/03

Comfort Gile, 45, Health Worker, Wannune, 5/12/03

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Comfort Joel, 36, Housewife, Eja, 26/11/02

Comfort Kungwa, 35, Health Worker, Apka, 5/12/03

Dan Ejeh, 36, WASU Staff, Obi, 27/11/02

David Tsavnum, 45, Farmer, Ugondozua, 3/12/03

David Anga, 47, Health, Administrator, Katsina-Ala, 2/12/03

David Orshi, 38, Health Worker, Ukazo, 24/11/03

Dooshim Ako, 35, Civil Servant, Makurdi, 24/11/03

Edward Akuto, 48, Medical Doctor, Makurdi, 8/12/03

Elijah Echono, 54, Health Worker, Otukpo, 17/12/03

Elizabeth Onah, 38, Housewife, Ojokwe, 27/11/03

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Eunice Yoo, 22, Farmer, Abetse, 4/12/03

Fatima Idrisu, 65, Housewife, Onyangede, 18/12/03

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Hemen Dookicha, 60, Farmer, Tyemimongo, 1/12/03

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James Zasha, 52, DFID Staff, Makurdi, 16/12/03

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