WALDEN UNIVERSITY
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2016

Donor Coordination and Health Aid Effectiveness in the Nigerian Health Sector

Ifeoma Edna Uduji
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

 Part of the Health and Medical Administration Commons, and the Public Health Education and Promotion Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Ifeoma Uduji

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Suzanne Richins, Committee Chairperson, Health Services Faculty
Dr. Magdeline Aagard, Committee Member, Health Services Faculty
Dr. Raymond Thron, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2016

Abstract

Donor Coordination and Health Aid Effectiveness in the Nigerian Health Sector

by

Ifeoma Edna Uduji

MSc, University of Lagos, 2008

BS, Nnamdi Azikiwe University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Sciences

Walden University

June 2016

Abstract

Development partners and donors increasingly acknowledge the importance of coordinating their activities to achieve the outcome of the official development assistance to developing countries. Although stakeholders have recognized the importance of harmonizing donors and development partners' efforts in the Nigerian health sector, little research has addressed the influence of coordination on the health aid effectiveness. This qualitative case study determined the influence of coordination among the donors and development partners involved in the HIV/AIDS, malaria, and nutrition program on the outcome of these programs in Nigeria. Data were collected through interviews with 22 program officers participating in the health programs and through document review. The document reviewed were reports of coordination efforts, and outcome evaluation reports. Data were managed using NVivo, while coding and themes were adopted for data analysis. Findings revealed the partial coordination efforts in the health system development. Coordination efforts should be at both national and state level to ensure adequate implementation of the health program. Most participants reported a need for the government of the recipient country to strengthen their commitment and own coordination process for development partners to adhere to the guidelines of the coordination platforms. These results could have implications for positive change by identifying the bases to achieve sustainable effectiveness of health aid in Nigeria through development of Country Coordination Mechanism for all health programs to provide guideline of harmonizing activities of development partners.

Donor Coordination in the Nigerian Health Sector: A Critical Step to Health Aid Effectiveness

by

Ifeoma Edna Uduji

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

June 2016

Dedication

I dedicated this work to Almighty God for His divine provision and strength through my doctoral program. Thank you Jesus!

Acknowledgement

I would like to show my appreciation to my Chair, Dr. Suzanne Richins, who provided her valuable professional support throughout my dissertation progress. Dr. Richins, you were patient and knowledgeable. You kept encouraging me through the process. I could not think of a better Chair. Thank you so much!

I would also like to acknowledge Dr. Magdeline Aagard and Dr. Raymond Thron for their scholarly support through my dissertation progress. You all helped bring out the scholar quality of work.

My appreciation also goes to my lovely and understandable husband. Thank you for standing by and with me throughout this journey. Thanks to all my Walden friends who made this journey a communal one. Thank you all!

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Overview of Official Development Assistance (ODA) in Sub-Saharan Africa

The aim of ODA is to promote economic development and welfare of developing countries (Organization for Economic Cooperation and Development [OECD], 2008). ODA is a type of foreign aid, and assurance of the effectiveness of foreign aid is a major concern for donor countries and donor organizations (OECD, 2008). According to data from World Source Indicators, the volume of net ODA to the Sub-Saharan Africa (developing countries only) increased from US$40.2 million to US$46.2 million from 2008 to 2012. Despite the increase in the volume of ODA to developing countries, inadequate coordination among donor organizations and recipient countries has been one of the challenges to achieving the objectives of ODA. Although financial aid to the developing countries increased over the years, some scholars (Garner, 1995; Pereira & Villota, 2012; Fleisher, Gottret, & Schleber, 2007; Gelb & Sundberg, 2007) argued that these aids to developing countries were not hitting the target. As the number of foreign aid that donors and development partners provide to developing countries increases, the fragmentation of aid increases. The World Health Organization (WHO, 2004) indicated that poor coordination affects the outcome of health care intervention programs. Overlap and fragmentation of efforts occurs among donors, development partners, as well as the government of the recipient country, thus affecting the outcome of the health development aid they provide. Halonen-Akatwijurka (2005) argued that coordination failure among the donors, development partners, and recipient country contributes aid to developing countries. He pointed out that this coordination failure is more among the

donors and development partners with relatively similar priorities. On the other hand, improved harmonization of donors' and development partners' efforts, many scholars argued, will improve the efficiency of aid to developing countries (Bigsten, 2006; Pereira & Villota, 2012; Buse, Gilson, Parignani, & Walt, 1999).

The challenges with achieving effectiveness of aid, particularly health aid to developing countries, have been the focus of agenda among the ODA community and other stakeholders in development assistance. Studies revealed that donors, development partners, and recipient country governments failed to achieve coordination in some developing countries in Sub-Saharan Africa (Agbanu, 2010; Custer, 2010; Cheelo, Jönsson, Sundewall, & Tomson, 2010). For example, the stakeholders' collaboration on health program implementation in Ghana has been limited; insufficient information flow between members of the donor organizations inhibited health program implementation and policy formulation (Agbanu, 2010). In Kenya, uncoordinated donor specialization resulted in uneven geographical and sectorial distribution of aid (Custer, 2010). The development aid is clustered in a particular region of the country. For Zambia, difficulties occurred in achieving the aim of the Paris Declaration in the Zambian health sector as a result of poor harmonization and alignment of stakeholders' activities in the Zambian health sectors (Cheelo et al, 2010). Evidence showed that poor health aid alignment in other developing countries in Sub-Saharan Africa, such as Tanzania, Namibia, and Uganda, affected the efficiency of health aid in these countries (Brugha, 2005); however, some developing countries have given a good return of the aid to them.

From recorded studies, Mozambique is one developing country in the Sub-Saharan Africa that, to a good extent, integrated the activities of donors and development partners with the activities of the government (Che Tita, 2011; Global Health, 2008). This integration of activities resulted in a better outcome of health aid to Mozambique compared to other developing countries in Sub-Sahara Africa. An improved level of integration of the Country Coordination Mechanism functions occurred in the health sector in Mozambique (Global Health, 2008).

Framework for Donor Coordination

Donor coordination, sometimes referred to as *donor harmonization*, is a major concern for the development organizations. It has been the main agenda at the global level, including at the High Level Forum on Harmonization held in Rome in 2003, the Paris Declaration on Aid Effectiveness in 2005, the Accra Agenda for Action in 2008, and the Busan Partnership for Effective Development Co-Operation in 2011. These fora provided international discussion between donor nations and organizations on aid and development. During the High Level Forum on Harmonization in Rome, the focus was on improving the overall management and efficiency of ODA (OECD, 2003), which was reviewed in 2005. After a couple of years, stakeholders met in Paris to evaluate the implementation of the consensus reached during the high-level forum in Rome. One of the major decisions from the Paris Declaration was to scale up effectiveness of aid by strengthening harmonization between the multilateral, bilateral development organizations, and the recipient countries and eliminating duplication of efforts (OECD, 2005). Still to measure success of previous forums, the Accra Agenda for Action focused

on designing strategies for the acceleration of the implementation of the Paris Declaration principles on aid effectiveness (OECD, 2008).

The Busan Partnership for Effective Development Co-operation pursuant to the Paris Declaration and the Accra Agenda for Action encouraged united efforts for aid (OECD, 2011). Balogun (2005) classified donor harmonization as (a) establishment of common arrangement by donors and development partners for planning, managing, and delivering aid they provide; (b) integration of donors and development partners efforts with that of the government of recipient country; and (c) the information sharing between stakeholders to promote transparency and improve coordination.

Coordination and harmonization of stakeholders' activities was deemed imperative to achieve the aim of aid by donor organizations. Coordination between all stakeholders in the health sector is paramount to avoid loss-of scale, unclear ownership of project, cross-purpose, as well as duplication of efforts (Frey, Lonhmeier, Lea, & Tollefson, 2006; Lawson, 2013; Longoria, 2005). Effective health aid will improve development in the health sector. This study evaluated the level of coordination among donors and development partners in the health sector by analyzing three health programs (HIV/AIDs, malaria, and nutrition) that are sponsored by more than five health donor organizations.

Background of Study

This section will present an overview of Nigerian health care development and an overview of aid coordination in Nigeria's health sector, including an overview and evidence of coordination.

Overview of Health Care Development

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

The Federal Ministry of Health launched the Health Sector Reform Programme (HSRP) in 2004 to improve access to quality health care services, reduce the burden of disease, and to promote effective partnership, collaboration, and coordination (NSHDP, 2010). The HSRP was implemented from 2002 to 2207. Although the HSRP recorded some success, the large majority of the problems it was designed to address still persist (NSHDP, 2010).

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

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

According to the National Planning Commission (2010), Nigeria received a little above $6.00 billion of development assistance from 1999 to 2007. Of this amount, grants and credits constituted about $3.2 billion and $2.8 billion respectively, with the rest of the aid from international nongovernmental organizations (NGOs; National Planning Commission, 2010). The health sector received about 54%, while education, poverty alleviation, governance, women empowerment and agriculture sectors received 12%, 18%, 5%, 4%, and 1% respectively. This study focused on international aid to the health sector (National Planning Commission, 2010).

Almost all the donors and development partners in Nigeria are present in the health sector. These include WHO, United Nations, European Union, CIDA, UNICEF, DFID, WHO, and USAID. UNICEF represented 45.2% of the total contribution ($1.2 billion) to the health sector, and USAID, CIDA, DFID, European Union, WHO, and United Nations Development Programme (UNDP) represented 25.1%, 10.13%, 6.6%, 6.56%, 5.5%, and 0.09% respectively (National Planning Commission, 2010). Tracking resource flow from donor and development partners is challenging. Several organizations have provided conflicting reports on donors and development partners in Nigeria (Federal Ministry of Health, 2004); however, information available from the WHO Nigeria

Country Cooperation Strategy (2013) showed the type of partnership, principal areas of invention, and location in which each developmental partner in Nigeria health sector was involved. This information showed several donors and development partners in the health sector working in diverse area intervention across the states in Nigeria; however, some developmental partners have the same principle area of invention in the same states.

Overview of Aid Coordination in Nigeria

Coordination and alignment of health aids is the responsibility of both the recipient government and development partners. Efforts had been fragmented in the development of the heath sector in Nigeria; however, the Nigerian government and developmental partners have been working towards integrating all the activities in the health sector (Daniels, Onwukwe, & Khadduri, 2011). In an effort to implement the Paris Declaration on Aid Effectiveness, in 2007, the Federal Government of Nigeria introduced its policy on ODA (National Planning Commission, 2007). The Nigerian ODA Policy aimed to ensure effective use of ODA resources through good governance and improvement of collaboration between government and its development partners.

In addition to ensuring and supporting efforts to synergize activities of all development partners in Nigeria, the Nigerian government, through the Federal Ministry of Health and the development partners in Nigeria, developed some coordination platforms (WHO, 2009). These include: The Country Coordination Mechanism, Malaria Partnership, Integrated Maternal Newborn and Child Health Partnership, the formation of Development Partner Group on Health, the interagency coordination committee for polio eradication and routine immunization, and the Health Systems Forum. The Country

Coordination Mechanism is a framework driven by the recipient country and supported by the developmental partners to ensure the harmonization of all efforts towards the support of the malaria, HIV/AIDs, and tuberculosis programs (Global Fund, 2008). The Country Coordination Mechanism provides the framework for flow of information and resource management. The Integrated Maternal Newborn and Child Health Partnership strategy focuses on linking, integrating, incorporating all interventions, programs, and policies in the field of maternal newborn and child health from home to community to health facility (UNICEF, 2009).

Further, the formation of the Malaria Partnership is key to the goal of the Global Partnership for Malaria Free World and to coordinate all actions against malaria. The recipient government and all developmental partners in the malaria program develop a framework to integrate all their activities (Global Fund, 2004). In an effort to facilitate aid coordination in the health sector, the Development Partner Group on Health was formed. The Development Partner Group on Health is a collection of all the bilateral and multilateral international development organizations in the health sector (Global Health, 2008). This group meets quarterly to deliberate on issues in the development of health sector and one of these issues is harmonization and alignment of all their efforts. (Global Health, 2008). The bilateral and multilateral engagement between Nigeria and donor organizations accrued benefits to Nigeria, particularly in the health sector (Global Fund, 2004). In spite of all these efforts to coordinate the activities of donor organizations, one of the challenges is "getting all partners to be committed to the process of harmonization and alignment" (WHO, 2009, p. 2). There is evidence of high transaction cost in dealing

with donor activities in Nigeria vis-à-vis benefits being delivered (National Planning Commission, 2010). There is limited flow of data and information that make for transparency and mutual accountability.

Evidence of Coordination

The level of donor coordination is difficult the measure. To evaluate the implementation of the Paris Declaration, the OCED's Development Assistance Committee relies on the results of a qualitative survey on measureable indicators (OECD, 2008). These indicators are as follows:

- ownership: number of countries with national development strategies,
- alignment: percent of bilateral aid that is united; number of partner countries with procurement and public financial management in line with the accepted good practices; percent of aid that flows to the government sector that is reported on partners' national budget; percent of donor development program that is in line with the existing coordination program and the recipient country's national development strategies; percent of donors and of aid flows that keyed in to the public financial management systems and the procurement system of recipient country; number of parallel projects implementation unit per country,
- harmonization: percent of aid provided as program-based approaches; and percent of field mission, and country analytical work that are joint,
- managing for result: number of countries with transparent and monitorable performance assessment framework, and

- mutual accountability: number of partner countries that undertake mutual assessments of progress in implementing agreed commitment on aid effectiveness (OECD, 2005).

The effectiveness of donor coordination and aid in a developing country relies on the ability of the country to own the development process, align its development activities with the activities of the development partners (that is, no overlap of donor activities), ensure a joint effort between donor organizations working in the country, develop and implement a performance assessment framework, and ensure mutual accountability between the development partners and the country.

Problem Statement

The general problem that donors and development partners encounter is alignment and coordination of foreign aids in recipient countries. At the global level, there are over 100 major donor organizations active in the health sector (Schleber et al., 2007). Despite the large number of foreign health aid, scholars (e.g., Genhard, Kitterman, Mitchell, Nielson, & Wilson, 2008; Schleber et al., 2007) argued that health aid in developing countries does not improve access to health care in these countries. Lack of coordination mechanisms makes it difficult for the global communities to achieve aid effectiveness in the recipient countries (Genhard et al., 2008; Schleber et al., 2007). The Nigerian health care system is characterized by fragmented health care delivery, low quality information and data, and poor coordination among key players (National Strategic Development Plan, 2010). Abernethy, Chua, Grafton, and Mahama, (2007) pointed out that it is important that communication channels between all stakeholders in health sector are open

to encourage a shared opinion with the aim of reaching some level of agreement over the priorities to be pursued.

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

Purpose of Study

The purpose of this study was to determine the level of coordination and alignment of activities among donors and development partners in the Nigerian health sector.

This study assessed the history of health aid in Nigeria, the total number of health aid donors, and development partners (2009-2013). Further, the study evaluated the level of coordination and flow of information among these donor agencies in the health sector by analyzing three health programs (HIV/AIDs, malaria, and nutrition) sponsored by more than five health donors and development partners. The research also evaluated the financial implications of fragmentation of health aid in Nigeria, the effect of fragmentation to achieving the goals of the health support programs, and the effect of fragmentation on sustainability of health aids.

Research Question

In line with the purpose of this study the results addressed the following research question:

- How does coordination between donor organization and development partners influence the effectiveness of development aid in health sector in Nigeria?

Framework for the Study

The 2011 Busan Partnership for Effective Development is a follow-up summit on the Paris Declaration on Aid Effectiveness to develop modalities on how to improve aid effectiveness commensurate with the volume of aid to the developing countries (OECD, 2011). In as much as there is need for the developing countries to own the process of aid in their countries, there is also need for donors to take responsibility of scaling up coordination among themselves for more effective aid optimization (OECD, 2011). This study was based on the *policy model* concept (Stern, 2008). The policy model proposes that donor harmonization and alignment, as well as country ownership, improve accountability and contribute to wider development goals (Stern, 2008). Donor coordination and donor recipient alignment are means to effective development outcome (OECD, 2011).

The alignment of health donor activities can have an impact on effectiveness of aid to developing countries, as opposed to localized and transitory effect. Evidence showed that without effective harmonization of efforts donor organizations would not achieve health development goals in developing countries (Buse & Walt, 1999). The growing concern in donor community on the relatively unproductive cost of aid as a

result of inadequate harmonization of donors and development partners' actions spurred efforts towards improving development aid effectiveness (OECD's Development Assistance Committee, 2003). I elaborate further on the framework for this study in Chapter 2.

Nature of the Study and Study Design

The nature of this study was a qualitative research method case-study approach. The case study approach is based on a constructivist paradigm (Yin, 2003). Case study is a strategy of inquiry in which the evaluator of one or more programs collects information using data collection procedures like interview, documents review, participant observation, and so forth (Creswell, 2009). The study focused on outcome evaluation of three health intervention programs funded by at least five health care donors to discover the impact of harmonization of the activities of the health care donor agencies on the effectiveness of health aid in Nigeria. As the researcher, I interacted with participants. These participants included personnel who worked directly on the health intervention programs whom I used as cases for the study. Through this series of interactions, I allowed the participants to tell their stories to obtain better understanding of the phenomenon under study.

Purposeful sampling was ideal for this study. The cases for this study were three health intervention programs (HIV/AIDs, malaria, and nutrition) that had at least five donor agencies participating in each of the health program. I chose programs with more than five donor organizations contributing to the program because it would be easy for two or three donor organizations funding the same program to coordinate their activities.

In addition to the health programs, personnel directly working with development partners involved in these programs formed the population for this study. This qualitative study design provided an analysis of the influence of harmonization of the activities of these development partners on the effectiveness of the aid they provide.

I used the NVivo 10 software to analyze data. Analyzing cases for this study involved organizing the data by specific cases for further in-depth study and comparison. NVivo 10 was used to collect, organize, and analyze case data collected from interviews, and documentary review.

Definitions

Aid effectiveness: Aid effectiveness is about ensuring impact of development aid (OECD,2008).

Alignment: "Alignment entails efforts to bring the policies, procedures, systems and cycles of the multilateral and bilateral actors into line with that of the country being supported" (Global Health, 2009, p.2).

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

Civil social organizations: NGOs, community-based organizations, and youth serving organizations working in health sector (Federal Ministry of Health, 2010).

Development partners: Organizations working towards achieving development in health sector, by providing financial and/or technical support for health development projects (Federal Ministry of Health, 2010).

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

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

Federal Ministry of Health: The Ministry supervising the health activities in Nigeria at federal, state, and local government levels. The Ministry develops and ensures the implementation of policy that strengthens the health system of the country (Federal Ministry of Health, 2013).

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

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

National Health Strategic Development Plan: A document that "reflects shared aspiration to strengthen the national health system and to vastly improve the health status of Nigerians" (National Health Strategic Development Plan, 2010, p. 5).

National Planning Commission: A government agency with focus on key national development issues that coordinates the formulation and implementation of developmental programs at federal, state, and local government levels.

Official development assistance (ODA): Flow of assistance to developing countries and multilateral institutions provided by official agencies, including state and local governments (OECD, 2008).

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

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

Assumptions

This study was based on the premise that all the participants in the study would answer the interview questions openly and truthfully; all the participants would voluntarily accept participation in the study. Also, collaborative and cooperative approach of interaction would be used to get the consent of the participants, such that there would be no breach of confidence. Another assumption was that personal bias could affect the participants' level of collaboration and communication during the study. I made this assumption because some of the participants may have feared that their identity would be revealed. Nonetheless, the study was designed to factor in these biases into the final analysis of data to minimize the potential effect of personal biases on the result of the study.

A further assumption was that case study method of analysis was an appropriate methodology for this study. Creswell (2009) pointed out that one of the advantages of using case study is that it allows the researcher to explore in-depth a program (p. 13). Yin (1994) explained that case study is a preferred qualitative methodology when *why*, *what*, or *how* research questions are being used, when the researcher has little control over the contemporary phenomenon under study.

Scope and Delimitation

The scope of this study centered on three health intervention programs—nutrition, malaria, and HIV/AIDS—that more than five donors and development partners were funding. This study covered at least five donors and/or development partners for each health intervention program—WHO, UNICEF, DFID, USAID, Global Funds, Gavi Alliance, CIDA, PATH 2, Bill and Melinda Gates Foundation, and Japan International Cooperation Agency (JICA)—that were funding malaria, nutrition, and HIV/AIDS programs. These donors fund malaria, nutrition, and HIV/AIDS programs in Nigeria.

The study participants consisted of personnel of all the organizations for nutrition, malaria, and HIV/AIDS programs.

Limitations

The first factor that may have limited this study was the internal validity of using case study qualitative method because the researcher does not have control over the events (Yin, 1994). Therefore, findings from this study are only applicable to this study; however, to reduce internal validity issue, the sampling was done purposefully, and member checking was applied at the end of data interpretation. Cases (health intervention programs) included were those programs funded by five or more donors and development partners. The selection of health programs with more than five (not less than five) funders was because the level of coordination between these donors was what I would evaluate. Coordination may not have been relevant if it was only one donor or two development partners funding a health program.

The second factor that might have posed a limitation to this study was the participants' response. The participants might not have been willing to share information on their level of coordination and on the effectiveness of aid they provided. To address this limitation, I communicated the significance of the study to participants, how the outcome of the study might help to improve aid effectiveness, and how it could reduce the cost implication of fragmentation of efforts. This might have helped to reduce their bias as to what the information they provided would be used for.

Significance

In this study, I evaluated the level of coordination between donor organizations, program implementers, and other developmental partners in the health sector, and the impact of this coordination to the health aid effectiveness towards improving access to primary health care in Nigeria. This study may increase awareness of the gaps in health intervention programs as a result of inadequate coordination. It may also provide information for policymakers on the need to create policies or standards to ensure coordination among all the donor agencies and other stakeholders in the health sector. In addition, coordination among all the stakeholders would improve adequate data capturing. Availability of data is essential for policymaking, as well as policy reform (Cibulskis & Hiawalyer, 2002). Information on health services deliveries and health aids provided by foreign aid organizations can help donor organizations and other development partners to increase their effectiveness, efficiency, and responsiveness. Furthermore, the result of this research provides information for the health stakeholders on the effectiveness of the existing coordination mechanisms.

The 2005 Paris High Level Forum on Aid Effectiveness contained as one of its ensuring principles to improve coordination between donor organizations and the government of the participating country (OECD, 2008). It highlighted the need to improve coordination between all donor agencies working in the same recipient country. Coordination among the health aid donor organizations will reduce fragmentation and proliferation of health aids as well as transaction cost (Bigsten, 2006; OECD, 2011). Lawson (2013) found that inadequate donor coordination may reduce the cost effectiveness of global aid; and Pereira and Villota (2012) pointed out that donors recognized that aligning aid with long-term aid development goals is one way to ensure adequate aid effectiveness.

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

Summary

Chapter 1 introduced the study by providing the background for the study, the theoretical framework, the overview of aid coordination in Sub-Saharan Africa and Nigeria, the research problem, and the significance of the study. Nigeria is one of the developing countries in Sub-Saharan Africa. Nigeria gets ODA to strengthen its health sector. In addition, other donor organizations provide financial assistance to Nigeria to

improve health delivery system. Also, the government of Nigeria is making efforts to improve the health care delivery and coordinate the government's efforts with donor organizations' efforts to improve health care delivery.

Furthermore, in Chapter 1 I provided brief description, responsibilities of all stakeholders in the health sector, and the coordination efforts made by all of stakeholders. There are several coordination platforms that focus on strengthening the coordination of health activities of Nigeria's government and those health activities sponsored by donor organizations. The harmonization efforts serve as a means to improve effectiveness of health aid and reduce transaction cost of aid. Studies revealed that achieving effective coordination between donor organizations and recipient government is challenging. This study analyzed the coordination level between the donor organizations in the Nigerian health sector and the coordination level between donor organizations in the Nigerian health sector and the recipient country.

Chapter 2 contains a review of the literatures on aid coordination theory, the theoretical foundation, and the conceptual framework of this study. It will also include a review the Nigerian health care delivery system and the level of coordination between donor organizations in the Nigerian health sector.

Chapter 2: Literature Review

Introduction

In this chapter, I discuss the literature review strategy, the theoretical foundation, and the conceptual framework for this study, as well as the aid coordination theory. The literature review section in this chapter includes the overview of the situation in Nigeria regarding the level of coordination of aid in health care delivery and the essence of aid coordination and information sharing among donors and development partners in health sector. In addition, health care financing and donor organization support in the Nigeria health care development and challenges of aid coordination health care development in Nigeria will be reviewed.

The coordination of health aid to developing countries for effective outcome is a growing concern to the donors, developmental partners, and other stakeholders in the health sector. The Nigerian health sector is among the sectors in developing countries that experience a challenge in international development assistance coordination (WHO,2013). According to the WHO (2009), the challenges facing aid in Nigerian health sector are getting all partners to be committed to the process of harmonization and alignment and fragmentation of service delivery from donors and development partners. Donors and development partners concentrate more on one health program, neglecting other health concerns. For example, there is no balance between aid for polio eradication and aid for other health intervention programs (WHO, 2009). Almost all the donors and development partners provide aid for polio eradication, while there are few, perhaps no donors and development partners that provide aid for other health intervention programs

to address other disease burden in Nigeria. This challenge is an inadequate flow of information among donors, developmental partners, and the government (WHO, 2009).

The Nigerian health care system is complex with many of international organizations and other developmental partners. The flow of information between all stakeholders in the health sector for health development is limited (Daniels et al., 2011). There is insufficient flow of information and relevant data, which makes transparency and mutual accountability between the government and donor organization difficult (National Planning Commission, 2010). Health development aid coordination involves coherence in activities and communication from all the donors and development partners and other relevant stakeholders in the health sector.

Based on the aid coordination paradigm, which focuses on the coordination and alignment of donors, development partners, and the recipient government activities, this study will seek to determine the level of coordination between the development partners and the government in the health sector and the impact of coordination on the effectiveness of health aid in Nigeria.

Literature Search Strategy

The literature for this study was obtained from different databases. Searches for literature for on the research problem were conducted in the Walden University Library and other databases: ProQuest Central, ProQuest (Health Medical Complete), Social Science Research Network, NCBI; PubMed, SAGE. Also, searches were done on Google Scholar and other search engines for organizations such as WHO, OECD, Centers for Disease Control and Prevention, World Bank, Global Fund, UNICEF, Management for

Education Research Consortium, and European Network on Debt and Development. In addition, articles were obtained from journals such as *Journal of Sociology* and *Social Welfare, Health Affairs*. Key words included *donor coordination and aid effectiveness*, *Aid effectiveness*, *Impact of coordination among donors on aid effectiveness*, *aid effectiveness in developing countries*, *coordination of donor organization in developing countries*, *aid coordination in Sub-Saharan Africa*, *health aid coordination in Nigeria*, *foundation of aid coordination in developing countries*, *foundation of aid coordination in Nigeria*, *aid coordination theory*, *stakeholders coordination*, *impact of stakeholders coordination on official development outcome*, and other similar keywords. In addition to the database search, document and archive review was also one of the literature search strategies used. Table 1 shows the summary of literature searched by keywords categories. The literature found supported this study; however, not all literature found was included in the literature review.

Table 1

Literature Searched by Keywords Categories

Keyword Categories searched	Scholarly journals & articles	Doctoral Dissertation	Books	Total
Coordination of health aid	194	6	-	200
Stakeholders coordination	75	40	10	125
Aid coordination theory	15	7	-	22
Foundation of aid coordination in Nigeria	13	5	-	18
Aid coordination in Sub-Saharan Africa	55	18	-	73
Donor coordination and aid effectiveness	92	45	4	141
Coordination of donor organization in developing countries	48	21	-	69
Aid effectiveness in developing countries	50	13	-	63
Health Care Financing in Nigeria	4	-	2	6

Theoretical Foundation

As the official development aid to developing countries is rising, the donor community has begun to question its effectiveness. The literature on the framework of coordination showed that the objective of several high-level fora held by the donor community on aid effectiveness focused on improving coordination, alignment, and harmonization of the activities of the donor organizations with the activities of the recipient country (Lawson, 2013; OECD, 2011). Thus, if there is adequate coordination and alignment of efforts between donors, developmental partners, recipient country, and other stakeholders, it would improve the outcome of the official development aid to developing countries. Research showed that the outcome of health development aid in Mozambique was effective because stakeholders in the health sector understood and implemented the country's coordination mechanism in the health sector (Global Health, 2009). Coordination in organizations is deemed an effective tool to achieving common goals. Coordination theory provides a background for the review of the level of donor coordination and aid effectiveness in Nigeria.

Conceptual Framework and Aid Coordination Theory

This section reviews the conceptual framework for the study and the aid coordination theory.

Review of Conceptual Framework

The ODA community, through a working committee (Working Party on Aid Effectiveness) created in 2003, initiated an international development corporation framework for the coordination of aid to developing and underdeveloped countries

(OECD's DAC, 2005). This framework focuses on all high-level fora held on aid effectiveness by the member of the ODA committee, heads of state, and ministers of the developed countries and the recipient countries.

The High Level Forum on Harmonization held in Rome in 2003. Concerned with the inadequate monitoring of ODA, which generates unproductive cost of aid, the development committee decided to hold its first forum in Rome to identify gaps existing in the official development aid to developing country and how to address them (OECD, 2003). It was highlighted that harmonization of donor activities would help to reduce transaction cost of aid to developing countries as well as improve aid outcome. This forum established standards for coordination and inspired donors to ensure coordination of their activities (Lawson, 2013).

The Paris Declaration on Aid Effectiveness. In 2005, the Paris Declaration on Aid Effectiveness was held as follow-up on the Declaration adopted at the High Level Forum on Harmonization in Rome in 2003. At this forum, delegates recognized that donors and recipient countries are making effectiveness of aid a priority. During this forum, specific goals were highlighted; donors sought to implement common action plan and agreement at country level for joint planning, funding, monitoring, and evaluation of the processes. Another strategy is to increase harmonization of aids and alignment of donor activities with the recipient country priorities and procedure (OECD, 2005).

Unlike the Rome Forum, the Paris Declaration was an evaluation object. It highlights an indicator that is used to measure the recipient country's commitment, transparency between donors and recipient country, as well as alignment and

harmonization of development efforts (OECD, 2005). Stern (2008) suggested that these indicators form the basis for overall measurement on coherence and evaluation of cross-cutting activities. Another difference between the Paris Declaration and Rome Declaration is that the Rome Declaration concentrated solely on coordination among donors while the Paris Declaration looked into coordination among donors and coordination between donors and recipient countries.

The Accra Agenda for Action. The High Forum held in Accra in 2008 was aimed to discuss how to accelerate the implementation of the Paris Declaration outcome. The process report on Paris Declaration surveys conducted in 2006 and 2007 were evaluated during this forum. Some delegates were not impressed with the reports; they noted that there was a relative decrease in the emphases on donor coordination and a relative increase in the alignment of donors with recipient countries' priorities (Wood, 2008). The delegates stressed the importance of maintaining both donor coordination and alignment of donor activities with the recipient countries' priorities and procedures.

A notable feature about Accra Agenda for Action is that it broadened stakeholders' involvement during high-level fora. It was reported that civil society organizations and NGOs participated in discussions (OECD, 2008).

The Busan Partnership for Effective Development Co-Operation

The forum held in Rome in 2011 followed the Accra Agenda for Action and previous fora monitoring survey on the implementation of the indicators of aid effectiveness. It was pointed out that although the previous high-level fora proved to be relevant in the development cooperation, there was need for improvement (OECD, 2011).

Effective cooperation will be a result of commitment and contribution from private sector, civil society organizations of the recipient country and donors (OECD, 2011). There is a need to strengthen democratic ownership of the development processes and policies to achieve sustainable outcome through collaborative managing of result, continuous communication between stakeholders, and monitoring and evaluation of processes. The Table 2 highlights the major outcomes of the aid effectiveness forums.

Table 2

Highlight of Aid Effectiveness Forums and their Major Outcomes

Forum	**Year**	**Major Outcomes**
The High Level Forum on Harmonization held in Rome	2003	Established standards for coordination and inspired donors to ensure coordination of their activities.
The Paris Declaration on Aid Effectiveness	2005	Established an indicator that is used to measure the recipient country's commitment, transparency between donors and recipient country, as well as, alignment, harmonization of development efforts.
The Accra Agenda for Action	2008	Broadened stakeholders' involvement during High Level Forum. It was reported that civil society organizations and nongovernmental organizations participated in discussions

(table continues)

Forum	Year	Major Outcomes
The Busan Partnership for Effective Development Co-Operation	2011	Highlighted the need to strengthen democratic ownership of the development processes and policies to achieve sustainable outcome through collaborative managing of result, continuous communication between stakeholders, and monitoring and evaluation of processes.

Review of Aid Coordination Theory

Coordination is essential for the effective collaboration of inter-organizational stakeholders. Aid coordination has great influence on the success of the aids to developing countries. The Harrod-Domar growth model implied that foreign aid is an addition to the capital of a developing country, such that there would be an increase in the savings of that country. Also, Hense, and Terps (2000) made the observation that foreign aid may lead to an increase in savings, but such increase does not commensurate with the foreign aid received. Meanwhile, scholars argue that little progress was made on aid

coordination since the Paris Declaration in 2005 (Hyde'n, 2008, Whitfield & Fraser, 2009).

Literature Review

Overview of Health Care Situation in Nigeria

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

The goal of the National Health Policy developed by the Government, through the Federal Ministry of Health is to establish a comprehensive health care system, based on primary health care that is preventive, promotive, and rehabilitative to citizens at all levels within the available resources. Also, the government along with donors and development partners initiated programs like: Integrated Management of Childhood Illness, and Integrated Maternal Neonatal and Child Health to improve maternal and child

health (WHO, 2009). Also, integrated disease surveillance and response intensified to notify health workers about disease outbreak for treatment and follow-up; however, low population coverage, timeliness, and quality of service still remain challenges (WHO, 2009; United States International Development Agency, 2014).

Nigerian Health Care System

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

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

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

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

Nigeria tertiary health care system. The tertiary health care system consists of highly specialized services by teaching hospitals and other special hospitals providing care for specific disease conditions, specific group of patients. Uneven distribution of the tertiary health care system is a challenge.

Management of Nigeria's Health Care System

In principle, the management Nigeria's health care system is decentralized into three; the federal, state, and local government level. The Federal government, through the Federal Ministry of Health ensures the comprehensiveness of the multi-sectorial inputs, community involvements at the local, state and federal level; ensuring that health care

services are appropriately supported by an efficient referral system. In addition, the host Government ensures that support provided by donor organizations are in consonance with the overall national health policy (Health Policy; Federal Ministry of Health, 2004); moreover, the Ministries of Health ensures coordination of actions between development partners and other sectors towards achieving health development goals. During the Busan Partnership for Effectiveness Development Co-operation, it was agreed that developing countries would lead coordination efforts to manage proliferation of aid at country level (OECD, 2011). The Federal Ministry of Health develops modalities and institutionalizes appropriate processes (Country Coordination Mechanism) for effective coordination of international agencies and NGOs operating in health sector. Also, the Federal Ministry of Health collaborates with United Nations agencies, multilateral and bilateral donor organizations to harness and align their assistance in the health sector. Furthermore, the Federal Ministry of Health collaborates with the National Planning Commission for proper coordination of the activities of the donor organizations in the health sector (Health Policy; Federal Ministry of Health, 2004).

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

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

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

Further, the developmental partners support government efforts to promote financial management system in line with Paris Declaration on Aid Effectiveness (NSHDP, 2010).

Although, the management of Nigeria's health care system seems to be coordinated; in practice, the system is often a duplication and confusion of roles and responsibilities among different levels, as well as agencies (WHO, 2002). The implication is weakness in coordination and tracking of activities at different levels, and between other stakeholders in health sector. Currently, the federal, state, and local government, as well as other government agencies and donors are involved, to various degrees; contribute to the management of health system functions, service provision, and financing.

Nigeria's Health Care Financing

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

The state and local governments have statutory contribution for the funding of the primary health care facilities, which include: provision and maintenance of facility equipment, purchase of essential drug, and payment of salaries for personnel at the primary health care level. Contributing less than one-quarter of total health expenditure, the government has not been participating strongly in the funding of health care system in

Nigeria (Olaniyan & Lawason, 2010). On the other hand, according to the National Health Account (2009), the Government Health Expenditure was 18.69%, 26.40%, and 26.02% of the Total Health Expenditure from 2003 to 2005.

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

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

Donors and Development Partners' Support in the Nigeria's Health Care Development

This section will provide an overview of the donors and development partner support to the development of health sector in Nigeria with focus on the donors and development partners that are funding Malaria, HIV/AIDS, and Nutrition programs.

Donors and development partners provide financial support for the Nigeria's health care system strengthening. Besides funding, these donors and development partners provide technical support by mobilizing and training of health care professionals and health care workers in order to achieve their objectives in Nigeria. The Malaria program in Nigeria is funded by 8 development partners (Nigeria Malaria Operational Plan, 2104). The HIV/AIDS, malaria, and nutrition programs have 10, 9 and 8 development partners funding them in Nigeria.

Malaria Program

Donor support to the Malaria Program in Nigeria increased tremendously over the years. The support from various donors and development partners for malaria control programs has been beneficial to Nigeria. Currently, the largest donors are the Global Fund, President Malaria Initiative, the World Bank, and the DFID. Other development partners include the Clinton Health Access Initiative, UNICEF, and the WHO (Nigeria Malaria Operational Plan, 2014).

President's Malaria Initiative, a part of the Global Health Initiative focused on helping Nigeria to reduce mortality caused by malaria by 2015, as compared with 2009-2010 baseline levels (Nigeria Malaria Operational Plan, 2104). This goal is expected to

be achieved by reaching 85% coverage of the most vulnerable groups. These groups are: pregnant women and children under 5 years of age.

Nigeria was also one of nine countries to pilot the Affordable Medicines Facility-malaria (AMFm). The AMFm was focused on making the ACTs affordable as other cheap antimalarial monotherapies. The World Ban Malaria Booster Program provide $280 million in the first and second phase of the program to support a broad set of malaria intervention programs in seven states (World Bank, 2013). Although the World Bank Booster Program ended in June 2013, the country requested an extension of the project to June 2014, at no cost. The DFID launched a 5-year £50 million malaria program in 2008 (DFID ,2012). Nigeria received $600 million of Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) Round 8 in 2008; $ 375 million for the Phase I and Phase II of this grant from August 2012 to October 2014 was released (Nigeria Malaria Operational Plan, 2014).

Donors' assistance is spread to ensure its benefits in many states. The National Malaria Control Program (NMCP) works with donors to ensure that the malaria programs are not clustered in one geopolitical zone; however, the decentralized system of Nigerian health care and its large population is the challenge that donors face in providing assistance (Nigeria Malaria Operational Plan, 2104).

HIV/AIDS Program

The majority of the funding for HIV and AIDS program in Nigeria comes from development partners. These development partners are (the President's Emergency Plan

for AIDS Relief (PEPFAR), Global Fund, UNICEF, WHO, DFID, JICA, USAID, and World Bank.

The World Bank loaned US$140.3 million to Nigeria to support a 5-year HIV/AIDS Programme Development Project I (2002-2007) (World Bank, 2009). World Bank also went on to contribute US$225 million towards an HIV/AIDS Programme Development Project II (2009-2013) (World Bank, 2012). Through PEPFAR, the United States allocated a large amount of money to Nigeria. In financial year 2011, PEPFAR provided approximately US$488.6 million to Nigeria for HIV/AIDS prevention, treatment and care (PEPFAR, 2012). By August 2012, the Global Fund approved US$360,454,493, and disbursed US$275,586,635 in funds for Nigeria to expand HIV/AIDS treatment, prevention, and care programmes (Global Fund, 2004). To achieve an increase in gender sensitivity, prevention, interventions, and to increase access to antiretroviral treatment, funding are on decentralizing HIV prevention and support programs, making it available at the primary health care facilities, and at community levels.

Nutrition Program

Malnutrition is a critical problem in Nigeria, especially the Northern part of the country. The rates of stunting, underweight, and wasting among children in Nigeria are 58%, 41%, and 16% respectively (Akinyele, 2009). These levels are high when compared with the WHO's standard. According to the Vitamin and Mineral Damage Assessment Report (2004), 25% of the Nigerian children that have lower immunity results from vitamin A deficiency. This leads to frequent ill health and poor growth in children.

Donors and development partners are involved in improving nutrition in Nigeria include USAID, DFID, UNICEF, WHO, World Bank, UNFPA, EU.

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

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

Coordination of Aid in the Health Care Delivery

The relationship between all the stakeholders in the health sector is a public-private partnership. Stakeholders in the Nigerian health care sector include: the Federal

Ministry of Health, International donor organizations, civil society organization, Federal Agencies, and Private Organizations. It is important to capture the input of all stakeholders to facilitate the developmental process of the inter-organizations common goal (El-Gohany, Osman, & El-Diraby, 2006). All stakeholders' involvement is paramount for the common effective developmental process.

Coordination among interest groups means that the opinion of all the interest groups should be considered and mobilized irrespective of their degree of activeness (Jocobs, 1993). Meanwhile, some scholars found evidence of persistent duplication of aid (Aldasoro, et al, 2010; Santiso, 2011). The duplication of efforts of all stakeholders decreases the effectiveness of aid flow for the development of all sectors in the recipient country. The coordination of aid in health care delivery adopts same framework as of the official development committee forums on aid effectiveness. The framework adopts five principles -ownership, alignment, harmonization, managing for results, and mutual accountability- for effective aid. As explained in Chapter 1, these principles serve as indicator to measure and monitor the implementation of aid to recipient countries.

The attention to aid coordination in health sector grew as a result of the increase in the number of donor organizations active in the health sector (Buse, &Walt, 1997). All the donor organizations are interested, as to the effectiveness of the aid they provide. Coordination of aid remains a concern as the proliferation of donor activities increases (Walt, et al., 1999). Several developing countries designed coordination mechanism to address the issue of proliferation of donor activities and to align the donor activities with the policy of the recipient country. Coordination mechanism is a model that captures all

the key players in health sector and the flow of information from player to another. Although coordination mechanism is designed to help reduce duplication of donor activities, the duplication of donor activities in health sector in some countries still persist (Walt, et al., 1999).

Why Aid Coordination in Health Sector

The idea of coordinating aid flow to developing countries is to achieve aid effectiveness. Lawson (2013) explained that the primary aim for aid coordination is that effectiveness of aid to recipient countries is reduced by fragmentation of aids. The number of donor organizations and the ODA in the health sector is increasing, thus, the need for aid coordination in health sector.

Duplication

With the increase in the number of donors in the health area, donors focus on one area in the sector and this focus may result in the duplication of their roles and activities. Aid coordination focuses on containing aid increase and ensuring reduction of fragmentation of both multilateral and bilateral aids.

Alignment

Aid coordination involves coordination among donors, coordination between donors and recipient government, and intra-government coordination (Edi, & Setianingtias, 2007). To achieve the aim of development assistance - improve economic and social welfare of the recipient country- donors would have to study the health status- the existing system and policies- of the recipient country to understand processes and procedure, and also highlight areas that need development. Donor organization should

not impose their system on recipient countries; rather they should adopt the systems of the recipient country (OECD, 2005).

Competition

Lawson (2013) pointed out that uncoordinated efforts may lead to the competition among donors; donors competing for same programs or materials. Competition may cause shift of focus of donors from achieving aim of development aid to struggle for market recognition.

Information Sharing and Coordination

The flow of information in the official development community is between the recipient country's government, the donor organizations, and between donors and other relevant stakeholders. Information sharing helps donors to be aware of what other donors are doing at federal, state, and local government levels, as well as community and ward levels. The recipient government has the responsibility to capture all the donor organizations funding projects in the country, their area of focus, and period of projects. The donor organizations have the responsibility to share their focus, areas of interest, and goals, with the recipient country, other donor organizations.

A review on information flow in between donor organizations and the Federal Ministry of Health showed that the information flow between stakeholders in the health development programs is limited. The effort made by the Federal Ministry of Health by creating an International Cooperation and Resource Mobilization Unit to coordinate donor missions and provide technical assistance to all donor organizations did not achieve its goal. Other recent efforts of introducing and providing central data collection,

joint review of activities have not improved communication between partners (Daniels et al., 2011). For example, it was reported that not all the stakeholders, especially the civil society organizations, and the private health sector were represented at the Joint Annual Review (JAR)- a joint annual review on the NSHDP held in 2013. Also, the Development Partners to Health Group tasked to ensure update matrix of all health programs sponsored by international donors provide limited information (Daniels et al., 2011). They do not capture all the international donor organizations that are working in Nigeria.

Summary

The review of literature covers an overview of the health care situation in Nigerian, organization of the system, health aid management and delivery in Nigeria. According to the literature, coordination between development partners is essential to achieving aid effectiveness in Nigeria. Although, the literature review highlighted these issues, there are limited studies and information related directly to development partners' activities and level of coordination in Nigeria.

According to National Health Account, out-of-pocket spending contributes more to the total health expenditure. Contributions of development partners to health care financing from 2003-2005 increased from 4 to 5.6% of the total health expenditure, and government. The government contributed 67.22% of the total health expenditure in 2005, while 3% of the total health expenditure was contributed by other firms in 2005. Furthermore, coordination among donor partners is essential to ensure alignment and harmonization of efforts, to reduce fragmentation. Also, it might have financial

implication. Fragmentation of effort might duplicate costs of implementing health program.

Chapter 3 explores the research methodology. The discussion covers key methodological issues such as the research design, research population, sampling techniques, analytical instruments, and data collection methods. Chapter 3 also covers the ethical issues of trustworthiness, and protections that were provided for study participants.

Chapter 3: Research Method

Introduction

This chapter describes the methodology used to determine the level of coordination and alignment of activities among donors and development partners in Nigeria's health sector. In this study, the coordination and communication level between donors and development partners funding the same health invention was determined. Also, in this chapter, the research design, role of the researcher, methodology, participant selection criteria, population instrumentation, data analysis plan, issues of trustworthiness, and ethical issues of the study will be discussed.

Research Design and Rationale

For this study, I used case study design to determine the impact coordination between donors and development partners had on the effectiveness of development aid in health sector in Nigeria. The objects of this study were three health intervention programs: a malaria program, HIV/AIDS program, and nutrition program. These health intervention programs are funded by more than five donors and development partners.

This study used Stake's (1995) direct interpretation of collective case study. The appropriateness of the collective case study design for this study is because, with collective case study, the researcher selects multiple cases (two or three cases) to illustrate the issue under study (Creswell, 2007). In addition, there was a nested case study (Patton, 2002); each case (health intervention program) was made up of smaller cases (stories of participants), which were used to analyze the main cases (health

intervention programs). Case study centers on presentation of specific cases and thematic analysis across cases (Patton, 2002).

This study was based on constructivist assumption. With constructivist assumptions, the researcher seeks to establish the meaning of a phenomenon from the participants' point of view (Creswell, 2009). This study was based on the constructivist paradigm. In this study, during data collection, the participants provided information, which included their experience and an opinion on the level of harmonization and/or fragmentation of activities of donors funding same health intervention program, and how coordination affect the outcome of the health program. As the constructivist evaluator, I captured and interpreted the experience of program participants including funders, and its effect on attaining the program goals (Patton, 2002).

Role of a Researcher in the Study

As the researcher, I was an instrument for this study; an observer, the interviewer, and the data analyst. I identified and selected appropriate participants for the study. Based on the purpose of the study and the research design, I critically identified appropriate cases and participants who had in-depth knowledge of the cases to be studied. The cases were the health intervention programs, and the participants were those personnel working directly on the cases. I also interviewed the participants, reviewed documents, and analyzed the data collected. Patton (2002) pointed out that in data analysis, the researcher acts as a catalyst on raw data, generating themes and codes, interpreting the codes to generate finding. In this research, I analyzed data collected from the interviews and document reviews.

During this research study, the relationship that existed between participants and me as the researcher was as Maxwell (2013) called it, a "working research relationship" (p.90). Maxwell (2013) referred to the relationship of researcher with study participants as the "gatekeeper", explaining how the researcher initiates the relationship with participants as the "key design" (p.91), of the study; the type of relationship between the researcher and study participants neither interfered nor facilitated the entire study.

Methodology

Population

The general population of this study was made up of individuals involved in the management of the health intervention programs (HIV/AIDS, malaria, and nutrition) in Nigeria. These health intervention programs were used as cases in this study. The study population was limited to those directly involved with the donors and development partners funding these health intervention programs in Nigeria. Each of these health intervention programs was used as a case because it had more than five donors and development partners funding it. For each of the programs, the population size was from seven to eight—that is, one program officer or employee from each donor or development partner. Table 3 presents total number of participants interviewed from each health intervention programs used as cases for this study.

Table 3

Number of Participants for HIV/AIDS, Malaria, and Nutrition Programs

Development Partners	HIV/AIDS	Malaria	Nutrition
Family Health International	1	1	1
Global Fund	1	1	1
Partnership for Strengthening Health System in Nigeria (PATH2)	1	1	1
UNICEF	1	1	1
UNAIDS	1	-	-
USAIDS	1	1	1
WHO	1	1	1
World Bank	1	1	1
Total	8	7	7

HIV/AIDS, malaria, and nutrition have more than five funders. HIV/AIDS has eight development partners, Malaria has seven, and Nutrition has seven development partners.

Sampling Strategy

Sampling is done to select a sample from a population. In this study, samples were the cases (health intervention program) and the individual working directly on the cases selected. Purposeful sampling was used to select the cases that would be used for this study. Using purposeful sampling, a researcher will select information-rich cases that inform the understanding the problem and central phenomenon in a study (Creswell, 2007; Patton, 2012). Information-rich cases are cases that will provide in-depth information on the phenomenon under study. The selection of health intervention program with more than five donors and development partners funding it allowed me to determine the coordination among development partners. The aim of this study was to determine the level of coordination between donors and development partners in the health sector and how coordination influences the effectiveness of the aid they provide. Thus, to determine the existence of coordination, health intervention programs that have more than five donors and development partners as funders were used as cases for this study. These study participants included personnel working with donors and development partners that are funding the health intervention programs that were used as cases in this study. They provided information relevant to answering the research question of this study.

Criterion sampling was used to reduce the problem with nonresponse from participants. Criterion sampling involves selection of sample or case based on its richness in information (Patton, 2012). The criteria for selecting participants for this study were their knowledge and experience with the subject of study as well as their experience with the cases selected. The participants for this study were personnel working or supervising the health intervention programs used as cases in this study. Also, the use of health intervention programs (that were used cases for this study) that had more than five donors and development partners funding them permitted me to evaluate the coordination between the donors and development partners funding these programs. Participants were contacted via telephone and/or e-mail to be informed about the study. Further contact was face-to-face interviews using open-ended questions. The study questionnaire was administered via telephone for participants that might not be available for face-to-face interview.

Instrumentation

A preliminary open-ended questionnaire was administered to the participants. The interview questions were designed for each of the health intervention programs being evaluated. Open-ended questions get clarity and amplify responses from participants (Singleton & Strait, 2005). The study's committee members subjected the survey questions to critical review to ensure the consistency and relevance of the final survey questions to the study and participants. This review ensured consistency and quality of content, format, question arrangement, and randomization of the survey questions. Randomization ensured quality responses. The survey questions measured participant

perception on the level of coordination among donors and development partners and how coordination, if any existed, affected the outcome of the development aid they provided for the health. In addition, the survey questions measured if there was any effort made by donors and development partners to limit duplication of activities for each health intervention program. Furthermore, the survey questions measured the level of commitment of donors and development partners to ensuring the harmonization of their activities, and they measured financial implications of running parallel activities for one health intervention program.

The following were the survey questions:

1. What are the existing efforts to ensure coordination of activities of the development partners funding this health program?

   This question is for participants to explain efforts (if any) made by partners to limit duplication of donors and development partners' activities for the health program.

2. How do the coordination efforts influence the alignments of your organization's activities with the activities of other partners funding this program?

   This question is for the participants to explain the level of coordination (if any) that exist between their organization and other partners.

3. How committed are partners to this/these coordination mechanism?

This question will enable the participant to provide information on the level of partners' involvement to adhering and implementing the coordination mechanism.

4. What are the communication channels among development partners involved in this program?
5. How does the existing coordination mechanism influence the outcome of the program?

   Answering this question, the participant will provide information on outcome evaluation of the program, with respect to coordination.
6. What is the cost implication of coordination to the cost of implementing this health program?

   This question will be for the participant to provide information on the cost of running parallel program; cost of fragmentation of activities.
7. What are the challenges of achieving coordination/harmonization of activities?

Data Collection Procedure

The survey questions were used to interview study participants for each of the health intervention program selected as case study. Face-to-face interviews were conducted after getting the consent of participants. Data collection lasted for about 2 weeks after getting consent of the participants. In addition, data from the interviews were corroborated with data from document review of the cases. The documents that were reviewed for this study included the following: reports of activities of the development

partners funding the health intervention programs, reports of the coordination efforts and activities on the health programs, and an outcome evaluation report of health programs. Data from document review were used to validate the information collected from interview.

Data Analysis Plan

Researchers analyze data to deduce findings (Patton, 2002). In qualitative research, depth and detail analysis of data requires the development of suitable coding schemes, theme analysis, and data representation and verification (Creswell, 2007; Patton, 2002). According to Patton (2002), in case study analyses, the inquirer organized data by specific cases for in-depth study and comparison. In this study, responses from open-ended interviews and data from document review constituted the data. Data coding, themes, and data representation and conclusion were the three stages of data analysis used in this qualitative data research.

Data Coding

Data coding involves reducing the data into meaningful segments and assigning names for the segment (Patton, 2002). Data coding was done to produce transcript of the open-ended responses from the participants. Individual case synopses will be conducted on each case to identify what is peculiar in each participant's response. The deductions from each participant's responses were further worked, and key words, possible sequences, and generic sequences were identified and enumerated. These sequences will be nested in a more conceptual frame (Miles & Huberman, 1994). There will be a code book that will contain description of each code, criteria for including and excluding codes

(MacQueen, McLellan, Kay, & Milstein 1998). Core codes and subcodes for each case were displayed on single sheet to explain content and for easy retrieval. The codes and subcodes for each case were further reduced and combined form "meta-codes" based on research variables; coordination, information flow, cost of fragmentation, and health aid effectiveness.

Themes

Themes are codes converted into broader categories (Creswell, 2007). The researcher reduces codes to themes by counting frequency of codes and noting the patterns (Creswell, 2007; Huberman & Miles, 1994). The NVivo software was used to identify pattern regularities, and the pattern regularities were compared for the three cases.

Data Representation and Conclusion

Themes were presented in research variables; coordination, information flow, cost of fragmentation, and health aid effectiveness. Themes were displayed and data that support each theme based on the research variables were identified and represented. Conclusion was based on the themes that emerged from data coding and how they relate to the research variables.

Issue of Trustworthiness

Saturation and Sample Size

The guiding principle for sample size in qualitative research is concept of saturation (Mason, 2010). Saturation is that point when an inquirer no longer finds new information (from selected participants) that adds to the understanding of the case

understudy (Creswell, 2007). For qualitative research, Atran et al. (2005) suggested that a sample size of ten is adequate to establish a reliable consensus. Meanwhile, the principle of saturation was applied during this study to determine if the sample size is appropriate for the study. Saturation is when no new information is forthcoming from the subsequent participants (Patton, 2002). Thus, during data collection, interview stopped when saturation was attained. That is, when further participants' interview, provided same information as information from previous participants.

Validity and Reliability Check

Member checking was used to check the validity and reliability of data collected from interview and document review. Member checking involves soliciting for one of participant's views of the credibility on the finding and interpretations (Ely et. al, 1991). Member checking technique is considered by Lincoln and Guba (1985) to be the most critical technique for establishing creditability in qualitative research (Creswell, 2007). The member checking for this study involved critical review and interpretation of the draft of the researcher's work to determine if data analyses, interpretation, and conclusion by the researcher are appropriate.

Ethical Procedures

One hallmark of ethical research is respecting the people, communities, and organizations that will work the researcher. The process includes the researcher establishing a working relationship with the participant, not allowing personal bias to affect the interpretation of participants' responses, signing confidentiality agreement and consent form with the participants.

During this research study, data confidentiality, and integrity were maintained. A confidentiality agreement was signed by the researcher and the participants. This agreement assured participants that their privacy will not be violated; only the information that agree to the disclosed will be disclosed and the findings from the research will not be presented to harm or alienate them. On the other hand, informed consent was signed to ensure the participant for this study understand they reserve their right to accept or decline participation in the study, the research plan, the method of information gathering, and how the information gathered will be used.

Summary

This chapter provided detailed explanation of the methodology for this study, which includes the population, research design, selection criteria, and issues on validity of data. Also, the chapter provided a description of how case-study addressed the research question by employing purposeful sample and selected participants who provided in-depth information relevant to the research questions and information on the health intervention programs that were used as cases.

Data collection methods included interview and document review. After receiving participants' consent, open-ended questions were used to interview them. Data collected were analyzed by the researcher using NVivo software. Also, included in this chapter were the steps taken to ensure ethics during this study.

Chapter 4: Results

Development partners provide health aid to Nigeria by funding health intervention program to improve the health care delivery to the populace. The concern of the development partners is effectiveness of the health aid to the developing country. Meanwhile, the health stakeholders advocate for donor coordination to improve the effectiveness of aid. This research looked into the influence of donor coordination on the effectiveness of health aid to Nigeria by analyzing three health intervention programs: HIV/AIDS, malaria, and nutrition health programs. Data were collected by interviewing the program officers of the development partners working on these health intervention programs. In addition to the interviews, documents—reports of activities of the development partners funding the health intervention programs, reports of the coordination efforts and activities on the health programs, and outcome evaluation report of health programs—were reviewed to validate the data collected from the interviews.

The subsections that made up this chapter are data collection process, data analysis, results, evidence of trustworthiness, results, and chapter summary. Data collection process includes description of the participants, location, and methods of data collection. The data analysis subsection highlights the method used for data coding and representations. In the last two subsections, the results and the issue on the trustworthiness of the results are discussed.

Data Collection Process

To determine the influence of donor coordination on the effectiveness of health aid in Nigerian health system, I used qualitative, case study design. Data were collected by interviewing program officers using open-ended questions.

Before the recruiting the participants, Walden University's Institutional Review Board (IRB) approved the research (IRB approval number: 10-07-15-0333841). After the IRB approval, I applied and got approval from the National Health Research Ethics Committee of Nigeria to conduct the study in Nigeria.

This study analyzed three health intervention programs. These interview questions were used for the health intervention programs. The data for this study were collected by interviewing 22 program officers (participants), that is, eight participants for HIV/AIDS program, seven participants for malaria program, and seven participants for nutrition program. Each program officer represented a development partner funding health intervention program.

I contacted the research partners (development partners) for their approval to conduct the interview of their program officers working on the health intervention program. Out of the 27 research partners contacted, 21 responded and signed letter of cooperation. The letter of cooperation represented the approval from research partners. It stated the organization's responsibilities to provide the list of participants to be interviewed, to provide an office space for the interview, to share documents to be reviewed, and for participants to be available for member checking. The letter of cooperation also stated that the research partner reserves the right to withdraw from the

study at any time if circumstances change. Once I received the approval of each development partner, with the names of the program officer working directly on the health intervention program selected for the study, I contacted the participants to agree on date and time for the interview. I also explained the modalities and the expected time of the interview. The participants signed a consent form. The consent form provided the title of the research, the name and affiliation of the researcher, background information of the study, interview procedures, risk and benefits of the participating in the study, as well as the voluntary nature of the study. Participants were interviewed in their offices on the date and time that was scheduled with them. Participants' interviews were face to face and the interviews were audio recorded. The interview duration ranged from 30 minutes to 1 hour. I transcribed interviews afterwards. After the interviews, participants provided documents on the health program for the data review process.

Data Analysis

After the interview, the initial coding of the data was keyed into the NVivo platform. Coding for data began with identification of key categories.

Data from Initial Interviews for HIV/AIDS Program

The following questions were asked and coded responses were as follows: What are the existing efforts to ensure coordination of activities of the development partners funding HIV/AIDS program? The responses included the different kinds of groups to foster and ensure coordination in HIV/AIDS program. There are the United Nation Joint Program on HIV/AIDS (eight participants), Expanded Team on HIV/AIDS (eight participants), Global Fund Forum of Coordination (eight participants), and Development

Partners Group (DPG) on HIV/AIDS (eight participants). The second question was how coordination efforts influenced the alignments of the organization's activities with the activities of other partners funding this program. The identified influences were streamline duplication of efforts (seven participants) and aligned agendas of Development Partners (four participants). The categories that emerged from the third question (How committed are partners to this/these coordination mechanism?) were as follows: partial commitment (six participants), no specific work plan for Development Partners Group (four participants), and United Nations agencies committed to United Nations Joint Program on HIV/AIDS (six participants). The fourth question enquired about the channel of communication between development partners funding the health program. The responses were as follows: quarterly meeting (eight participants), through e-mails (eight participants), through DPG Secretariat (UNAIDS; four participants), and during subteams' monthly meetings (three participants). The fifth question addressed the influence of coordination mechanism on the HIV/AIDS program (How does the existing coordination mechanism influence the outcome of the program?). The following categories emerged: improved outcome (five participants), government commits resources (two participants), developed the President's HIV Response Plan (three participants), streamlined duplication activities (four participants), and reduced dwindling resources (three participants). On the sixth question (What is the cost implication of coordination to the cost of implementing this health program?), eight participants affirmed that coordination helped to reduce cost of implementing HIV/AIDS program. The seventh question addressed the challenges of achieving coordination/harmonization

of development partners' activities (What are the challenges of achieving coordination/harmonization of activities?). The categories that emerged included the following: some partners have no office in recipient country (two participants), different donors' agendas (seven participants), poor coordination efforts at implementing level (six participants), low commitment the recipient country (six participants), no consistency from the recipient country (seven participants), and inadequate of domestic finances (eight participants). Table 4 is the summary of participants' response from interview for HIV/AIDS program.

Table 4

Summary of Participants' Response from Interview for HIV/AIDS Program

Questions	Response	Number of Responses
Q1: What are the existing efforts to ensure coordination of activities of the development partners funding HIV/AIDS program?	United Nation (UN) Joint Program on HIV/AIDS	8
	Expanded Team on HIV/AIDS	8
	Global Fund Forum of Coordination	8
	Development Partners Group on HIV/AIDS	8
Q2: How do coordination efforts influence the alignments of your organization's activities with the activities of other partners funding this program?	Streamline duplication of efforts	7
	Aligns agendas of Development Partners.	4
Q3: How committed are partners to this/these coordination mechanism?	Partial commitment	6
	No specific workplan for DPG.	4
	UN Agencies committed to UN Joint Program on HIV/AIDS	6

(table continues)

Questions	Response	Number of Responses
Q4: What are the communication channels among development partners involved in this program?	Quarterly meeting	8
	E-mails	8
	Through DPG Secretariat (UNAIDS)	4
	Sub-teams monthly meetings.	3
Q5: How does the existing coordination mechanism influence the outcome of the program?	Improved outcome	5
	Government commits resources	2
	Developed the President's HIV Response Plan.	3
	Streamlined duplication activities.	4
	Reduced dwindling resources	3
Q6: What is the cost implication of coordination to the cost of implementing this health program?	Reduced cost	8

(table continues)

Questions	Response	Number of Responses
Q7: What are the challenges of achieving coordination/harmonization of activities	Some partners have no office in recipient country	2
	Different donors' agendas	7
	Poor coordination efforts at implementing level	6
	Low commitment the recipient country	6
	no consistency from the recipient country	7
	Inadequate of domestic finances	8

Data from Initial Interviews for Malaria Program

Question 1: What are the existing efforts to ensure coordination of activities of the development partners funding Malaria program? Categories: Roll-Back Malaria Partnership Program (seven participants), Global Fund on Malaria (seven participants), and National Malaria Control Program (seven participants).

Question 2: How do coordination efforts influence the alignments of your organization's activities with the activities of other partners funding this program? Categories: Partners understood policy and guidelines (six participants), reduced duplication (five participants), and yet to achieve coordination at state level (four participants).

Question 3: How committed are partners to this/these coordination mechanism? Categories: Partners are committed to providing funds to drives the coordination mechanism (five participants), and not all partners are committed (four participants).

Question 4: What are the communication channels among development partners involved in this program? Categories: E-mail (seven participants), meetings (seven participants), joint site visits (four participants), joint advocacy (four participants), and joint communiqués after meeting (five participants).

Question 5: How does the existing coordination mechanism influence the outcome of the program? Categories: Improved program outcome (six participants), identified coexisting donor activities in same state (four participants), and mobilized additional resources (three participants).

Question 6: What is the cost implication of coordination to the cost of implementing this health program? Categories: Reduced cost (seven participants).

Question 7: What are the challenges of achieving coordination/harmonization of activities? Categories: Different donors' agendas (five participants), lower commitment by staff of the recipient country, (six participants), no continuity and consistency of the effort from the recipient country, (five participants), no coordination between development partners and implementing partners (four participants), and inadequate availability of domestic finances (three participants). Table 5 is the summary of participants' response for the malaria program.

Table 5

Summary of Participant Response from Interview for Malaria Program

Questions	Response
Q1: What are the existing efforts to ensure coordination of activities of the development partners funding Malaria program?	Roll-Back Malaria Partnership Program Global Fund on Malaria National Malaria Control Program
Q2: How does coordination efforts influence the alignments of your organization's activities with the activities of other partners funding this program?	Partners understood policy and guidelines Reduced duplication Yet to achieve coordination at state level
Q3: How committed are partners to this/these coordination mechanism?	Partners are committed to providing funds drives the coordination mechanism Not all partners are committed
Q4: What are the communication channels among development partners involved in this program?	E-mail Meetings Joint site visits Joint advocacy Joint communiqués after meeting

(table continues)

Questions	Response
Q5: How does the existing coordination mechanism influence the outcome of the program?	Improved program outcome Identified coexisting donor activities in same state. Mobilized additional resources
Q6: What is the cost implication of coordination to the cost of implementing this health program?	Reduced cost
Q7: What are the challenges of achieving coordination/harmonization of activities	Different donors' agendas, Lower commitment by staff of the recipient country No continuity and consistency of the effort from the recipient country No coordination between development partners and implementing partners Inadequate availability of domestic finances

Data from Initial Interviews for Nutrition Program

Question 1: What are the existing efforts to ensure coordination of activities of the development partners funding Nutrition program? Categories: Efforts to reinvigorate coordination of partners in Nutrition program (three participants), Strategic Plan of Action for the Nutrition Program (four participants), Nutrition Partner Coordination Forum (three participants), no coordination effort (two participants).

Question 2: How do coordination efforts influence the alignments of your organization's activities with the activities of other partners funding this program? Categories: Activities awareness amongst partners (five participants), and no significant influence (three participants).

Question 3: How committed are partners to this/these coordination mechanism? Categories: Committed to partner mapping (four participants), no commitment (five participants).

Question 4: What are the communication channels among development partners involved in this program? Categories: E-mail (seven participants), and meetings (seven participants).

Question 5: How does the existing coordination mechanism influence the outcome of the program? Categories: Minimal improvement (five participants), and no positive influence yet (two participants).

Question 6: What is the cost implication of coordination to the cost of implementing this health program? Categories: Reduces cost of implementation (five participants), and no coordination, can't say (three participants).

Question 7: What are the challenges of achieving coordination/harmonization of activities? Categories: Fragmented coordination (six participants), partners not focused on only nutrition program (five participants), inadequate finances from recipient country (six participants), and no consistency of the effort from the recipient country (6 participants). Table 6 is the summary of participants' response for the nutrition program.

Table 6

Summary of Participant Response from Interview for Nutrition Program

Questions	Response	Number of Responses
Q1: What are the existing efforts to ensure coordination of activities of the development partners funding Nutrition program?	Efforts to reinvigorate coordination of partners in Nutrition program	3
	Strategic Plan of Action for the nutrition program	4
	Nutrition Partner Coordination Forum	3
	No Coordination effort	2
Q2: How do coordination efforts influence the alignments of your organization's activities with the activities of other partners funding this program?	Activities awareness amongst partners	5
	No significant influence	3
Q3: How committed are partners to this/these coordination mechanism?	Committed to partner mapping	4
	No commitment	5
Q4: What are the communication channels among development partners involved in this program?	E-mail	7
	Meetings	7
Q5: How does the existing coordination mechanism influence the outcome of the program?	Minimal improvement	5
	No positive influence yet	2

(table continues)

Questions	Response	Number of Responses
Q6: What is the cost implication of coordination to the cost of implementing this health program?	Reduces cost of implementation	5
	No coordination, can't say	3
Q7: What are the challenges of achieving coordination/harmonization of activities	Fragmented coordination	6
	Partners not focused on only nutrition program	5
	Inadequate finances from recipient country	6
	No consistency of the effort from the recipient country	6

After analyzing the data and coding data from the interview, I further reviewed coded data to ensure accurate representation of the categories identified.

Evidence of Trustworthiness

In order to ensure the reliability and validity of the evidence, I returned to Creswell (2007) who explained that as data are collected, an indication of reliability and validity is at that point when information provided from participants on the same questions are repeated. As the interview progressed, common categories emerged. The emergence of common categories ascertained the reliability and the validity of data collected during the interview. At the time, I interviewed the fifth participant on each case, I noticed the participants provided almost same response to the interview questions (but in different words). The repetition of response was confirmed, after I interviewed the seventh participants for each program. Thus, I ascertained the repetition of core

categories. After the data analysis, I took the transcript to the participants. Information provided to participants included transcribed interview, codes, themes, and interpretation. Participants reviewed the information at separate meetings and provided modifications as necessary. The modification did not affect the analysis and findings from initial interview data. Member checking helped to validate the information collected during the interview and the data collected from document review. In this study, I used interview, document review, and member check to validate and ensure reliability of the evidence gathered from this study.

Results

This research sort to determine the influence of donor and development partners' coordination on the aid they provide to the Nigerian health sector by analyzing the three health intervention program funded/ supported by more than five development partners in Nigeria. From the analysis of data collected during the interview, codes were further reduced to themes. The themes are arranged according to each research question.

Themes from HIV/AIDS Program

Existing coordination efforts to ensure coordination of activities.

Theme: Formed working teams to ensure coordination. Participants explained that teams were formed to focus ensuring and strengthening the coordination of activities of development partners and donors funding the HIV/AIDS program. These groups are: United Nation Joint Program on HIV/AIDS, Expanded Team on HIV/AIDS, Global Fund Forum of Coordination, and Development Partners Group on HIV/AIDS.

Influence of coordination efforts on alignments of development partners' activities

Theme: Reduced duplication and aligned agendas of activities. Participants pointed out that, to some extent, the existing coordination efforts had helped to streamline duplication and align agendas of development partners.

Development partners' commitment to the existing coordination mechanism.

Theme 1: No specific work plan for DPG, resulting to partial commitment.

Theme 2: UN Agencies committed to UN Joint Program.

Two themes emerged from this question. Some participants stated that because there is no specific work plan for the Development Partners Group on HIV/AIDS, partners make little effort to align their efforts. Participant A stated that, "Participants are not committed to the DPG because DPG does not have a specific work plan"; however, some participants said that there are some partners are committed to the coordination efforts. For example, participant A stated that "it is easy for UN agencies to commit to coordination mechanism of the UN Joint Team". The statement by other participants supported this statement; "Within the UN Joint Team, plan is based on the country needs, and agencies are assigned responsibilities based on their comparative advantage".

Communication channels among development partners involved in HIV/AIDS program.

Theme: Through Quarterly meeting, e-mails, subteams monthly meetings, and DPG Secretariat (UNAIDS). Participants pointed out that e-mails and quarterly meeting are major channels of communication among the development partners funding and

support HIV/AIDS program. In addition, information from the DPG Secretariat and minutes of the sub-team monthly meetings also provides information among the development partners.

Influence of coordination mechanism on the outcome of the program.

Theme 1 Improved outcome and get Government commits resources. Some participants explained that coordination mechanism has helped to improve outcome of HIV/AIDS program. Also through coordination government got to commit resources for the program. Participant stated "with operation plan that was developed to address the gaps in HIV/AIDS, and to improve coordinating partners, there is improved outcome with coordination. Also, UNAID has engaged with to government and influence them to commit resources to improve response to HIV program".

Theme 2 Develop the President's HIV Response Plan. Participant stated "UNAID has engaged with to government and influence them to commit resources to improve response to HIV program".

Theme 3 Streamlined duplication activities and reduced dwindling resources. Participants explained that another influence of coordination on development partners' activities is that it has streamlined duplication of activities and reduced dwindling funds.

Cost implication of coordination to the cost of implementing the health program.

Theme: Reduced cost. Participant explained that coordination has helped to reduce cost of implementing HIV/AIDS program. Participant X stated "coordination has helped to reduce cost of implementing HIV/AIDS programs, by reducing duplication of efforts, by UN agencies and other development partners in same states or LGA".

Challenges of achieving coordination/harmonization of activities.

Theme 1 Different donors' agendas. Participant X stated that "Some donors come with their agenda on the health intervention program they want to support, that may not be in line with country need; "lop-sided agenda". Participant A also said something in line with what Participant X said, "Some donors come with pre-customized agendas that are not based on the country's need". In addition, Participant B stated that "Some partners do not compromise their agenda".

Theme 2 Poor coordination efforts at implementing level. Participants explained that, although there is coordination at the national level, there is less coordination at the state and local government levels. Participants A stated, "State and local government level of coordination is not good, because there is no platform for all the players in HIV to come together at the state level and local government level".

Theme 3 Low commitment and consistency from the recipient country, and inadequate of domestic finance. Participants explained that recipient country does not show full commitment to coordination process. Also, inadequate domestic funding does not encourage ownership and sustainability of the health program. Participant B stated, "There is no strong leadership from the recipient country".

Theme 4 Inadequate communication. Inadequate communication is another challenge that poses an effective coordination of development partners' efforts. Participant A stated that "unwillingness of partners to divulge complete information" is one of the challenges.

Themes from Malaria Program

Existing coordination efforts to ensure coordination of activities.

Theme: Formed working teams to ensure coordination. Participants explained the development partners working with the recipient country formed the Malaria Control Program. This program is in line with the objectives of the Global Roll Back Malaria Program. Participant O stated, "Nigeria, National Malaria Control Program was formed in line with the objectives of the Roll-Back Malaria Partnership Program with WHO, bilateral donors, and the multilateral donors working on it".

There are also technical working groups within the Malaria Control Program. Participant J explained, "Within the Malaria Control Program, there is the Technical Working Groups; that bring together technical situation and discussion on the malaria program". These efforts focus on coordinating the activities of development partners funding the malaria program in Nigeria.

Influence of coordination efforts on alignments of development partners' activities.

Theme 1: Partners now understand the policy of the recipient country. Participants noted that, with the existing coordination efforts between the government and the development partners, development partners now understand the malaria policy of the recipient country.

Theme 2: Reduced duplication of activities. Participants explained that existing coordination efforts has helped to reduce duplication of efforts. Participant O stated, "These coordination efforts have help to reduce parallel programs".

Themes 3: Yet to achieve coordination at state level. Some of the participants explained that although the coordination efforts have helped development partners to plan together at national level, development partner are yet to achieve coordination at the state level. Participant J stated, "At national level, the coordination is strong compare to at state level".

Development partners' commitment to the existing coordination mechanism.

Theme: No all partners are committed. Participants explained that not all partners are committed to working with the existing coordination mechanism. Participant W explained, "Partners funding Malaria Program in Nigeria are committed to the existing coordination mechanism. The challenge is between development partners and implementing partners".

Communication channels among development partners involved in malaria program.

Theme: E-mail, Meetings, Joint site visits, Joint advocacy, Joint communiqués after meeting. Participants explained that e-mails, meetings, joint communiqués after meetings are the channel of communication between development partners. In addition, joint site visits, and joint advocacy are also channel of communication.

Influence of coordination mechanism on the outcome of the program.

Themes 1: Identified coexisting donor activities in same state. Participants explained that during the Joint meetings, it became obvious that there were clusters of activities from different development partners on the same project, in the same location.

Participants W explained that, “The existing coordination mechanism (CM) helps identify where there are coexisting donor activities in same state”.

Theme 2: Improved program outcome and mobilized additional resources. Participant M explained, “The existing coordination mechanism (CM) has helped to improve the outcome of malaria program in Nigeria. For example, ownership of INTN increased from 8% in 2009 to 50% in 2012”. Participant O’s statement supported Participant’s M statement; “In addition to improving outcome of the malaria program, with the existing coordination mechanism, donors and development partners helps mobilize additional resources for Nigeria”.

Cost implication of coordination to the cost of implementing the health program.

Theme: Reduced cost. Participants explained that coordination efforts helped to reduce cost of implementing malaria program. Participant J stated, “With all the coordination efforts, the cost of implementing malaria program is lower compared to with the coordination efforts by the partners and recipient country”.

Challenges of achieving coordination/harmonization of activities.

Theme 1: Different donors’ agendas. Participant W explained, “Different donors’ agendas, budgeting cycle makes it difficult to harmonize both activities and other financial matters”.

Theme 2: No continuity, commitment, and consistency of the effort from the recipient country, and inadequate of domestic finances. Participant M explained, “There is no continuity and consistency of the effort from the recipient country as a result of

frequent changes of the management". This was supported by Participant J's statement, "The level of commitment from the staff of the recipient country is low".

Theme 3: No coordination between development partners and implementing partners. Participant O explained, "The coordination effort is stronger at national level than at state level. This affects the implementation of the program".

Themes from Nutrition Program

Existing coordination efforts to ensure coordination of activities.

Theme 1: Formed a forum to ensure coordination. Participant C explained, "Nutrition Partner Coordination Forum in the North-East coordinated by UNICEF. The partners meet every 2 weeks to discuss what is happening in Adamawa and Yobe states". Also, Participant N stated "the quarterly nutrition partners' meeting between Federal Ministry of Health and other development partners has been reinvigorated".

Theme 2: Plan to develop strategic plan for coordination. Participant C explained, "Few years ago, coordination for nutrition program was fragmented; coordination was mainly done by the Nutrition Department, Federal Ministry of Health. There was no coordination between the National Planning Commission and the Federal Ministry of Health. This effects the coordination of development partners' activities for the Nutrition Program".

Theme 3: No coordination. Some participants explained that there is no coordination among the development partners funding the Nutrition Program.

Influence of coordination efforts on alignments of development partners' activities.

Theme: 1: No significant influence. Participants explained that there is no significant influence on the coordination effort on the program. Participant N stated, "I have not noticed any influence of the coordination efforts on the alignment of the development partners' activities. This is because of little effort to harmonize the activities of partners working in Nutrition program. However, this little effort is an avenue for partners in nutrition program, to come together".

Theme 2: Improved awareness. Some of the participants explained the coordination effort for nutrition program brings the partner together and encourage them to work to achieve common objectives.

Development partners' commitment to the existing coordination mechanism.

Theme: No all partners are committed. Participant U explained that "Partners are committed to ensuring that the partner mapping the Government is doing".

Communication channels among development partners involved in HIV/AIDS program.

Theme: Through e-mails and meetings. Participants explained that the development partners funding nutrition program communication through e-mails and during meetings.

Influence of coordination mechanism on the outcome of the program.

Theme 1: Minimal improvement.

Theme 2: No positive influence yet. Some participants said that there are the coordination efforts on nutrition program have recorded minimal improvement of the program. While some participants explained that there is no influence of coordination on

the outcome of the program because, the coordination efforts are still at the incubation stage.

Cost implication of coordination to the cost of implementing the health program.

Theme 1: Reduces cost of implementation. Some participants explained that minimal coordination efforts helped to reduce cost of implementing nutrition program. For example, participant P stated, "With coordination efforts like the partner mapping and need assessments, the outcome of the nutrition program has improved compared to what it was about two years ago".

Theme 2: No coordination, can't say. Some participants said that there is no adequate coordination effort for the nutrition program; thus, it would be difficult to analyze the influence of coordination on the program.

Challenges of achieving coordination/harmonization of activities.

Theme 1: Fragmented coordination. Participants explained that the recipient country is not committed to harmonize their coordination effort the development partners' coordination efforts.

Theme 2: Partners not focused on only nutrition program. Participant P explained "The development partners in the Nutrition Partner are cross-cutting in other health programs".

Theme 3: No consistency of the effort from the recipient country, and inadequate of domestic finances. Table 7 is the summary of the themes for the HIV/AIDS, malaria, and nutrition programs.

Table 7

Summary of Themes that Emerged from All Three Cases (HIVAIDS, Malaria, and Nutrition)

Questions	**HIV/AIDS**	**Malaria**	**Nutrition**
Q1:	Formed working teams to ensure coordination	Formed working teams to ensure coordination	#1Formed a forum to ensure coordination #2 Plan to develop strategic plan for coordination #3 No coordination
Q2:	Reduced duplication and aligned agendas of activities.	#1Yet to achieve coordination at state level #2 Partners now understand the policy of the recipient country #3 Reduced duplication of activities.	#1 No significant influence. #2 Improved awareness.
Q3:	#1No specific work plan for DPG, resulting to partial commitment. #2 UN Agencies committed to UN Joint Program	No all partners are committed	No all partners are committed
Q4:	Through Quarterly meeting, E-mails, sub teams' monthly meetings, and DPG Secretariat (UNAIDS)	Through E-mail, Meetings, Joint site visits, Joint advocacy, Joint communiqués after meeting	Through e-mails and meetings

(table continues)

Questions	HIV/AIDS	Malaria	Nutrition
Q5:	#1 Improved outcome and get Government commits resources #2 Develop the President's HIV Response Plan. #3 Streamlined duplication activities and reduced dwindling resources	#1 Identified coexisting donor activities in same state. #2 Improved program outcome and mobilized additional resources.	#1 Minimal improvement #2 No positive influence yet
Q6:	Reduced cost	Reduced cost	#1 Reduces cost of implementation #2 No coordination, can't say
Q7:	#1 Some partners have no office in recipient country #2 Different donors' agendas #3 Poor coordination efforts at implementing level #4 Low commitment and consistency from the recipient country, and inadequate of domestic finances	#1 Different donors' agendas, #2 No continuity, commitment, and consistency of the effort from the recipient country, and inadequate of domestic finances #3 No coordination between development partners and implementing partners	#1 Fragmented coordination. #2 Partners not focused on only nutrition program. #3 No consistency of the effort from the recipient country, and inadequate of domestic finances.

Summary

Chapter 4 presented the findings from qualitative interviews of purposeful sampling of 8 Program Officers working on HIV/AIDS program, 7 Programs Officers working on Malaria Program and 7 Program Officers working on Nutrition Program in Nigeria. The interview explored the influence of donor coordination on the effectiveness of health aid to Nigeria. The interviews were conducted, transcribed, and NVivo aided in the coding and analysis of data collected. Also, documents for each health program were review to support data from interviews. Analysis showed that there are efforts to coordinate development partners' activities for each health program, and these efforts have helped to improve outcome of the programs; however, there are challenges that impede these coordination efforts.

Chapter 5 presents the interpretation of results in line with data finds and scope of study. Chapter 5 also explains limitation of the study and recommendation for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Coordination of donor activities was one of the focuses of Paris Declaration (OECD, 2008). The purpose of this study was to examine the influence of donor coordination on health aid. The primary research question focused on how coordination between donor organization and development partners influenced the effectiveness of development aid in the health sector in Nigeria. This qualitative study used three health intervention programs as case studies. Participants were the program officers managing the health intervention programs. Open-ended questions were asked during the interviews. Also, I reviewed documents for each health intervention program for further information on the cases. From the analysis of the data collected, the development partners as well as the government of the recipient country were making efforts to coordinate the activities of the development partners in the health sector. These coordination efforts helped to improve the outcomes of some health intervention programs and have helped to reduce cost of implementing health intervention program; however, these coordination efforts did not exist for all the health programs. The HIV/AIDS and the malaria programs were more coordinated than the nutrition program. Also, there were more coordination efforts and activities at the national level than at the state level. In addition, the government of the recipient country was not driving the coordination effort as it ought to have been.

Although there were existing coordination efforts, not all the development partners worked according to the guideline of these efforts. This partial commitment was

a result of the lack of process ownership from the recipient country. Findings revealed that lack of strong leadership by the recipient country affected the coordination of development partners' effort. Development partners sometimes deviated from the country's set agenda. Also, the government did not commit adequate resource to implementing and sustaining the health programs.

Findings also showed that there was stronger coordination at the national level than at the state level. This variance affected the implementation of the health program.

Interpretation of the Findings

Based on the information in the literature review, the Nigerian government, through the Federal Ministry of Health and the development partners in Nigeria, developed some coordination platforms to ensure and support efforts to synergize activities of all development partners in Nigeria (WHO, 2009). This study finding confirmed that different coordination forums and groups were formed for different health intervention programs to ensure coordination of activities of development partners.

In addition, the literature revealed that the Country Coordination Mechanism is a framework driven by the recipient country and supported by the developmental partners to ensure the harmonization of all efforts towards the support of the malaria, HIV/AIDs, and tuberculosis programs (Global Fund, 2008). From the study, there was a Country Coordination Mechanism to ensure harmonization of all efforts towards the support of the malaria, HIV/AIDs, and tuberculosis programs, but the recipient country did not own the process. However, the existing Country Coordination Mechanism do not include nutrition program and some other health programs.

According to the literature, evidence of coordination is the recipient country's ability to own the development process, align its development activities with the activities of the development partners (that is, no overlap of donor activities), ensure a joint effort between donor organizations working in the country, develop and implement a performance assessment framework, and ensure mutual accountability between the development partners and the country. This study showed that there is still gap in the alignment of Nigeria's health development agendas with the some of the development partners' agendas. Some of the development partners did not key into the country's agenda. They deliberately withheld information. This confirmed information from the literature: in the Nigerian health care system, sharing information between them on activities across the health sector is inadequate (Daniels et al., 2011 & National Planning Commission, 2010).

Evidence showed that without effective harmonization of efforts, donor organizations would not achieve health development goals in developing countries (Buse & Walt, 1999). Effective harmonization and alignment of activities will be difficult to achieve if development partners do not align their agenda with the priorities of the development country. The outcome from the Paris Declaration focused on encouraging coordination among donors and coordination between donors and recipient countries.

Limitations of the Study

The limitation of this study as mentioned in Chapter 1 includes the internal validity of conducting qualitative study. This limitation was addressed by triangulation. I used document review to validate data from interviews. Also, purposeful sampling was

done to ensure the collection of in-depth information on the cases, and member checking was done to validate the information collected and analyzed. The second limitation that was mentioned in Chapter 1 was participants' unwillingness to share complete information. The original assumption on this limitation was accurate. Out of the 28 participants contacted, 22 agreed to participants in the study. Twenty-two participants represented a good number of participants for a qualitative study, and I believe the participants provided accurate information on the questions they were asked.

Recommendations

The growing concern in the donor community about the relatively unproductive cost of aid as a result of inadequate harmonization of donors and development partners' actions spurred efforts towards improving development aid effectiveness (OECD's Development Assistance Committee, 2003). Based on the findings of this study, I recommend that there should be a Country Coordination Mechanism for all health intervention programs. Each health program has peculiarities. As a result of these peculiarities, there should be a coordination mechanism for each health intervention program. In addition to developing and strengthening coordination mechanism for each heath program, coordination mechanisms should be designed to integrate activities at the national, state, and local government levels, to ensure coordination at all levels.

The government of the recipient country should strengthen the already existing coordination mechanism and ensure that all development partners funding and supporting health programs must key into the priorities as in the coordination mechanism. According

to the OECD (2005), donor organizations should not impose their system on recipient countries; rather, they should adopt the systems of the recipient country.

Last, governments should own the process of health development for sustainability, and coordination efforts should be cascaded to the state level to ensure adequate and quality implementation of health intervention programs.

Implications

From the result of my analysis, I concluded that Country Coordination Mechanisms should be developed for all health intervention programs to provide guideline of harmonizing the activities of the development partners in line with priorities of the recipient country. Participants stressed that the government of the recipient country should own the coordination process and strengthen the already existing coordination mechanism and ensure that all development partners funding and supporting health programs must key into the priorities as in the coordination mechanism.

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

Theoretical Implication

The study supported the theories on the influence of donor coordination on the effectiveness of aid to developing countries. Findings from the study indicated that development partners funding and supporting health programs that have already existing coordination platforms experienced reduced cost of implementation. These findings supported Bigsten's (2006) and Lawson's (2013) findings. Coordination among the health aid donor organizations will reduce fragmentation and proliferation of health aids as well as transaction cost.

Pereira and Villota (2012) believed that donors recognized that aligning aid with long-term aid development goals is one way to ensure adequate aid effectiveness. This study supported this assumption. Participants pointed out that because development partners funding and support for the same health program started making effort to harmonize their activities, the outcome of the health program improved. Also, those participants that were funding health program that did not have written coordination guidelines and platforms yet did not experience much improvement in the outcome of the health program.

Conclusion

The coordination of health aid to developing countries for effective outcome is a growing concern to the donors, developmental partners, and other stakeholders in the health sector. The Nigerian health sector is among the sectors in developing countries that has experienced a challenge in international development assistance coordination. To identify the gap and suggest ways to achieve aid effectiveness through coordination, I

asked seven questions to identify existing coordination efforts, the impact of the existing coordination efforts, and the challenges of aligning and harmonizing activities.

Participants' responses to these questions revealed the partial coordination efforts in the health sector development. Coordination effort should be at both national and state levels to ensure adequate implementation of the health program. Most participants reported that there was a need for the government of the recipient country to strengthen their commitment, as well as the development partners to adhere to the guidelines of the coordination platforms. Findings also revealed a need for governments to own the coordination process in their country and ensure that development partners key into their health priorities. To mitigate this coordination challenge and to achieve sustainable effectiveness of health aid in Nigeria, all stakeholders in the health should commit to transparency and encourage adequate flow of information. In addition to government chairing the coordination process, development partners should key into the country's health priorities as they provide aid for health care development.

References

Abernethy, M. A., Chua, W. F., Grafton, J., & Mahama, H. (2007). Accounting and control in health care: Behavioral, organizational, sociological and critical perspectives. In C. S. Chapman, A. G. Hopwood, & M. D. Shields (Eds.), *Handbook of management accounting research, 2,* 805-827. Oxford, England: Elsevier Ltd.

Agbanu, S.K. (2010). The Impact of Stakeholder Collaboration on Effectiveness of Health Program Implementation in Ghana. (Doctoral Dissertation). Available from ProQuest Dissertations &Theses Full Text Database (UMI 3403055).

Akande, T.M. (2004). Referral System in Nigeria: Study of a Tertiary Health Facility. *Annals of African Medicine, 2*(3), 2004:130-133*: ISSN: 1596-3519*. Retrieved from: http://www.ajol.info/index.php/aam/article/view/8321

Akinyele, I.O, (2009). Ensuring Food and Nutrition Security in Rural Nigeria: An Assessment of the Challenges, Information Needs, and Analytical Capacity. (Background Paper No. NSSP 007). Retrieved from: Nigeria Strategy Support Program (NSSP) website: http://reliefweb.int/sites/reliefweb.int/files/resources/978476C306273C0B492576A200070E53-Full_Report.pdf

Aldasoro, I., Nunnenkamp, P., & Thiele, R. (2010). Less Aid Proliferation and More Donor Coordination? The Wide Gap Between Words and Deeds. *Journal of International Development 22*(7), 920-940. doi: 10.1002/jid.1645.

Alenoghena, Aigbiremolen, A.O., Abejegah, C., Eboreime, E. (2014). Primary Health Care in Nigeria: Strategies and Constraints in Implementation. *International Journal of Community Research IJCR 2014, 3*(3), 74-79. *ISSN: 2315 – 656. Retrieved from: http://www.arpjournals.com.*

Alesina, A. & Dollar, D. (2000) 'Who gives foreign aid to whom and why?, *Journal of Economic Growth 5*(1), 33–63. doi:10.1023/A:1009874203400

Atran, S., Medin, D. L., & Ross, N.O. (2005). The cultural mind: Environmental decision making and cultural modeling within and across populations. *Psychological Review, 112*(4*), 744-776*. Retrieved from: http://groups.psych.northwestern.edu/medin/publications/Atran,Medin,Ross2005.pdf

Balogun, P. (2005) Evaluating progress towards harmonization. (Working Paper 15). Retrieved from: London: Department for International Development.

Bangdiwala, S., Fonn, S., Okoye, O., & Tollman, S. (2010). Workforce resources for health in developing countries. *Public Health Reviews, Vol. 32, No 1,* 296-318. Retrieved from http://publichealthreviews.eu/show/f/36

Bigsten, A. (2006). *Donor coordination and the uses of aid.* (Working Papers in Economics, No. 196). Retrieved from: Göteborg University, School of Business, Economics and Law website: https://gupea.ub.gu.se/bitstream/2077/2723/1/gunwpe0196.pdf

Brugha R. (2005). The Global Fund at three years – Flying in crowded air space. *Tropical Medicine and International Health, 10*(7), 623–626. doi: 10.1111/j.1365-3156.2005.01437.

Buse, K., & Walt, G., (1999). Aid coordination for health sector reform: A conceptual framework for analysis and assessment. *Health Policy, 38*(3), 173-187. doi: 10.1016/0168-8510(96)00855x

Buse, K., & Walt, G. (1997). An unruly melange? Coordinating External Resources to the Health Sector: A Review. *Social Science and Medicine, 45:* 449-65.

Cheelo, C., Jönsson, K., & Tomson, G. (2010). Stakeholders' perceptions of aid coordination implementation in the Zambian health sector. *PubMed, Health Policy, 95*(2-3), 122-128. doi: 10.10161j.healthpol.2009.11.010.Epub 2009 Dec.11

Cheelo, C., Jönsson, K., Sundewall, J., &Tomson, G. (2010). Stakeholder perceptions of aid coordination implementation in the Zambian health sector. *Health Policy, 95,*122 - 128*: Elsevier*. doi:10.1016/j.healthpol.2009.11.010

Che Tita, J. (2011). *The coordination of corporate social responsibility in Sub-Saharan Africa: The case of transnational corporations in Cameroon*. ProQuest Dissertations and Theses. (Order No. 3496904)

Cibulskis, R. E. & Hiawalyer, G. (2002). Information systems for health sector monitoring in Papua New Guinea. *Bulletin of the World Health Organization, 80*(9), 752-758. Retrieved from: http://www.search.proquest.com

Creswell, J.W. (2007). Qualitative inquiry & research design: Choosing among five approaches. (2nd ed.). Oaks, CA. SAGE Publications.

Creswell, J.W. (2009). Research Design: Qualitative, Quantitative, and Mixed Methods Approached (3rd. ed.). Oaks, CA. SAGE Publications.

Daniels, D., Onwukwe, I., & Khadduri, R. (2011). *Summary report on coordination and alignment in the Nigeria health sector.* Retrieved from: http://www.manniondaniels.com/wp-content/upLoads/2011/10/MD-Summary_coordination_report_13_April1.pdf

Department for International Development. (2012). *Operational Plan 2011-2015, DFID Nigeria.* Retrieved from: http://www.gov.uk/government/world/nigeria

Department for International Development. (2013). *Summary of DFID's work in Nigeria 2011-2015.* Retrieved from: http://www.gov.uk/government/world/nigeria

El-Gohary, N.M., Osman, H., & El-Diraby, T.E. (2006). Stakeholders Management for Public Private Partnerships. *Science Direct, International Journal of Project Management. 24*(2006), 595-604.

Federal Ministry of Health. (2010). *The National Strategic Health Development Plan (2010-2015), Abuja, Nigeria*. Retrieved from: http://www.health.gov.ng/doc/NSHDP.pdf

Federal Ministry of Health. (2004). *Revised National Health Policy.* Retrieved from: http://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf

Fleisher, L.K., Gottret, P., & Leive, A.A., Schieber, G.J. (2007). Financing global health; Mission unaccomplished. *Health Affairs, 26*(4), 921-934. doi: 10.1377/hlthaff.26.4.921.

Fraser, A. &Whitfield, L. (2009). Introduction: Aid and sovereignty. In: Whitfield, L. & Fraser, A. (eds). The Politics of Aid: African Strategies for Dealing with Donors. Oxford, Oxford University Press, 1–26.

Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. *American Journal of Evaluation 2006; 27,* 383. doi: 10.1177/1098214006290356

Gabhard, N., Kitterman, K., Mitchell, A.A., Nielson, D., & Wilson, S. (2008). Healthy aid? Preliminary result on health aid effectiveness. *The Annual Meeting of American Political Science Association.* Boston, Massachusetts, Brigham Young University.

Garner, P. (1995). Is aid to developing countries hitting the spot? *British Medical Journal, 311*(6997), 72–73. doi*: http://dx.doi.org/10.1136/bmj.311.6997.72*

Global Fund (2004). *The Global Fund to Fight AIDS, Tuberculosis and Malaria – Partnership Strategy.* Retrieved from: http://www.theglobalfund.org/documents/board/20/GF-BM20-04_Report_of_Policy_and_Strategy_Committee.pdf

Global Health. (2008). *Resource requirements for human resources for health in Mozambique*: *Workforce Alliance and Results for Development Institute*. Retrieved from: http://www.resultsfordevelopment.org/focus-areas/global-health-workforce-alliance

Gupta, M.D, Gauri, V., & Khemari, S. (2003). Decentralized delivery of primary health services in Nigeria: Survey evidence from the states of Lagos and Kogi states. *The World Bank Developed Research Group.* Retrieved from: www.worldbank.org/publicsector

Gupta, S., Verhoeven, M., &Tiongson E. (2003). Public spending on health care and the poor. *Health Economics, 12,* 685-696. doi: 10.1002/hec.759

Halonen-Akatwijuka, M. (2005). Coordination Failure in Foreign Aid. *The B.E. Journal of Economic Analysis & Policy, De Gruyter, 7*(1), 1-40. Retrieved from: https://ideas.repec.org/p/wbk/wbrwps/3223.html

Hansen, H. & Tarp, F. (2000). Aid effectiveness disputed. *Journal of International Development, 12*(3), 375–398. doi: 10.1002/(SICI)1099-1328(200004)12:3<375::AID-JID657>3.0.CO;2-M

Hansen, H. &Tarp, F. (2001). Aid and growth regressions. *Journal of Development Economic, 64*(2), 547–70. Retrieved from: https://www.nottingham.ac.uk/credit/documents/papers/00-07.pdf

Hill, P.S., Dodd, R., Brown, S., & Haffeld, J. (2012). Development corporation for health: Reviewing a dynamic concept in a complex global aid environment. *Global Health, 2012, 8,* 5. doi: 10.1186/1744-8603-8-5

Hyde´n, G. (2008). After the Paris Declaration: Taking on the issue of power. *Development Policy Review 26*(3), 259–274. doi: 10.1111/j.1467-7679.2008.00410.x

Kujenya, J. (2009). *Trouble national health insurance scheme*. *National health insurance scheme*. Retrieved from: http://www.nigeriafirst.org

Lawanson, A.O. (2014). Health care financing in Nigeria: National health accounts perspective. *Asian Journal of Humanities and Social Studies, 2,* 2, *(ISSN: 2321 – 2799).*

Lawanson, A. O. (2010). Health Care Financing in Africa: What Does NHA Estimates Do Reveal about the Distribution of Financial Burden?. *Journal of Medicine and Medical Sciences, 4*(4), 155-166. Retrieved from: http://interesjournals.org/JMMS/Pdf/2013/April/Lawanson.pdf

Lawson, M.L. (2013). *Foreign aid: International donor coordination of development assistance.* Congress Research Service. Retrieved from: http://www.fas.org

Lincoln, Y. S. & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Longoria, R.A. (2005). Is inter-organizational collaboration always a good thing? *Journal of Sociology and Social Welfare, 32*(3), 123-138. Retrieved from: https://questia.com/library/journal/1G1-135842523/pdf

MacQueen, KM., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for team-based qualitative research. *Cultural Anthropology Methods Journal, 10(2),* 31-36. Retrieved from: http://cdc.gov/hiv/pdf/library_software_answr_codebook.pdf

Miles, M. B., & Huberman, A. M., (1994). Qualitative data analysis: An expanded source-book (2nd ed.). Thousand Oaks, CA: Sage.

National Planning Commission, (2010). *A Review of Official Development Assistance to Nigeria (1999-2007).*

Olaniyan, O., & Lawanson, A. (2010) Health Expenditure and Health Status in Northern and Southern Nigeria: A Comparative Analysis Using NHA Framework. *Paper presented at the 2010 CSAE conference held at St Catherine College, University of Oxford*, Oxford, UK. Available online at www.csae.ox.ac.uk/conferences/2010-EDiA/.../451-Lawanson

Lawanson, A. O, Olaniyan, O. (2009). Health expenditure and Health Status in Northern and Southern Nigeria: A comparative analysis using National Health Account Framework. *Afr J Health Econ 2009*(2), 31-46.

Maxwell, J.A. (2013). Qualitative Research Design: An Interactive Approach (3rd ed.). Los Angeles, CA. SAGE Publications.

Olise, P. (2007). Primary health care for sustainable development. Abuja: Ozege Publications.

OECD. (2003a). *Harmonizing donor practices for effective aid delivery: Good practice papers,(1)*. Retrieved from: http://www.oecd.org/dac/harmonisingpractices.

OECD. (2003b). *Rome declaration on harmonization. Rome, Italy*. Retrieved from: https://www.AidHarmonization.org.

OECD. (2005a). *Managing Aid: Practices of DAC Member Countries*. Organization for Economic Co-operation and Development-Development Assistance Committee. Retrieved from: http://www.oecd.org\dac\.

OECD. (2005b). *Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability. Paris*. Retrieved from: http://www.oecd.org.

OECD. (2007). *Statistical annex of the 2006 development co-operation report: organization for economic co-operation and development, development co-operation directorate.* Retrieved from: https:// www.oecd.org/dac/

OECD. (2008). survey on monitoring the Paris Declaration effective aid by 2010? What will it take: Overview. *2008*(1), 27–29.Retrieved from: http://www.oecd.org/development/monitoring/pdf

OECD. (2009). *The Paris Declaration on aid effectiveness and the Accra Agenda for action.* Retrieved from: http://www.oecd.org/development/ effectiveness/34428351.pdf.

OECD. (2011). *The Busan partnership for effective development cooperation*. Retrieved from: http://www.oecd.org

Patton, M. Q. (2001). Qualitative evaluation and research methods (3rd ed.). Thousand Oaks, CA: Sage.

Patton, M. Q. (2002). Qualitative Research and Evaluation Methods (3rd ed.). Thousand Oaks, CA: Sage.

Pereira, J & Villota, C. (2012). *Hitting the target? Evaluating the effectiveness of result-based approaches to aid.* Retrieved from: European Network on Debt and Development website: http://www.oecd.org/dac/peer-reviews/Hitting-the-target.pdf

Rahman, M.A. (1968) 'Foreign capital and domestic savings: A test of Haavelmo's hypothesis with cross country data. *Review of Economics and Statistics, 30*(1), 137–38.

Stake, R. E. (1995). The art of case study research. Thousand Oaks, CA: Sage.

Starfield, B. 1994. Is primary care essential? *Science Direct 2*(8930), 1129-1133. doi: 10.1016/S014-67366(94)90634-3

Soyibo. A. (2004). *National Health Accounts of Nigeria, 1998-2002*. Retrieved from: World Health Organization

Soyibo, A., Olaniyan, O., & Lawanson, A. (2009) *A situational analysis of the Nigerian Health Sector. Management Education Research Consortium.* Washington DC.

Steinwand, M. C. (2010). *The Political Economy of Foreign Aid.* Retrieved from: ProQuest Dissertations and Theses Database (Order No. 3410583).

Stern, E.D., (Altinger, L., (cond.) Feinstein, O., Marañón, M., Schultz, N., & Nielsen, N.S). (2008). *Thematic study on the Paris Declaration, aid effectiveness and development effectiveness*. Retrieved from: http:///www.oecd.org/dac/evaluationnetwork

Sundberg, M. & Gelb, A. (2007). *Making aid work: the end of the cold war and progress toward a new aid architecture should make aid more effective.* Retrieved from: World Bank: International Bank for Reconstruction and Development.

UNICEF. (2009). *Tracking progress on child and maternal nutrition*. (ISBN: 978-92-806-4482-1). Retrieved from: http://www.unicef.org/publications/index_51656.html

Walt, G., Parignani, E., Gilson, L., & Buse, K. (1999). Health sector development: From aid coordination to resource management. *Health Policy Plan, 14*(3), 207-18.

Weisskopf, T. E. (1972). An econometric test of alternative constraints on the growth of underdeveloped countries. *Review of Economics and Statistics, 54,* 67–78.

Welsh, E. (2002). Dealing with data: using NVivo in the qualitative data analysis process forum. *Qualitative Social Research, 3* (2*)*. Retrieved from http://search.proquest.com/docview/867759998?accountid=14872

Wiltshier, F. (2011). Researching with NVivo forum. *Qualitative Social Research, 12(1).* Retrieved from http://search.proquest.com/docview/870465599?accountid=14872

Wood, B. (Eds. Kabell, D., Muwanga, N., Sagasti, F.). Evaluation of the Implementation of the Paris Declaration, Phase One Synthesis Report. Ministry of Foreign Affairs of Denmark, July 2008, p. 21.

Woods, L. (2002). Qualitative Data Analysis--Explorations with NVivo. *Nurse Researcher, 9*(4), 86. Retrieved from: http://search.proquest.com/docview/200770158?accountid=14872

World Bank. (2009). *World Bank Annual Report, 2009.* Washington, DC.

World Bank. (2012). *World development indicators 2012.* Washington, DC.

World Bank. (2013). health expenditure per capita. Retrieved From: http://data.worldbank.org/indicator/SH.XPD.PCAP

World Health Organization. (2000). *Nigerian Health System Report.* Retrieved from: www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf

World Health Organization. (2013). *WHO Country Cooperation Strategy: Nigeria 2008-2013. Brazzaville, WHO Regional office for Africa*. Retrieved from: http://www.who.int/countryfocus/cooperation_strategy/ccs_nga_en.pdf

World Health Organization-United Nations Children Fund (WHO-UNICEF) (1978). *Declaration of Alma Ata*. Retrieved from: http://www.unicef.org/about/history/files/Alma_Ata_conference_1978_report.pdf

Yin, R. K. (1994). Case study research: Design and methods (2nd ed.). Thousand Oaks, CA: Sage.

Curriculum Vitea

Ifeoma Edna Uduji Ph.D.

Primary Health Care Systems Development +234(0)806 0586 999
National Primary Health Care Development Agency (NPHCDA)
FCT, Abuja, Nigeria **senoritaifeoma@gmail.com**

ACADEMIC QUALIFICATION

PhD in Health Sciences, Public Health Policy June, 2016
Walden University, Minneapolis, United States

MSc in Pharmaceutical Chemistry; 2008
University of Lagos, Nigeria

BSc in Pure and Industrial Chemistry; 2005
Nnamdi Azikiwe University, Awka

PROFESSIONAL EXPERIENCE

Zonal Technical Officer/Data and Surveillance Officer April, 2014 – Present
National Primary Health Care Development Agency (NPHCDA), Federal Ministry of Health, Nigeria

- Work with donors, the State Director, Primary Healthcare, and local immunization officers to improve the immunization coverage in Enugu State during the Routine Immunization (RI) in 2015.
- Work with the donors, state and local government representatives to effectively plan for primary healthcare activities by collating and analyzing data generated from monthly Routine Immunization (RI) and Integrated Disease Surveillance Report (IDSR).
- Ensures routine immunization and state immunization activities data from the State and LGAs are properly recorded in the District Health Information Software (DHIS).
- Conducts supportive supervision at the LGA to ensure adequate record keeping of RIs, SIAs and other health activities.
- Facilitate micro-planning training for the National Immunization Plus Days (NIPDs) and for RIs.

- Ensure the vaccines are adequately distributed to the local government during NIPDs and RIs

- Collaborate with donors and implementing partners to facilitate community mobilization training and retraining programs for the Local Immunization Officers, Disease and Surveillance Notification Officers at state and Local Government Level.

- Co-work, facilitate, and monitor distribution and utilization of materials provided by the agency and other donors to state and LGA of assignment and ensured increased access to quality primary healthcare delivery.

- Ensure that all cases are of AEFIs are line-listed and serious cases reported and adequately followed up.

- Monitor the routine immunization at State and LGA levels to ensure adequate coverage of target population.

Scientific Officer/Monitoring and Evaluation Officer; 2011 to 2014
National Institute for Pharmaceutical Research and Development (NIPRD), Federal Ministry of Health, Nigeria.

- Developed the Monitoring and Evaluation (M&E) Policy that ensured effectiveness and efficiency of the M & E of the Institute's mandate and objectives.

- Worked across a broad spectrum of responsibilities in sponsored and partnership projects in the Institute, including health projects like ANDI, Procurement, Installation, Service, Maintenance and Use of Scientific Equipment (PRISM), STEP-B, and administration.

- Organized and collaborated with Enhancing Nigerian Advocacy for a Better Business Environment (ENABLE) and successfully held Nigeria Pharmaceutical Research and Industry Business Summit to set the stage to eliminate limits on interaction and to create a sustainable platform for dialogue, networking and strategic partnerships.

- Worked with all the heads of department to produce the Institute's biannual report as one of the feedback mechanisms relevant to the implementation of the Institute's strategic plan.

- Worked with IT department to develop a frame work/data base for the effective documentation of the institute's project report, data, activities, publications, staff profile, collaboration, etc. for effective referral systems.

- Co-worked and coordinated technical evaluation of STEP-B bid and awarded contract.

Assistant Technical Manager July, 2010 to June, 2011
Quality Control Officer (In-Process) November, 2009 to June, 2010
Bio-Organics Nutrient Systems Limited, Nigeria.

- Initiated and established corporate working relationship between Bio-Organics Nutrient Systems and Nigerian Expanded Export Program (NEEP); a USAIDS sponsored program, designed to expand our market within ECOWAS region.

- Conducted a market research analysis with the Marketing Manager in Ghana. Analyzed Ghana market vis-à-vis Nigerian Market and suggested appropriate strategies for our product penetration in the Ghana market.

- Developed a quality assurance and management procedure used to improve quality production processes in line with Hazard Analysis and Critical Control System (HACCP) plan. Member of 6-member food safety management team fostering the acquisition and integration of the food safety certification.

- A member of 6-member food safety management team that orchestrated the integration of systems, and operations following the certification of Bio-Organics by Global Alliance for Improved Nutrition (GAIN) and Food Safety Management System. We engaged in continuous assessment, process mapping and internal auditing of the system to ensure quality assurance.

- Member of the management team that developed and initiated strategies, and achieved organizational objectives. Supervised a team of 10 and achieved quality production and implementation processes.

Administration Executive Assistant April 2007 – November.2007
Geometric Power Limited, Nigeria.

- Responded to complex enquiries for information from public and district staff, providing technical support and referring to staff where appropriate.

- Prepared the presentation materials, coordinated and launched campaigns to consultants.

- Communicated and handled incoming and outgoing electronic communications.

Assistant Program Officer (NYSC) March, 2006 – February, 2007
Pipeline and Products Marketing Company/ Nigerian National Petroleum Corporation (NNPC)

- Ensured prompt programming, bunkering, loading and off-loading of petrol vessels.

- Ensured adequate distribution of petroleum product to the major oil marketers.

- Ensured adequate retail distribution of the petroleum products.

RESEARCH

- Donor Coordination in Health Sector: A Critical Step to Health Aid Effectiveness in Nigeria. (Ph.D. Dissertation Research; on-going).

- Hypoglycaemic Effect of the Aqueous Extract of the Leaves of Allanblackia Floribunda Oliv. (Guttiferae). (MSc Thesis Research).

Previously served on corporate committee/team

- Planning, Monitoring and Evaluation Committee
- Research and Ethics Committee
- Website Content Management Committee
- Process Mapping and Internal Auditing Team
- Food Safety Management team

CERTIFICATION COURSES AND TRAININGS

Global Health e-Learning Center (USAID) Certificate course

- Monitoring and Evaluation Fundamentals
- HIV Basics (Part 1)
- Malaria

Family Health International e-Learning Training Certificate Course

- Research Ethics Curriculum

ISO9001 Certification

World Health Organization Training /Workshop

- Training of Independent Supervisors on Micro Planning –National Immunization plus Days – State Level
- Training of Independent Monitors on Micro Planning –National Immunization plus Days – State Level
- Injection Safety and Waste Management (Training of the Trainer, TOT)
- Mastering Essential Management Skills
- Advance Effect Following Immunization (TOT)
- Clinical Sensitization on CSM Based Surveillance (TOT)
- Midwives Life Saving Skill Training (TOT)

COMMUNITY SERVICE

World Health Organization (WHO)
Position- Volunteer; Independent Supervisor **2009**

World Health Organization (WHO)
Position – Volunteer; Independent Monitor **2008**