An Appraisal of Healthcare Donor Supports and Nigerian National Development

By

Shidali Nasiru; PhD
Department of Political Science & International Relations
University of Abuja, Abuja
Email: nshidali@gmail.com
&
Maiye B. Olusegun
Department of Political Science & International Relations
University of Abuja, Abuja
Email: olusegunb.maiye@gmail.com

Abstract

This study examined donor agencies and national development with special reference to the health sector. It is premised on the fact that healthcare is key to national productivity of the country as the people remain the most important drivers of development in every society. Malaria, poliomyelitis and HIV/AIDS endemics have reduced the labour force, power and outputs in Nigeria both in terms of quantity and quality. Billions of dollars have found its way to the Nigerian economy from developed countries in form of aid to the health sector through the various health intervention programmes. Marx's Labour Theory of Value has been adopted as the theoretical framework for the study which, premise on the place of labour in the development process of a state. A combination of primary and secondary data sources were used to extract the relevant information for this study with the instrumentality of questionnaire deployed for the primary data collection. It therefore concludes that the huge amount of monies that have been used to intervene at various points by donors in the Nigerian health sector have not commensurately result into the development of the country, especially the health care delivery system. Based on the assumption that donors' presence in the health sector is to help achieve a healthy Nigeria, it is however emphatic to say that donor interventions have no intention to develop the quality of labour outputs in Nigeria that would guarantee national development. It recommends among other thing that there is urgent need for a more robust national health plan that is locally driven and geared towards the development of community health delivery. More so, proper donor coordination and alignment should be ensured and the governments at all levels should take primary healthcare delivery as priorities so that Nigerians can be healthier and more productive.

Keywords: Development, Donors, Interventions, Surplus Value, Healthcare

Introduction

The place of labour in the production process cannot be over emphasized as human efforts are harnessed by human beings to covert natural resources into valuable goods and services. The health status of the nation's workforce impacts their contributions to national development. Health is indeed wealth because only a healthy spirit, body and soul can create and add value. Health is a fundamental driver of economic growth and development. In economic parlance, it is believed that health and education are the two important factors for human capital development and have been demonstrated to be the basis of an individual's economics productivity. As with economic well being of individual households, good health is a critical input into poverty reduction, economic development at the scale of whole society (Sachs, 2001).

As declared in the WHO constitution adopted in 1948, health is a state of complete physical, mental and social well being and not merely the absence of disease or infinity. Health is wealth goes the popular saying and therefore in every country, the health sector is critical to social and economic development, with ample evidence linking productivity to quality of health care. Economic development occurs when it has a trickle-down effect on the poor masses by enjoying all the basic necessities of life which are all embodied in having good health. In Nigeria, the vision of becoming one of the leading 20 economies of the world by the year 2020 is closely tied to the development of its capital through the health sector (Osotimehin, 2009).

It is posited that, given poor health infrastructure, illness and disease shorten the working lives of people, thereby reducing their lifetime earnings. Strauss and Thomas (1998) and Schultz (1999) suggested that good health has positive effects on the learning abilities of children, which leads to better educational outcomes, school completion rates, higher mean years of schooling, achievements and increases the efficiency of human capital formation by individuals and households. Report of the Global Thematic Consultation on Health (2013) pointed out that "health is both a driver and a beneficiary to economic growth and development and a key indicator of what people-centered, right-based, inclusive and equitable development seek to achieve. Ill health affects productivity, and therefore, reduces

incomes and also tends to wipe away savings and diminish ability to invest, because healthy nations are likely to attract larger amount of foreign direct investment, since investors avoid environment where labour force are likely to be weakened by heavy disease burden and where access to health care is limited (Alsan, Bloom & Cannin, 2006).

However, the context of health is rapidly changing. In advanced countries, health care systems are deemed financially unstable, while in emerging economies like Nigeria they are still being shaped. These systemic changes result from the government pressure to contain the cost of health care delivery. These costs have increased due to the growing number of ageing population and sophisticated technological advancement in medicine (in developed countries) and high unemployment rate, population explosion and poor accountability in third world countries like Nigeria. Concerns for affordability of health care are rife and there is a need to operate the health system in a more efficient manner. Nigeria is faced with the challenge of ineffective use of past opportunities to develop a vibrant and sustainable health care delivery; so the future of health care remains uncertain. That is not to say that the government is not doing anything. Nigeria has made significant improvements in its health sector in recent years, but still faces sizable challenges. For instance, the total fertility rate is 5.7 children per woman, the mortality rate of children under 5 years old is estimated at 157 per 1,000 live births, and the total contraceptive use (any method, among married women) is at 14.6 percent while modern contraceptive methods have a 9.7-percent prevalence rate, adult HIV prevalence is estimated at 5 percent, and immunization rates are low, with only 23 percent of children receiving all of their recommended vaccinations (National Population Commission and ICF Macro, 2008). Nigeria's economic and geographic health discrepancies are pronounced, with poorer households receiving far less medical care than the relatively wealthy, and Northern regions lagging far behind Southern states with respect to many health indicators (National Population Commission and ICF Macro, 2008).

Health care development aid in Nigeria is linked directly to addressing health issues in the country. According to WHO (2000), Nigeria has 10% of global disease burden due to high disease burdens and its relative large population on the African continent (National Strategic Health Development Plan NSHDP, 2010). The health indicators in Nigeria have remained below country targets and internationally set benchmarks (National Strategic Health Development Plan, 2010). The Federal Ministry of Health in recognition of the health developmental challenges has made efforts to improve access to health care in Nigeria. This is to show that the health sector of the country is not one that is totally relying on donors.

In addition to the NHIS, donors and development partners, such as United Nations Children Fund (UNICEF), United Kingdom's Department for International Development (DFID), World Health Organization (WHO), United States Agency for International Development (USAID), Global Funds, Gavi Alliance, Canadian International Development Agency (CIDA), and Partnership for Transforming Health System in Nigeria

(PATH 2) among others, 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 $6billion 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 focuses on general donor supports for the Nigerian health sector vis-à-vis national development in the fourth republic.

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 ($1.2billion) 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).

At a broader level, the National Health Bill which was first proposed in 2006 to improve its poor health sector by allocating at least 2 percent of the federal government's revenue to the health sector is still not signed into law. Nigerians die daily of preventable diseases like malaria and HIV/AIDS, while several others have been rendered physically incapacitated by poliomyelitis thereby affecting the working population of the Nigerian state. Since the health status of a people affects their contributions to the national economic development, it is expedient to note the surge in the number of donors to the Nigerian health sector. How their donations have helped the sector and by extension, impacted national development is worthy of intellectual examination.

Objectives of the Study

This study intends to achieve the following objectives:

i. To examine the current state of the Nigerian health sector in the face of donor agencies
ii. To identify the political economy of donor interventions in the Nigerian health sector
iii. To ascertain the extent to which the Nigerian health sector donor interventions have aided national development

iv. To identify measures that could help enhance donor interventions in the health sector.

Methodology

This is a case study research paper and it covered the entire gamut of Nigerian health sector in its broader scope. However, special focus was placed on the donor agencies in the sector that have assisted the country in fighting the three healthcare programmes of malaria, poliomyelitis and HIV/AIDS. These donors include World Bank, Japan International Cooperation Agency (JICA), Department for International Development (DFID), The Global Health Fund, United States Agency for International Development (USAID), United States Centers for Disease Control and Prevention, Norwegian High Commission, Rotary International, United Nations Joint Programme of Support on HIV/AIDS in Nigeria, World Health Organization (WHO), CIDA, UNFPA, UNICEF, EU among others. The above are in addition to the donor unit of the Federal Ministry of Health (FMoH) and National Agency for the Control of AIDS (NACA).

The population sampled for this study is made up of relevant of members of staff of donor agencies that are involved in the three health programmes of HIV/AIDS, Polio and Malaria. This did not in any way mean that other health challenges like maternal health, tuberculosis, etc. particularly, the sampled population was 200 (two hundred) covering all the major stakeholders in the donor segment of the Nigerian health sector and national development. The respondents were found in the Federal Ministry of Health (FMoH), National Agency for the Control of AIDS (NACA), USAID, DFiD, GHF and WHO. The collected data were presented using simple percentage tables and charts to give in clear terms the reliability and coherence nature of the answers from the respondents. Researcher's interpretations of responses also helped in the data analysis exercise.

Literature Review

Nigerian Health Care Situation

Nigeria is the most populated country in Africa with the population of about 205 million (as extrapolated from the last census conducted by the Census Board in 2006 and based on the growth rate). 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, Fonn, Okoye, & Tollman, 2010 & Alenoghena, Aigbiremolen, Abejegah & Eboreime, 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 (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, Verhoeven, &Tiongson, 2003).

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 Sector

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

Donor Agencies and Nigeria's Health Sector Development

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.

The level of donor coordination is difficult the measure. 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.

Development

Several attempts have been made by many scholars to give development definitional attention based on their state of existence, such as political, economic, social, cultural, technological, religious, gender and educational perspectives. On that note, Henry (cited in Nwaorgu, 2006) pointed out most emphatically that the word development delineates a vast arena but does not specify what play as being enacted. This is due to the imprecision of the concept and the difficulty of its measurement as a socio-economic phenomenon. However, Heninecke cited in Nwaorgu (2006) held that despite the complex nature of development, social scientist have been able to identify, describe and analyze development, as well as conceptualise developments.

In Africa the idea really started coming into vogue after the early 1960s when many African countries had become politically independent and it would appear that this change occurred on account of the initiative of the Western world to redefine its relationship with the former colonies in the light of new realities. First, the categories; developed and

underdeveloped countries were used in the place of the old partnership of the colonial days expressed in the "Dual Mandate" a new partnership in development was proposed (Ake, 1981).

To Nnadozie (2004), man is viewed as both the subject and object of development. Development is taken as the ability and capacity of man to adequately interact with his physical environment and other individuals to constantly improve himself and humanity. This idea is captured very well by Nnoli cited in Nnadozie (2004: 11) when he stated;

> Development, first and foremost, is a phenomenon associated with changes in man's humanity and creative energies, not in things. It is the unending improvement in the capacity of the individual and society to control and manipulate the forces of nature as well as themselves and other individuals and societies for their own benefit and that of humanity as large. It is a process of actualizing man's inherent capacity to live a better and more rewarding life. It implies increasing skill and capacity to do things, greater freedom, and responsibility and material well-being.

According to Lenin (1970), it is ascension from a primitive or agrarian stage of reality to a more complex and heterogeneous stage. Some scholars view development to mean the same thing as economic growth which includes availability of social amenities such as adequate water supply, electricity, and so on requires for the sustenance of lives.

Thirlwall (2003) explains development to mean socio-cultural, political, economic, and the spiritual well being of a society. He further stated that in a developed state there is assurance of good quality of life, exercise of all human right enhanced quality of all human right enhanced quality of the equity and justice, as it takes into consideration the wellbeing, growth and advancement of individual with the society.

Development according to Ake (1981) is the process by which people create and recreate themselves and their life circumstance to realize higher level of civilization in accordance with their own choice and values from this context development can be a multi-dimensional process involving major societal changes in terms of social structures, attitudes, as well as the acceleration of economic growth, and reduction of inequality and eradication of extreme poverty. Rodney (1981) sees development from the point of view of the individuals in terms of skills acquisition and personal development, increased capacity, creativity, greater freedom, self-discipline, responsibility, and material wellbeing.

At the societal level, development entails the ability of man to take his destiny in his own hands. Therefore, development means an overall social process which is dependent upon the out-come of man's effort to subdue his physical and natural environment. Conversely, development at whatever level of analysis precludes unequal relations and contact between the forces of capital and peripheral nation-states. This is the result of dependency in the third world. Development is according to Rodney (1981), the ability of a man to conquer his environment and to utilize its resources to his own advantage.

Development is seen as a social and dynamic process the goal of which is sustained change. The process does not necessarily entail evolution or gradualism, nor does it abhor violence. In fact, according to radical scholars, development as a dialectical process is anti-convention and more often than not involves struggles, violent upheavals and radical changes. Accordingly, development is conceived as the ability of the people to exploit, manipulates and control their physical environment, as well as themselves and other individuals outside of themselves for the betterment of everybody and that of humanity. It abhors any form of exploitation of man by man. It also entails the constant improvement in this capacity and ability of the people including the unending increase in their political, social, economic, cultural, psychological and technological capacity and awareness, among other things, to actualize themselves individually and collectively. It is therefore worthy to conceive development as the ability of a people effort to put the entire resources of a society to its full utilization. Safe as the above conceptions may sound, it is apt to say that development if the ability of a group or society to fully explore and exploit the environments through the active labour force for the betterment of all.

Theoretical Framework

As a scientific adventure, the labour theory of value located within the broad spectrum of the Marxist theory of political economy becomes handy. As a political economist, Marx is generally situated in the continuity of the great classical school of Adam Smith and David Ricardo. He obviously owes a lot to Ricardo, and conducts a running dialogue with that master in most of his mature political economic writings. Marx inherited the labour theory of value from the classical political economy school. Here the continuity is even more pronounced; but there is also a radical break, For Ricardo, labour is essentially a numeraire, which enables a common computation of labour and capital as basic elements of production costs. For Marx, labour is value. Value is nothing but that fragment of the total labour potential existing in a given society in a certain period say a year or month which is used for the output of a given commodity, at the average social productivity of labour existing then and there, divided by the total number of these commodities produced and expressed in hours (or minutes), days, weeks, months of labour (Sik, 1991).

This does not imply that Marx's concept of value is in any way completely detached from consumption. It only means that the feedback of consumers' behaviour and wishes upon value is always mediated through changes in the allocation of labour inputs in production, labour being seen as subdivided into living labour and dead (outdated) labour, i.e. tools and raw materials. The market emits signals to which the producing units react (Mcllelan, 2007).

The 'law of value' is but Marx's version of Adam Smith's 'invisible hand'. In a society dominated by private labour, private producers and private ownership of productive inputs, it is this 'law of value', an objective economic law operating behind the backs of all people, all 'agents' involved in production and consumption, which, in the final analysis, regulates the economy, determines what is produced and how it is produced (and therefore also what can be consumed). The 'law of value' regulates the exchange between commodities, according to the quantities of socially necessary abstract labour they embody (the quantity of such labour spent in their production). Through regulating the exchange between commodities, the 'law of value' also regulates, after some interval, the distribution of society's labour potential and of society's non-living productive resources between different branches of production. Again, the analogy with Smith's 'invisible hand' is striking (Collins, 1993).

Marx's critique of the 'invisible hand' concept does not dwell essentially on the analysis of how a market economy actually operates. It would above all insist that this operation is not eternal, not imminent in 'human nature', but created by specific historical circumstances, a product of a special way of social organisation, and due to disappear at some stage of historical evolution as it appeared during a previous stage (Carver, 1991). And it would also stress that this 'invisible hand' leads neither to the maximum of economic growth nor to the optimum of human wellbeing for the greatest number of individuals, i.e. it would stress the heavy economic and social price humankind had to pay, and is still currently paying, for the undeniable progress the market economy produced at a given stage of historical evolution.

The formula 'quantities of abstract human labour' refers to labour seen strictly as a fraction of the total labour potential of a given society at a given time, say a labour potential of 2 billion hours a year (1 million potential producers, each supposedly capable of working 2000 hours a year). It therefore implies making an abstraction of the specific trade or occupation of a given male or female producer, the product of a day's work of a weaver not being worth less or more than that of a peasant, a miner, a house-builder, a milliner or a seamstress. At the basis of that concept of 'abstract human labour' lies a social condition,

a specific set of social relations of production, in which small independent producers are essentially equal. Without that equality, social division of labour, and therefore satisfaction of basic consumers' needs, would be seriously endangered under that specific organisational set-up of the economy. Such equality between small commodity owners and producers is later transformed into equality between owners of capital under the capitalist mode of production (Mcllelan, 2007).

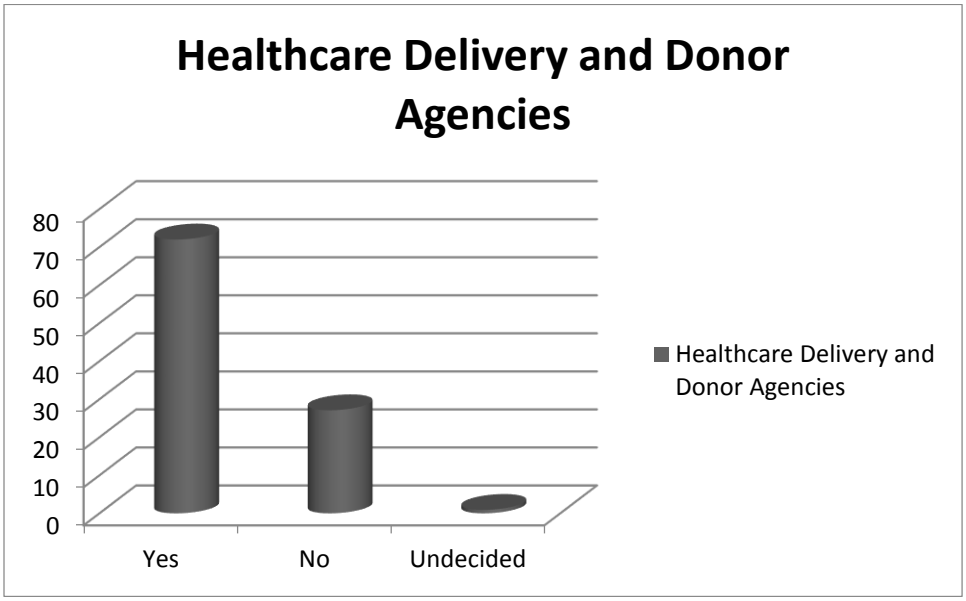
The sum total of value produced in a given country during a given span of time (e.g. one year) is determined by the sum total of labour-inputs. Competition and movements of capital cannot change that quantity, the sum total of values equals the sum total of 'prices of production'. The only effect of capital competition and capital mobility is to redistribute that given sum and this through a redistribution of surplus value between different capitals, to the benefit of some and at the expense of others.

From the foregoing, it is obvious that the place of human resources in the development process of every society cannot be underestimated. It is the human capabilities that create values out of both the renewable and non-renewable resources available in the society. Aside every other motivation, the health conditions of a people are paramount to their inputs in the development process. When human beings are well and sound, the propensities of exerting more energies in the production process are very high. Even the qualities of outputs are also enhanced when both the animate and inanimate objects of production are in the right states of health.

The average Nigerian worker resumes work by 8:00AM everyday and closes by 4:00PM thereby investing an average of 1760hours into the production process in a year, safe the four-week annual leave. Labour inputs are enhanced by their health conditions as only a healthy being can be productive with all other factors remaining constant. Donor agencies are very much interested in the abundant human resources available in Nigeria that is the more reason why it has always become an obligation for them to intervene in health challenges facing the country at every point in time. With the high mobility rate of labour, the world powers wants a healthy Nigeria whose citizens can be better incorporated into the world labour utility for exploitation internally and/or externally.

Data Presentation

The data presented below summarized the opinions of respondents on healthcare donor supports and Nigeria's national development.



The Chart above reflects the opinions of respondents on whether donor agencies have helped improved healthcare delivery system in Nigeria within the period under review. The bulk of the respondents 77 of them, making up 72 percent of the respondents said YES, 29 (27.1%) said NO, while only 1 (0.9%) could not decide. The above makes it commendable, the negative impacts that donor agencies have had on the improvement of healthcare delivery in the country.

Discussion of Findings

No doubt that the opinions expressed by respondents have helped to fill the vacuum of the existing linkage between the donor interventions in the health sector and Nigerian national development. Based on the information received and dissected, the Nigerian government, through the Federal Ministry of Health and the donor agencies in Nigeria, developed some coordination platforms to ensure and support efforts to synergize activities of all development partners in Nigeria. This study found out that different donor forums and groups were formed for different health intervention programmes to ensure more impactful activities of development partners in the health sector within the period under review.

More so, the study revealed that the Country healthcare support 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 polio eradication programmes. This affirms the claims made by Global Fund, (2008). From the

study, there has been effort to ensure harmonization of all donations towards the support of the malaria, HIV/AIDs, and poliomyelitis programmes, but the Nigerian government did not own the process.

According to the study, there is no evidence of ownership of donations by the country, align its development activities with the activities of the donor agencies, 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 some of the donors' agendas. Some of the donors 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. Evidence showed that without effective harmonization of efforts, donor organizations would not achieve health development goals that would impact the general development of the country. 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.

Conclusion

It has been established that the development of the Nigerian state lies with the people of the country whose health and vitality must not be joked with. In line with Marx theory of value, the country's labour force is primary to her development. As one of the major recipients of the over $2billion of aids that have been transferred between the developed world and the continent of Africa, Nigeria's health sector has been the most intervened sector by donors in the country.

However, the country's citizens still die of preventable diseases and sicknesses due to negligence of the health sector by the government. Medical tourism eats a huge chunk of the national income as the elites in all spheres of the country travel outside the country for medical attentions on the slightest health challenges. Health aid remains the pillar on which the health sector rely on for survival as health sector budgetary provisions are meager, misallocated, misappropriated or/and misapplied. National health emergencies usually expose the trouble with the sector and by implication, Nigeria's development. While billions of dollars have come to the country's health sector as donor interventions, these has not really metamorphosed into development as malaria, poliomyelitis and HIV/AIDS still ravaged the people, shattered their health, reduce their productivity and affect the general development of the country.

Recommendations

Arising from the findings above, the study presents the following recommendations; there is urgent need to deliberately improve the healthcare infrastructures in the country by the government, especially. The federal government needs to come up with a pragmatic health plans that have the capacity to address both the current and future health challenges of the people. The sale of donor healthcare facilities like the insecticide treated nets, wheelchairs and antiretroviral drugs to Nigerians who ought to enjoy such free of charge needs to be put into proper check by arresting both the sales agents and their suppliers. There is the need for proper record keeping by the government of the citizens, to this end; the next National Census exercise must transparently accommodate the health needs of Nigerians. 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 programmes in the sector. Donors must be ready to release their donations to Nigeria with the trust that it will be judiciously utilized. This will address the culture of expatriates dominance of donor aid implementation in Nigeria. Since aligning donors and their interventions in the health sector development plan of the country, there is need for the creation of Donor Coordination and Alignment Unit (DCAU) in the Federal Ministry of Health (FMoF). The coordination mechanisms should be designed to integrate activities at the national, state, and local government levels, to ensure coordination at all levels. The successes recorded by Nigeria in Polio eradication need to be replicated in the fight against malaria and HIV/AIDS through intensive media awareness campaigns on disease prevention rather than current attention on disease control.

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