MATERNAL HEALTH CARE DELIVERY IN NORTHERN NIGERIA: AN ASSESSMENT OF ROTARY INTERNATIONAL'S INTERVENTION PROGRAMME (2000-2007)

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DECLARATION

I hereby declare that this dissertation entitled **MATERNAL HEALTH CARE DELIVERY IN NORTHERN NIGERIA: AN ASSESSMENT OF ROTARY INTERNATIONAL'S INTERVENTION PROGRAME (2000-2007)** is written by me, **John, Yemisi Ibiwunmi**, and it is the record of my research work in the Department of Public Administration under the supervision of Professor Adejo Odoh, Dr. Kola Obaitan and Dr. Haruna Yerima. The information derived from the literature has been duly acknowledged in the text and a list of references provided. The dissertation has not been presented for higher degree in any university.

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CERTIFICATION

This dissertation entitled: **MATERNAL HEALTH CARE DELIVERY IN NORTHERN NIGERIA: AN ASSESSMENT OF ROTARY INTERNATIONAL'S INTERVENTION PROGRAMME (2000-2007)** by **JOHN, YEMISI IBIWUNMI** meets regulations governing the award of the degree of Doctor of Philosophy (Public Administration) of the Ahmadu Bello University, Zaria and it is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This dissertation is dedicated to the Almighty God, the ever-present help in the time of trouble. My husband Professor Vincent Babatunde Ogunlela, for being a loving and caring husband in every way. And to the countless number of women out there, who are bearing the burdens of motherhood. I salute them all.

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ABSTRACT

Health is a basic human right that is vital to sustainable development, but this right appears to elude the majority of women, according to a 2003 World Bank Report. This is because as was reported by the United Nations Fund for Population Activities (UNFPA), "every minute, another woman dies in childbirth. In Nigeria, one in 13 women face a lifetime risk of maternal death while another estimated 2 million women are faced with other pregnancy-related diseases such as Fistula. Nigeria is only 2 percent of world's population but accounts for over 10 percent of the world's maternal deaths. This dismal situation informed a 1987 International Conference in Nairobi, Kenya, where nations all over the world made a commitment to reduce maternal mortality by taking measures to improve the health of mothers through the "Safe Motherhood Initiative". In spite of this, the problem did not abate. This led to the United Nations to include a 75 percent reduction in maternal mortality as one of its Millennium Development Goals (DMGs). In order to give support and supplement the efforts of governments in Nigeria, especially in the north, where maternal deaths were 1,549 per 100,000 as against that of 165 per 100,000 deaths in the southwest. Consequently, the Rotary International embarked on a maternal health project, which took place during 1995-2000 with a pilot Project in two Local Government Areas, and later scaled up to cover six States from year 2000 to 2007 (child spacing, Family health, and HIV/AIDS education). This study aimed to know the objectives of the Rotary Project, its strategies and outcomes. The two hypotheses were to test whether the Project contributes significantly to improvement of maternal health care service delivery; and whether the management structure of the Project contributed to its success. Data were gathered from both primary and secondary sources, which include interviews, questionnaires, Project documents and reports. Data from the six Project sites, namely, Adamawa, Jigawa, Kaduna, Kano, Katsina and Plateau States, were tested and they confirmed that the Project had contributed significantly to maternal health care service delivery in the states, and that the way the Project was organized and managed also contributed to its overall success. Findings revealed that strong advocacy and sensitization as well as involvement of Project host communities in the implementation of Project can further enhance its success and sustainability. Some of the weaknesses of the Project include the fact that Rotary allocated personnel, funds and other materials equally to the Project States, apart from Kano State, without giving due cognizance to the disparities in physical terrain, size and other peculiarities of each state. This affected the Project staff, especially the Liaison Field Workers (LFWs), such that they had to put in extra efforts in order to enhance the positive outcomes of the Project. Recommendations include, among others, that future projects should consider the peculiarities of each state while planning a project. Future research should also consider investigation into areas of finance and personnel management of Non-Governmental Organizations (NGOs) such as the Rotary International 3-H Project.

LIST OF ABBREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome

ANC – Antenatal Care

CHEW – Community Health Education Workers

CHO – Community Health Officers

CSOs – Civil Society Organizations

DFID – U.K. Department for International Development

EOC – Emergency Obstetric Care

FMOH – Federal Ministry of Health

HIV – Human Immunodeficiency Virus

IEC – Information Education and Communication.

L.D.C. – Less Developed Countries

MCH Coordinator – Maternal and Child Health Coordinator

MDG - Millennium Development Goal

N.P.C. – National Population Commission.

NEEDS – National Economic Empowerment and Development Strategy

NGOs – Non-Government Organisations

NYSC – National Youth Services Corp

PATHS – Partnership for transforming Health Systems

PHC – Primary Health Care

R.I. - Rotary International

R.I. 3-H Programme –Rotary International (Health, Hunger and Humanity) Programme

R.I. 3-H Project – Rotary International (Child Spacing, Family Health and HIV/AIDS Education)

RH Coordinator – Reproductive Health Coordinators

SDP – Service Delivery Point

SMOH – State Ministry of Health

SWAP – The Sector-Wide Approach to health development

TBAs – Traditional Birth Attendants

UNFPA – United nations Population Fund

UNICEF – United Nations Children Fund

USAID – United States Agency for International Development

USAID – United States Agency for International Development

WHO – World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Maternal Mortality or maternal death is defined as "the death of a woman while pregnant, or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to, aggravated by the pregnancy or its management, but not from accidental cause" (WHO, 1993).

The death of a mother is more than a personal tragedy; it represents an enormous cost to her nation, her community and her family. When a mother dies, her children lose their primary care giver, communities are denied her paid and unpaid labour and countries forego her contributions to economic and social development (Fathala, 1992).

An estimated 585,000 (over half million) mothers die each year from causes related to childbirth, ninety-nine percent (99%) of these in developing countries (Maine, 1987). In Nigeria, 1 in every 13 women face a lifetime risk of maternal death. Yet, most maternal deaths are preventable mainly through medical intervention and political will by the government (Shiffman and Okonofua, 2007).

Maternal mortality has received global attention. The reduction of maternal mortality is one of the Millennium Development Goals (MDGs), specifically, it is number five (5^{th} MDGs) of the MDGs. The target is to reduce it by 75% by the year 2015. The state of maternal and child health is one of the indicators of a

society's level of development, as well as an indicator of performance of the health care delivery system.

According to Goulet (1992:470), development is "a two-edged sword which brings benefits but also produces losses, and generates value conflicts. One of the benefits is the improvement in maternal well-being. But the gains or benefits of development will be felt differently according to factors such as: 'who are you' and 'where you live', among others" (Turner and Hume, 1997: 10). Development administration was created in the post-war period to play a major role in facilitating development through a system of bureaucracy. Bureaucracy has however been found to be affected by a number of issues such as: size of bureaucracy, poor administrative capacity, a nation's culture, bureaucratic bias against the rural poor, corruption, and issues of gender, to mention a few.

Maternal mortality is certainly a gender issue. Awareness to gender issues were brought to the fore in 1981, when the then UN Assistant Secretary General stated that women would not make full contribution to development 'until there were more women involved in the planning process, in the administration at all levels, and in all sectors'. And that this would increase women's participation in decision-making in public bureaucracies leading to "increase in overall productivity, to increase in public sector responsiveness to women's needs…" (Turner and Hume, 1997:97). One of the needs of women is certainly to live in good health, and for maternal mortality to be eliminated. But as Goetz (1992: 6) has argued, "public administration is in itself a gendered and gendering process,

such that the outcomes, internal organization and culture reflect and promote the interests of men. And so long as researchers treat men as the norm, the medical care of women continues to be compromised"(Women's Global Network for Reproductive Rights, 1994, 4: 27-28). Since constraints on public sector spending obviously affect both sexes, but in conditions of poverty, it is usually women who face the greatest problem in acquiring adequate health care (Ibid). And it is in the poorest parts of the world that women's lack of access to health care is at its most acute (Jacobson, 1993; Timyan, Measham and Ogunleye, 1993).

Health, a basic human right, that is vital to sustainable development, eludes the majority of women (World Bank Report, 2003). Harmful cultural practices perpetuated on women and girls… particularly during pregnancy; certain birthing practices … result in the mitigation of their health or their quality of life (Dawitt, 1994).

In a community-based study of women who delivered and are resident in northern Nigeria, it was reported that home delivery was still the norm throughout the zone, with 1791 (85.3%) deliveries at home; and that up to 80.5% of the deliveries were supervised by personnel with no verifiable training in sanitary birthing techniques (Galadanchi, Ejembi, Iliyasu, Alagh and Umar, 2007). They therefore concluded that "maternal health care as evidenced above is far from the ideal, and likewise, the achievement of the 5th Millennium Development goal is totally far-reaching; to reduce the maternal mortality ratio by 75% by the year 2015 with this level of maternal care (ibid:448).

The challenge of development according to the world Bank in its 1991 World Development Report is to improve the quality of life, especially in the world's poor countries. It is in an attempt to foster development that the 189 member countries of the United Nations adopted a total of eight (8) Millennium Development goals (MDGs) in September 2000. They committed themselves to making substantial progress towards the eradication of poverty and achieving other human development goals by the year 2015.

One of those eight MDGs, goal number 5 is "Improvement of Maternal Health". The target for this goal was to "reduce by three-quarters, that is to achieve a seventy-five percent (75%) reduction in maternal mortality between1999 and 2015.

Awareness to the appalling condition of women's health was drawn by the United Nations Fund for Population Activities (UNFPA) when it reported that "every minute, another woman dies in childbirth (UNFPA, 2008). The World Bank Report (2003) also reported that about half a million women die every year from the complications of pregnancy and childbirth, and that most of these deaths are preventable with simple technologies that have been available for decades.

The International Conference on Population and Development (ICPD, Cairo, 2004) also called the attention of the world to the magnitude of maternal mortality, and the necessity for its reduction. Maternal mortality ratios (Maternal deaths per 100,000 live births) are, on average, 30 times higher in developing countries than in high-income countries (The World Bank Report, 2003).

In Nigeria, one in every 13 women face a life time risk of maternal death. In the United Kingdom (UK), it is 1 in 5,100, while in Canada, it is 1 in 7,700 (FMOH, n.d).

Apart from the high number of women dying daily from pregnancy related causes, another estimated 2 million women are living with fistula, another debilitating disease with its attendant social and economic consequences (WHO, 1993). Nigeria alone accounts for between 800,000 and 1,000,000 women with fistula and 5,000 new cases are added every year (UNFPA, 2009); it is a disease which usually results from prolonged obstructed labour in pregnant women.

Rathgeber (1990) on why we must look at the health of women separate from men, opined that "women have special health problems that men do not experience; women are more vulnerable to certain conditions than are men…" According to Babalola and Adebayo (2003), women are seen primarily as child bearers, and child carers. Beyond these, they are also seen as community care-givers as well as contributing 60-70% of the labour needed in the agricultural sector in Africa (Ogunlela and Ogunlela, 2008) as well as their contributions in diverse ways to the economy (Boserup, 1995).

The causes of maternal death or maternal mortality, as well as the pregnancy-induced diseases such as fistula can be addressed if the government of Nigeria is willing to commit itself politically. According to Zinser (2007:7), www.globalhealthtv.com); "it is estimated that 15% of pregnancies experience complications world-wide, but in Nigeria, it stands at over 40%. Many pregnant

women still deliver at home due to exorbitant antenatal and post-natal costs. In most Nigerian villages, women still give birth with traditional birth attendants in huts, with no running water, no sterilization, no equipment and no skilled birth attendants capable of providing emergency obstetric care. Socio-cultural and economic factors that relate to the low status of women, poverty, ignorance and traditional harmful practices also account for the alarming Maternal Mortality Rate (MMR) in Nigeria".

The MMR landscape in Nigeria will only begin to change for the better when its government acquires the political will to institute the necessary programs (www.allafrica.com/westafrica).

According to Shiffman and Okonofua (2006:217):

> Maternal mortality in Nigeria first received international notice through a 1985 paper presented by obstetrician and gynaecologist, Kesley Harrison … at an international Safe Motherhood Conference in Nairobi, Kenya in 1987, which launched a global Safe Motherhood Movement. Harrison and other Nigerians attended, with a commitment to achieving in their country the objective agreed to at the conference; a reduction in the number of maternal deaths by half by the year 2000. The Federal Ministry of Health subsequently established a national Safe Motherhood Committee, and the Society for Obstetrics and Gynaecology of Nigeria (SOGON) heightened efforts to promote maternal mortality reduction. Also, Columbia University established the Prevention of Maternal Mortality Network, conducting formative research. However, these initiatives were not scaled up, and under the military government Safe Motherhood activities in Nigeria stagnated.

According to Zinser (2008:6), "maternal mortality is the least successful of all the MDGs because the current rate of progress is less than one-fifth of what is

needed to hit the target, as over 99% of maternal deaths occur in developing countries, with women still dying from pregnancy-related causes at the rate of one per minute. Only one-third of births in the poorest countries are attended by skilled health professionals".

The MDGs were developed in consultation with the developing countries, to ensure that they addressed their most pressing problems. Key international agencies, including the United Nations, the World Bank, the International Monetary Fund (IMF), the Organization for Economic Cooperation and Development (OECD), and the World Trade Organization (WTO) were involved, and they all helped to develop the Millennium Declaration and so they have a collective policy commitment. The MDGs assign specific responsibilities to rich countries, including increased aid … (Todaro and Smith, 2006).

The rich countries such as United States of America (USA), United Kingdom (UK), Germany, among others, often provide assistance or aid to the less developed countries (LDCs) or poor countries through some international non-governmental organizations or development partners. One such international non-governmental organizations or development partners is Rotary International, with its headquarters in Evanston, USA and with branches in many countries of the world.

Rotary International (RI) has through its 3-H programme (Health, Hunger and Humanity) embarked on various projects world-wide to provide assistance in the form of grants to tackle the MDGs. In Nigeria, a major project was undertaken

by RI to address maternal health. The project was tagged "Rotary International 3-H project (child spacing, Family Health and HIV/AIDS Education)". The project was implemented in Northern Nigeria.

1.2 Statement of the Problem

Nigeria is only 2% of the world's population, but accounts for over 10% of the world's maternal deaths in childbirth (Adamu, 2003; Shiffman and Okonofua, 2007). Nigeria has the second highest number of maternal deaths following after India (Ujah, et al, 2005a). The picture of maternal mortality and morbidity in Nigeria typifies that of most countries in Sub-Saharan Africa, some regions in Nigeria have some of the highest maternal mortality rates in the world (Amadi, 2007). Estimates from the National Health and Demographic Survey (2003) put Nigeria's National rates at approximately 800 per 100,000 live births. But there are marked regional variations in rates:

North East - 1,549 maternal deaths per 100,000 live births

North West - 1025 maternal deaths per 100,000 live births

South East - 286 maternal deaths per 100,000 live births

South West - 165 maternal deaths per 100,000 live births

Rural - 828 maternal deaths per 100,000 live births

Urban - 351 maternal deaths per 100,000 live births

National - 740 maternal deaths per 100,000 live births

Nigeria's 2006 National Population Census figures revealed that Nigeria's population is 140,033,542 (National Population Commission; 2006). The female

population is 68,293,683, which is approximately half of the overall population of the country. Therefore, any health condition which affects either the generality of a nation's population or that which affects half of the overall population, should in effect constitute a national concern. This fact was captured and highlighted by Awe, in Kisekka (1992) while commenting on the importance of women's health issues in Nigeria, that "the importance of a healthy female population cannot be over-emphasized in any discussion of women's contribution to the development of this nation; for it is when women are healthy that they can fulfill their reproductive and productive roles most effectively".

Nigeria was one of the countries that participated in the 1987 Safe Motherhood Initiative International conference with a commitment to take necessary measures to improve maternal health. The original goal of the Safe Motherhood Initiative was to halve maternal mortality ratios by the year 2000 (Ransom and Yinger, 2002). It was to be done through the following areas of care: Antenatal care, Delivery care, Postnatal care and Family Planning Services. However, years after the launch of this initiative, it was still reported that 1 woman in every 13 women face a lifetime risk of maternal death. In the United Kingdom, it is 1 in 5,100, and in Canada, it is 1 in 7,700 (FMOH, n.d). Also, out of an estimated 2 million women living with fistulae (VVF and RVF), Nigeria alone accounts for between 800,000 and 1,000,000 women with this obstetric fistulae, with additional 5,000 new cases added every year (WHO, 2009 and UNFPA, 2009). This various governments in Nigeria had tried over the years to address the

issue of maternal health at the national level. A number of policies in the health sector that are relevant to maternal health were put in place. Among them were the National Health Policy and Strategy (1988, 1998), which emphasized primary health care as the key to the development of the health care delivery system in Nigeria. The provisions of this policy were not strictly implemented especially the maternal health component, hence the poor state of maternal health. Other relevant policies include the National Policy on Population for Development, Progress and Self-Reliance (1988); Maternal and Child Health Policy (1994); National Adolescent Health Policy (1995); National Policy on HIV/AIDS/STIs, Control (1997); National Policy on the Elimination of Female Genital Mutilation (1998); and Breastfeeding Policy (1994). While the provisions of many of these policies are relevant to the promotion of maternal health, their targets were sometimes contradictory.

Another policy, National Reproductive Health Policy and Strategy to Achieve quality Reproductive and Sexual Health for All Nigerians, was formulated for implementation in 2001. This policy was developed to address among others, the unacceptably high levels of maternal and neonatal morbidity and mortality; the low level of male involvement in reproductive health; the low level of awareness and utilization of contraceptive and natural family planning services.

In that policy, specific roles were assigned to Non-Governmental Organizations in collaboration with the federal, state and local governments. Those roles include that:

i. Non-Governmental Organisations shall identify the reproductive health needs of the communities, through studies to provide relevant data

ii. Initiate pilot schemes that will serve as models for replication.

iii. Use innovative approaches in addressing reproductive health needs of the communities.

iv. Assist in developing Information, Education and Communication (IEC) materials and programmes.

v. Assist in Monitoring and Evaluation Programmes.

vi. Mobilise the community to embark on awareness campaigns to eradicate harmful practices.

vii. Assist in the development and maintenance of a functional referral system.

viii. Initiate studies on the knowledge, attitude, beliefs, practice and ethical considerations on reproductive health issues within the communities.

ix. Assist in the collation and updating of relevant data about reproductive health resources, the utilization or available maternal health services.

x. Assist in the retraining of various levels of health workers involved in reproductive duties.

This shows that the government of Nigeria has not been able to successfully tackle the problem of maternal mortality alone, hence, the need for the intervention by various NGOs to complement the efforts of the government.

Rotary International's 3-H project was established by Rotary International to intervene in the area of clinical service delivery in order to complement government efforts towards improving maternal health in Nigeria, especially in the North.

It is against this backdrop that the study was undertaken to precisely assess what Rotary International (RI) has done in the area of service delivery to improve maternal health in some northern states of Nigeria. This is premised on the fact that a large number of NGOs, especially the international ones, claim to be partners of the less developed countries (LDCs) in the development process or what is usually regarded as "development partners". This is why an assessment of such claims was carried out by studying Rotary International and focused on the following questions.

1.3 Research Questions

i. Why did Rotary International intervene in maternal health care delivery and what was the nature of its intervention?

ii. What were the objectives of Rotary International's intervention and what were the strategies adopted?

iii. What type of administrative system did the R.I. 3-H Project adopt in implementing the project?

iv. Were there any challenges encountered in the implementation of the R.I. 3-H project and what were the lessons learnt?

1.4 Objective of the Study

The primary objective of the study was to examine the nature of the intervention orchestrated by Rotary International to address the poor maternal health, an identified problem of great concern in the area of human development in a less developed country.

Specifically however, the sub-objectives of the study were:

i. To find out reasons for and the nature of the intervention of Rotary International in maternal health care service in Nigeria.

ii. To examine the objectives of RI 3-H Project in its project states in Nigeria.

iii. To find out the types of strategies adopted for the intervention in maternal health care service delivery?

iv. To examine how the R.I. 3-H Project was implemented.

v. To find out what type of outcomes or effects the R.I. 3-H Project had on the delivery of maternal health care services in Northern Nigeria.

vi. To ascertain if there were any challenges encountered in the course of implementing the project and the type of the lessons learnt.

1.5 Significance of the Study

The significance of this study stemmed from the fact that Nigeria is a developing country that has witnessed a proliferation of NGOs, both local and

international types. Each of those NGOs have been laying claims to being contributors to the development process. Whereas there have been arguments that NGOs are partners indeed, making positive contributions to promote development, there have also been arguments to the contrary that NGOs are conduit pipes for siphoning donors' funds without any tangible achievements towards the development process. Hence, this study was carried out to study a specific NGO, indepth, in order to ascertain what contributions or otherwise, it has made to the social development of a segment of the Nigerian population, that is, the health of mothers (maternal health). Other areas of significance can be itemized as follows:

i. This study has been able to establish a link between issues of Public Health and Public Administration. Maternal mortality which is an indicator of poor maternal health, is a Public Health issue; but has been established as an issue in Public Administration by examining the socio-economic causes of maternal mortality, using the three-delay model as expounded by Thaddeus and Maine (1994): Delay in decision to seek care – due to cultural practices which require a woman to obtain her husband's permission before she can access maternal health care services; Delay in arrival at a health facility – due to costs of transportation, drugs and supplies; Delay in provision of adequate care at the health facility – due to shortage of trained and competent personnel; the cultural and economic factors which can impact

negatively on policy implementation have been highlighted and documented.

ii. Development Administration is about carrying out programmes and projects that could bring about development in a country. The product of this study should be useful to scholars in the field of Development Administration, as it is a study into efforts made by a particular NGO to facilitate accessible maternal health care services.

iii. The study has been able to document the type of administrative system adopted by Rotary in the implementation of the project, and how such has impacted on the project's outcomes. This attempt should provoke studies of a comparative nature into types of administrative systems employed by the numerous NGOs working in the health sector in Nigeria.

iv. This study has been able to highlight the project strategies employed by Rotary to improve service delivery at the clinical service delivery point, which have been discovered to be an interplay of community mobilization strategies to facilitate project implementation. Such strategies could be of interest to policy makers in the debates in policy formulation, implementation and evaluation.

v. The study has revealed that a strong public health system must begin by recognizing that health care is a human right and that governments have a central role to play in ensuring the right to care. This right to care

includes access based on need and the conditions that make it possible to provide the care people need, recognizing that there should be shared risks and shared responsibilities, as well as government ensuring participation of the community in decision-making about health services.

vi. The product of this study may also be useful to the following:

a. The Nigerian government, because it has helped to document the activities of one of the numerous NGOs working in the country, and to be able to evaluate their contributions.

b. Policy makers at the three tiers of government it should serve to encourage them to prioritize their activities and make political commitment to a social problem of this magnitude affecting approximately half of their population.

c. Policy makers willing to undertake community development projects in their constituencies can consider replicating such a project.

d. Other NGOs, because this study could help to forestall conflict, generated by unnecessary competitions. It could help them to focus more on positive growth and more meaningful impacts through effective collaborative efforts.

e. The academia, because the study has provided additional scholarly materials on the role of NGOs in development.

f. The general reading public through the awareness created to the programmes and activities of Rotary International as an NGO, which has succeeded in promoting development partnerships through north-south linkages which is also one of the goals of the MDGs..

1.6 Scope and Limitations

Maternal health problems of which maternal mortality and maternal morbidity are of great concern world-wide, and especially in Nigeria. One of the ways through which Nigeria had attempted to tackle the problem was by instituting several policies, among which was the National Reproductive Health Policy and Strategy (2001). Components of this policy include Safe Motherhood; Family Planning Information and Services; Prevention and Management of Infertility and Sexual Dysfunction in both men and women; provision of safe abortion services; management of non-infectious conditions of the reproductive system, such as genital fistula, cervical, cancer, complications of female genital mutilation and reproductive health problems associated with menopause, among others. This study is however an assessment of the intervention by Rotary; the intervention was focused on the Safe Motherhood and Family Planning component. Therefore, this study did not cover the entire gamut of reproductive health but the Safe Motherhood and Family Planning components.

The issue of maternal health is an extensive area of study which has different dimensions ranging from public health, public finance, gynaecology and obstetrics, to public policy. However, this study does not pretend to touch on all

these areas, the thematic context of the study is within the context of policy implementation, especially in the area of health care service delivery.

Rotary International is a large world=-wide organization with many programmes, the researcher did not attempt to study Rotary as an organization in its entirety. Rather, the study was confined to the health arm of Rotary International and specifically to the 3-H Project (Child Spacing, Family Health and HIV/AIDS education) which was carried out in Northern Nigeria. The project covered six states of the Northern Nigeria, namely: Adamawa, Jigawa, Kaduna, Kano, Katsina and Plateau States. Rotary had planned to execute the project in all the states in Northern Nigeria but due to insufficient funds, the project was executed in only six states. But then, all the local government areas of the six states were included in the projects.

The scope in terms of period is specifically from the years 2000 to 2007. The justification for the time frame is premised on the fact that even though there was a pilot project of the programme (1995 to 2000), the main project was actually from year 2000 to 2007, and that period is the focus of this study.

The limitations were in the area of coverage of the 3-H Project itself; the project covered all the local governments in six states, a total of 166 local government areas. It was therefore not possible to interview or to administer questionnaires to all the beneficiaries of the project due to time and financial constraints. However, the researcher had to engage the services of research assistants who were sent out to administer the questionnaires to the respondents

within the sample area. This was quite expensive financially but since it was a task that must be done, the researcher had to resort to sourcing for necessary funds from family and friends in order to mitigate against these constraints.

1.7 Hypotheses Tested

The following hypotheses were formulated as guides for the study:

1. Hypothesis One

Null Hypothesis

H_o: Rotary International 3-H Project did not make any marked contribution to improve maternal health care service delivery in Northern Nigeria

Alternate Hypothesis

H_1: Rotary International 3-H Project has made marked contribution to improve maternal health care service delivery in Northern Nigeria.

2. Hypothesis Two

Null Hypothesis

H_o: The Rotary International management structure did not enhance the performance outcomes of Rotary International 3-H Project.

Alternate Hypothesis:

H_1: The Rotary International management structure has enhanced the performance outcomes of Rotary International 3-H Project.

1.8 Definition of Key Concepts

For the purpose of this study, the following interpretations shall be applicable to the terms stated below

1.8.1 Development

Turner and Hume (1997:10) stated that there has been considerable debate over the definition, explanation and practice of development. The struggle over meaning according to them, relates to critical policy matters such as what actions will be taken to alleviate poverty, who will have access to what resources, and who will be empowered?

Goulet (1992:467-75) defines development as a multidimensional process which involves.

i. An economic component dealing with the creation of wealth and improvement in conditions of material life, equitably distributed.

ii. A social ingredient measured as well-being in health, education, housing and employment:

iii. A political dimension including such values as human rights, political freedom, enfranchisement, and some forms of democracy

iv. A cultural dimension in recognition of the fact that cultures confer identity and self-worth to people

v. The full-life paradigm, which refers to or meaning systems, symbols, and beliefs concerning the ultimate meaning of life and history. Seers (1977:3) opine that “the questions to ask about a country’s development

are three: What has been happening to poverty? What has been happening to unemployment? What has been happening to inequality? If all three of these have declined from high levels, then beyond doubt this has been a period of development for the country concerned".

Todaro (1979) observes that development has three (3) dimensions:

i. Raising people's living level – their income and consumption levels of food, medical services, education, etc., through relevant economic processes.

ii. Creating conditions conducive to the growth of people's self esteem through the establishment of social, political and economic systems and institutions which promote human dignity and respect.

iii. Increasing people's freedom to choose by enlarging the range of their choice variable for example increasing varieties of consumer goods and services.

The explanation of development as enunciated by Todaro (1979) has been adopted for this study. This is because health is an important ingredient for measuring development. The World Health Organisation (WHO) as part of its 1978 Alma Ata Declaration affirms that health, which is a state of complete physical, mental and social well-being, is a fundamental human right. It stated further that 'the existing gross inequality in the health status of the people within a country is politically, socially and economically unacceptable; that governments

have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures" (WHO, 1978:6-12).

The indicators for the contribution of Rotary International 3-H project to development in this study are:

a. How R.I. 3-H project has raised the standard of maternal health care services in terms of resuscitation of health care facilities providing such services, number of sites providing such services at pre-intervention and post-intervention, human capacity building in terms of training and staff development for the sites; infrastructural capacity building in terms of number and types of equipment provided.

b. Institutional mechanisms of Project Planning Implementation, Monitoring and Evaluation: what was the level of involvement of Nigerians in the project life cycle?

c. Sensitization to increase awareness of the project, its components and to empower couples to make informed choices as regards family size, birth interval, to have children when they want it, and types of contraception.

d. How the R.I. 3-H project has contributed towards awareness of policy makers towards the deficiencies in one area of health needs, and to ensure sustainable development by

ensuring continuous provision of health care services in that area.

1.8.2 Maternal

Maternal is referred to as "pertaining to a mother" (Kotch, 2005). In the context of this study, maternal is used to refer to female of reproductive age, or women who are old enough to bear children: in this context it is specifically women between the age group of 15-49 years.

1.8.3 Maternal Health

The World Health Organization (WHO) defines maternal health as the health of women during pregnancy, child birth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.

Maternal health care therefore is a concept that encompasses family planning, pre-conception, prenatal, and postnatal care.

The study intended to examine the facilities and programmes organized for the purpose of providing medical and social services in those areas of intervention by Rotary International. These include accessibility of such services in terms of distance and cost, availability of skilled service providers, availability of necessary or basic equipment, empowerment of women to aid them to access maternal health care services, through awareness campaign and sensitization.

1.8.4 Non-Governmental Organizations (NGOs)

Blagojevic and Dam (1981) in The International Encyclopedia of comparative Law defines an NGO as a legally constituted organization created by natural or legal persons that operates independently from any government. The term is usually applied only to organizations that pursue some wider social aim that has political aspects, but that are not overtly political organizations such as political parties.

Rotary International is a private organization; it pursues a variety of activities that enhance the general welfare of the communities it serves. In this study therefore, Rotary International is referred to as an NGO. The 3-H project is one of its activities and it is the focus of this study.

1.8.5 Project Strategies

The Rotary International (R.I.) 3-H project was conceived as an interventional measure towards improving maternal health. The project strategies were:

i. *Advocacy and Sensitization:* This involved advocacy visits to the Federal, State and Local government officials of the Ministry of Health, Ministry of Education, Ministry of Women Affairs, Ministry of Local Government and Chieftaincy Affairs, Traditional Rulers, Opinion Leaders and Religious Leaders.

ii. *Awareness Campaign and Sensitization:* The public were expected to be sensitized and kept informed through the

development of Information-Education- and Communication (IEC) messages.

iii. *Training:* Training sessions for Medical Doctors, Nurses/Midwives, Community Health Extension Workers (CHEWs)/Community Health Officers (CHOs) and Traditional Birth Attendants (TABs).

iv. *Basic/Minimal Medical Equipment*: The project had planned to upgrade the infrastructure of the existing health facilities by providing some basic medical equipment.

v. *Contraceptive Supply*: Ensuring contraceptive supply was not part of the project's main objective. But effort had to be made by the project to bridge the gap in order to ensure regular supply.

1.8.6 Assessment

Assessment here refers to the performance of the project in relation to the set objectives. The indicators for measuring assessment of the R.I. 3-H project are:

i. Number of advocacy visits and the categories of people visited.

ii. Types of IEC materials developed and number of people sensitized.

iii. Types of training and achievements.

iv. Basic equipment provided to health facilities.

v. Contraceptive supply and contraceptives distribution and consumption.

vi. Number of sites brought to the level of being fully functional, partially functional and not functional (according to the project's criteria).

vii. Measures put in place for monitoring and evaluation.

1.8.7 Sustainability

Sustainability in this study refers to the measures that were required to be put in place to ensure the continuity of the project's clinical services even after the withdrawal of Rotary from the provision of such services. The indicators that are used for measuring this are:

i. Number of Letters of Commitment received from federal, state and local government agencies.

ii. Number of Meetings held with government officials and Non-Governmental Organizations towards ensuring sustainability.

iii. Specific actions taken particularly by Rotary International for the Continuation of services.

1.8.8 Management Structure

Management structure in this study refers to the organizational structure of the Project. It includes:

i. The project hierarchy

ii. The relationship between the different strata.

iii. The project reporting system

1.9 Plan of Study

The plan of the study is as follows:

i. Chapter One comprises the problem statement, its background, objectives of the study, the hypotheses, scope of the study and the limitations. Definitions of key concepts will be included.

ii. Chapter Two contains a review of a number of relevant literatures on the problem stated, as well as a theoretical framework to guide the study.

iii. Chapter Three presents the methodology used for the study. This comprises the methods adopted for data collection, methods of data presentation, and the method used in analyzing the data.

iv. Chapter Four provides an explanation to the concept of Rotary as an organization. It includes the definition of basic concepts in Rotary such as: Rotary Club, Rotary District, Rotary Foundation, among others. This is necessary to provide information and understanding of the fact that Rotary is not limited to a Rotary Club. This chapter gives an explanation of what Rotary is about; more importantly, the Rotary International 3-H project of which maternal health is part, including the components of the project and its strategies.

v. Chapter five comprises the presentation of all the relevant data collected as well as the analysis of the data.

vi. Chapter Six contains the summary of the study, the conclusions and recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This section covers a review of related literature on the role of NGOs in development and the global issue of maternal mortality. An attempt has also been made to discuss the various efforts that were made globally to address maternal mortality and to promote the health of women or what is called the promotion of safe motherhood. The section also incorporates a theoretical framework which was adopted for the study, in order to situate the study within an academic theory so as to facilitate a better understanding of the problem under study.

2.2 Maternal Health

2.2.1 What is Health?

Health is a state of complete physical, mental and social well-being (WHO, 1978).

2.2.2 Women's Reproductive Health

Reproductive health has been defined by the United Nations (UN) as:

> "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice,

> as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."

According to Babalola and Adebayo (2003), most existing discussion of women health has centred on their reproductive health issues particularly in the developing countries where women are primarily seen as child bearers and child carers. Reproductive health is defined by the world Health Organization in Fethalla, (1992) as "not merely the absence of disease or disorder of the reproductive system but as a condition in which the reproductive process is accomplished in a state of complete physical, emotional and social wellbeing. This definition implies that couples have the ability to reproduce, that women can go through pregnancy and childbearing safely and that men and women are able to regulate their fertility so as to enjoy responsible sexual behaviour. Emphasis is on voluntary fertility regulation, which Sadik (1990) considered "the freedom from which other freedoms flow". Although it is pertinent to point out that any definition of women's health must involve her total well-being condition of life that is determined not only by her reproductive functions but also by the effects of work load, nutrition, stress, interest and attitude. Any adequate conceptualization of women's health must consider these additional issues so as to formulate a conceptual framework that will facilitate gender-sensitive health policy and action.

The challenge of attaining health requires innovative ways to measure health. WHO – the first multinational organization with a charter to promote health – defines health in positive terms, as "a state of complete mental, physical, and social well-being and not merely the absence of disease". But such a concept is difficult to measure, and without such measurement it is difficult to know whether a population is "healthy", whether health is improving, and how the health status of one population compares to that of other populations (Ratzan, Filerman and LeSar, 2000). Mortality is most often used to assess a population's health status and to compare the status of different populations. Almost every country records deaths and publishes death rates with various levels of detail, coverage and accuracy. Death rates may show the age, sex, and ethnicity of the person who died, and the probable cause of death.

2.2.3 Maternal Mortality

Since mortality is used to assess a population's health status, it could be deduced that maternal mortality can be used to assess maternal health. Maternal death is defined as the "death of a woman while pregnant or within 42 days of termination of pregnancy, due to both obstetric causes and the conditions aggravated by pregnancy or delivery" (Abou Zahr and Wardlaw, 2001:562).

Maternal mortality is generally defined as the number of women who die as a result of pregnancy-related complications per 100,000 live deliveries (Stanton, C. Abderrahim, N. and Hill, K, 1997).

An estimated 500,000 women die each year throughout the world from complications of pregnancy and childbirth. Maternal death is usually measured by the maternal mortality ratio (MMR), the number of maternal deaths per 100,000 live births. It indicates the risk of a woman to die in pregnancy (WHO, 2004a:4) a MMR over 500 maternal deaths per 100,000 is considered a very high level of maternal mortality (Abou Zahr and Wardlow, 2001:566). Globally the MMR was 400 per 100,000 live births in 2000. With an average of 830, it is highest in Africa, followed by Asia with approximately 330 (WHO, 2004a:1). Altogether, 98% of maternal deaths occur in developing countries (UNICEF, 1998:1).

Recent estimates by WHO (2004a:1) reports that one woman dies every minute during childbirth or from pregnancy-related complications. Altogether, about 530,000 women die each year throughout the world from complications of pregnancy and childbirth. In many developing countries, maternal mortality is the main cause of death among women of reproductive age (15-49 years), contributing to 25-33% of all deaths in that age group (McCarthy and Maine, 1992:23; DRH, 2004:2). One out of 16 women dies of pregnancy-related causes in sub-Saharan Africa, while one out of 2,800 women dies in the industrialized world (WHO, 2004a:1). Table 2.1 shows the global distribution of maternal mortality estimates by regions:

Table 2.1: Global Maternal Mortality Estimates by Regions, 2000

Region	Maternal Mortality Ratio (Maternal Deaths Per 100,000 Live Births)	Number of Maternal Deaths	Lifetime risk of Maternal Death, 1 in:
WORLD TOTAL	400	529,000	74
DEVELOPED REGIONS	20	2,500	2,800
Europe	24	1,700	2,400
DEVELOPING REGIONS	440	527,000	61
Africa	830	251,000	20
Northern Africa	130	4,600	210
Sub-Saharan Africa	920	247,000	16
Asia	330	253,000	94
Eastern Asia	55	11,000	840
South-Central Asia	520	207,000	46
South Eastern Asia	210	25,000	140
Western Asia	190	9,800	120
Latin America and the Caribbean	190	22,000	160
Oceania	240	530	83

Source: WHO 2004a:2)

2.2.4 Maternal Mortality in Nigeria

Nigeria is only 2% of the world's population, but accounts for over 10% of the world's maternal deaths in childbirth (Adamu,2003; Shiffman and Okonofua, 2007:127). Nigeria has the second highest number of maternal deaths following after India (Ujah, et al, 2005a;28). The Nigeria Demographic and Health Survey (NDHS, 2003) puts the statistics of maternal mortality ratio in Nigeria at between 704 per 100,000, or 1,500 per 100,000 live births (depending on the region). The north has the highest ratio. The Fact Sheet on Safe Motherhood by the Federal Ministry of Health (Undated) puts maternal mortality estimates in Nigeria at 800

per 100,000 live births; the region variations in MMR in Nigeria is estimated at 165 to 1600 per 100,000 live births; the north also has the highest.

The statistics on Nigeria seem to differ, ranging from 165 to 800 per 100,000. this can be said to be due to unavailability of reliable data from government institutions, the poor data gathering methods and the fact that births and deaths are not totally reported nor documented in Nigeria, due to cultural and other social reasons. However, even though the data vary, it still can be seen that MMR in Nigeria is quite high.

In Nigeria, 1 in 13 women face lifetime risk of maternal death. In the UK, it is 1 in 5,100; while in Canada, it is 1 in 7,700 (FMOH, n.d.).

In addition to the number of deaths each year, over 50 million women experience pregnancy complications each year. Out of these, 15 million to 18 million develop long-term debilitating diseases (WHO, 1993 in Tsui et al, 1997; 188 and FMOH, undated). Such diseases include severe anaemia, reproductive tract infections and obstetric fistulae bladder or rectum incontinence which leads to constant leaking of urine, faeces or both.

The World Health Organization (WHO, 2009) estimated that 2 million women are living with fistulae. Nigeria alone accounts for between 800,000 and 1,000,000 women with this obstetric fistulae, with 5000 new cases added every year (UNFPA, 2009).

2.2.5 Causes of Maternal Mortality/Maternal Morbidity

Maternal mortality ratios are highest in low income countries – for example, the MMRs of Sierra Leone and Afghanistan are 2,000 and 1,900 per 100,000 live births, compared to MMRs of 11 in the United Kingdom and (in Germany (WHO World Health Statistics, 2007; accessed 28/5/2007). Therefore, a low level of economic development seems to have a significant impact on maternal mortality. According to Shiffman (2000:276), in no high-income country of the world is the MMR higher than 25 per 100,000 live births – this could be because wealthier nations have more financial resources to spend on public health, well-being and education on one hand, or because such countries seem to place greater emphasis on health care delivery services, while some developing countries may be rich but are characterized by corruption and irrational spending.

Maternal mortality however is also influenced by biological, medical and social factors, which are often closely connected (Sketelenburg et al, 2004:390). According to McCarthy and Maine (1992:24) the health status and reproductive status of a woman, her access to health care services and her health care behaviour are factors that impact on maternal mortality. The authors found that the health status of a woman strongly influences her risk of dying from complications due to infections (Ibid:27). Shiffman (2000:276) argues that better-nourished mothers, as in developed countries, are more likely to stay healthy during pregnancy and less likely than poor women to experience birth complications. In developing countries, over 50% of women suffer from severe anaemia (UNICEF, 1998:2) and

anaemic women are 3.5 times more likely to die in pregnancy than women without anaemia (Brabin et al, 2001).

Regarding the reproductive status, which includes birth intervals, number of children and age, recent studies reveal that birth intervals of less than 15 months increase a woman's risk of maternal death by 2.5 (Conde-Agudelo and Belizan, 2000:1257). Women with already three births or more and those who are above 35 years old are also more likely to suffer from pregnancy complications (Vadnais et al, 2006:29). For women under the age of 15, the risk of dying in pregnancy and childbirth is twice as high and for girls under 14 even five times as high than for women aged 20 to 24 (UNICEF, 1998:4). This is because the body of many adolescent women is not developed enough to carry a child (Chavliac 1992, in Ujah et al, 2005a:3).

Altogether, the reproductive and health status of a woman as well as her health care behaviour, which reflects her use of maternal health care services (McCarthy and Maine 1992:26-27), are strongly influenced by her socio-economic and cultural background. This study attempted to find out how the R.I. 3-H project was able to address access to maternal health care services and the cultural factors that prevent utilization of such services by women. In many cultures and societies of developing countries where the status of women is low, maternal mortality is very high (Key, 1987:59). Often, cultural traditions support early childbearing and a high number of children and also may prevent women from seeking health care, as mostly husbands and relatives make decisions on care-seeking of women (Lule

et al, 2005:15-16). As revealed in a study in Bangladesh, 35% of interviewed women explained that their religion does not allow them to leave the house, particularly during pregnancy, and another 35% cited the objections of their husband and relatives as a reason for not seeking care (Piet-pelon et al 1999, in Ensor & Cooper, 2004:70). Furthermore, more than 50% of women in most developing countries today do not participate in household decisions (Vadnais et al, 2006:75).

Therefore, UNICEF (1998:2) claims that the low status of girls and women in society as well as a lack of education are the main reasons for too early, too many and unwanted pregnancies, which contribute to high levels of maternal mortality. For example, women with less than seven years of education are twice more likely to have a child before the age of 20 than educated women (ibid:3) and also are less likely to make use of reproductive and maternal health services (Lule et al, 2005:14). In many developing countries, girls and women are still denied access to schooling and are more likely than boys and men not to receive education (Millennium Development Goals Report 2006:7). Accordingly, especially young women often lack access to information about reproductive health and related services (Freedman et al, 2005:71). Consequently, each year about 15 million women under the age of 20 get pregnant (UNICEF, 1998:4). As most pregnancies are unwanted and pregnant girls are often expelled from school (Chudi, 2003:14), abortion is a common consequence. On average, abortion causes about 13% of all maternal deaths globally; however, for girls between 15

and 19 years of age, it is the leading death cause. More than 150,000 teenagers annually die of abortion-related consequences (UNICEF, Ibid). Abortions are illegal in many developing countries, and therefore most of them are conducted in inadequate settings where the process can be life-threatening (WHO 1994, in Tsui et al, 1997:96). Altogether, 95% of unsafe abortions, which are characterized by insufficient proficiency of the provider, dangerous methods or unhygienic facilities, take place in developing countries – altogether about 19million annually (WHO 1993, 2004, in Fredman et al, 2005:73).

Another factor that contributes to high maternal mortality in developing countries is poor access to health care services. Often, women have to travel great distances to the closest centre that offers quality maternal health services, especially when they live in rural and remote areas. An insufficient rural infrastructure and undependable public transport or emergency transportation impedes access to care as well (Lule et al, 2005:17). As shown in a case study in Malawi, of the 90% of interviewed women who wanted to give birth in a health-care institution, only 25% were able to because of the too great distance from their village (Lule and Ssembatya, 1996: in ibid). Consequently, many women have to depend on local health services from providers who often do not have the skills or the equipment to treat obstetric complications, such as relatives or traditional birth attendants (Lule et al, 2005:17).

Moreover, most poor women in developing countries are constrained by the financial costs for health care. The cost of a birth with professional assistance or at

a hospital can cost between US$ seven and US$ 35, and a caesarean section can even be as expensive as US$100 (Gelband et al, 2001:6). These costs will translate to N1,050, N5,250 and N15,000 respectively in Nigeria, using the official Central Bank of Nigeria foreign exchange conversion rate of N150 to a US$1. It could therefore be seen that the financial cost is on the high side, and is therefore not easily affordable to most women. As 44% of the population in sub-Saharan Africa and over 30% of the south Asian population, where most maternal deaths occur, are living on less than US$ one a day (Millennium Development goals Report 2006:4), these costs are unaffordable for most family.

Even when services are financially and geographically accessible, women often do not receive the health care services they need. Many health facilities lack trained personnel and equipment to provide adequate maternal health care, especially those located in poor, rural or isolated regions (Lule et al, 2005:17). In the past years, immense migration of native medical professionals to wealthier countries (also referred to as "brain drain") and the marked reduction of health personnel due to HIV/AIDS in high prevalence countries aggravated this problem (Freedman et al, 2005:9). Currently, across 75 developing countries, about 334,000 midwives are missing, and 140,000 health professionals and 27,000 doctors lack proficient skills to provide adequate health care (WHO, 2005b:133).

As a consequence of all these constraints, the majority of women in developing countries today still deliver at home without the assistance of trained personnel, which contributes to a high number of maternal deaths. For example, in

30 of 53 countries, less than 50% of delivering women were attended by skilled personnel in recent years (Vadnais et al, 2006:71).

Altogether, most of the above mentioned barriers to care are reflected in Thaddeus and Maine's (1994) three-delay model. As shown above, the first delay occurs in the decision-making process, which is influenced by the woman herself, her husband and/or relatives, the status of the woman, her recognition of complications and the consideration of costs for treatment. The second delay of reaching a health facility is caused by the inaccessibility and distance of the health clinic and the non-availability or costs of transportation. The last delay phase characterizes the receiving of quality care after arriving at the health institution, which depends on the availability and quality of supplies, such as blood transfusion or antibiotics, equipment and competent personnel (in Stekelenburg et al, 2004:391). All these delays are interconnected (Ransom and Yinger, 2002:9) – for example, the first delay can also be influenced by the last two when women and their families do not seek care because they know that at the distant hospital health personnel or treatment is not available or the transportation costs are unaffordable (Freedman, et al, 2005:86).

Altogether, it can be concluded that inadequate health care services and the interrelation of economic, social, and cultural factors are responsible for the about half a million women in developing countries that still die in pregnancy and childbirth today.

As a summary of the causes of maternal mortality, the Society of Obstetric and Gynecology in Nigeria (SOGON, 2008) enumerated a three-phase delay model as the social causes of maternal mortality in Nigeria:

a. **Phase 1 delay – Delay in seeking Care**: This delay is caused by lack of knowledge of the patient and her family as to what to do, knowledge of where to get help, and quality of care.

b. **Phase 2 Delay – Delay in Reaching the Health Facility**: This is caused by unavailability of transportation, its affordability and the physical terrain.

c. **Phase 3 Delay - Delay Within the Health Facility**: This is dependent on availability of skilled staff, availability of drugs and equipment, availability of blood, the attitude of staff and promptness with which the patients are attended to.

All the above factors enumerated as the causes of maternal mortality revolve round the broad ambit of the medical and the socio-economic, all of which the political will of the government can resolve, if only the government would be willing to make the issue of maternal health a priority by focusing on ways and means to reduce maternal mortality.

2.2.6 Consequences of Maternal Mortality/Maternal Morbidity (Sicknesses)

The consequences are many and the impact quite wide; they are as discussed below.

2.2.6.1 Consequences of Maternal Mortality

Maternal mortality has many consequences which include:

i. Reduction of the life expectancy of women in the reproductive age (Key, 1987:59). This is because the woman's life is cut short at a younger age. Such women do not live up to their old age.

ii. Maternal mortality leads to communal loss. "When a mother dies, children lose their primary caregiver, communities are denied her paid and unpaid labour, and countries forgo her contributions to economic and social development' (John, 2010:10). "A woman's death is more than a personal tragedy … it represents an enormous cost to her nation, her community, and her family. Any social and economic investments that have been made in her life are lost. Her family loses her love, her nurturing, and her productivity, both inside and outside the home (www.safemotherhood.org, 2008).

iii. The death of a mother can directly or indirectly lead to the death of a new born baby. For example, children in Bangladesh under the age of ten that have lost their mothers are three to ten times more at risk to die within two years than children with a mother or with two living parents (FMOH, n.d).

iv. The death of a mother also means a reduction in the household income as well as a loss for the economy, as many women in developing

countries contribute a substantial share of labour in agriculture and trade (Jowett , Ibid).

It is also argued that complications of pregnancy and delivery considerably strain overall health systems, as maternal illness is one of the largest contributors to the disease burden of developing countries (Goodburn and Campbell, 2001:917). For example, pregnancy and childbirths – complications and abortions contribute notably to a health facility's expenditure as well as the need for hospital beds, which are often scarce in poor countries (Jowett, 2000:213).

Therefore, if maternal and newborn morbidity and mortality is not addressed effectively, it is estimated that by 2015, there will be at least 2.5 million maternal deaths and 49 million maternal disabilities. The consequences are at least 7.5 million deaths of children and US$45 billion loss in productivity in Africa alone (DRH, 2004:10). Altogether, investing in mother's health and preventing their death contributes to the health of children, poverty reduction and economic growth and therefore is crucial for the benefit of future generations (Liljestrand, 1999:880; Jowett, 2000:208).

Overall, maternal mortality represents a large-scale, multi-factorial problem in most developing countries today, with severe consequences for families, societies and nations.

2.2.7 Attempts to Fight Maternal Mortality

The problem of high mortality is a global issue, even though it is worse in the LDCs. The attempt to promote and maintain better health of mothers i.e. Safe

Motherhood, has undergone different stages in the global arena. The various attempts are as hereby discussed according to Freund (2009).

2.2.7.1 'Neglected Tragedy'

In 1985, an article was published which outlined that recent maternal and child health (MCH) programmes had failed to significantly reduce maternal mortality in the developing world. The authors, Rosenfield and Maine argued that most of the MCH programmes had focused on the prevention of childhood diseases only, criticized the lack of serious attention from policy makers, professionals and obstetricians and therefore titled maternal mortality a 'Neglected tragedy" (Rosenfield and Maine, 1985:83). In the same year, the WHO declared that there are at least 500,000 women dying annually from obstetric complications (Starrs, 2006:1130)

2.2.7.2 Safe Motherhood Initiative

Due to the increasing attention to maternal mortality raised by experts such as Rosenfield and Maine and the WHO publication, in 1987, the World Bank, UNFPA and the WHO organized the Safe Motherhood Conference in Nairobi, Kenya, where a document on future strategies for the improvement of the health of women was adopted (Key,1987:63, Starrs, 2006:1130). Following the Conference, the Safe Motherhood Initiative (SMI) was launched. It was led by the Safe Motherhood Inter-Agency Group (IAG) which was formed by the UNICEF, the World Bank, the WHO, UNFPA, the International Planned Parenthood Federation (IPPF) and the Population Council (UNICEF, 1998:6). The main aim of the

initiative was to raise awareness, encourage research and advocate for increased resources for safe motherhood. Governments and non-governmental organizations from more than 100 nations took part in the SMI (Ransom and Yinger, 2002:10).

The SMI participants such as women's rights advocates and health professionals realized that maternal mortality is not alone the outcome of insufficient or inaccessible healthcare, but also due to the lack of female education, early marriage, lack of access to reproductive health services, inadequate nutrition and women's low societal and economic status (Starrs, 2006:1131). Accordingly, the strategies proposed by the SMI included the provision and improvement of family planning, antenatal care, emergency obstetric care and safe legal abortion services, training of traditional birth attendants as well as the improvement of the socio-economic status of women and education and mobilization of the communities (McCarthy and Maine, 1992:30). The original goal of the SMI was to halve maternal mortality ratios by the year 2000 (Ransom and Yinger, 2002:10). This global promise was confirmed at a number of following international conferences for example at the International Conference on Population and Development in 1994 (Shiffman, 2000:275).

2.2.7.3 International Conference on Population and Development

Seven years after the Conference in Nairobi, the International Conference on Population and Development (ICPD) took place in Cairo, Egypt. By that time, every continent of the world had held a region specific Safe Motherhood conference (Starrs, 2006:1130).

The 79 countries that were participating at the ICPD conference adopted a programme of action, which, similar to the SMI, urges countries to significantly reduce maternal mortality, altogether by 75% by 2000, and reaffirms the earlier promoted health care interventions (WHO, 2004b:1). The Programme of Action in Tsui et al (1997:13) states the importance of reproductive health, which is defined as "a state of complete physical, mental and social well-being in all matters related to the reproductive system" and affirms safe motherhood as a major constituent of reproductive health (in Starrs, 2006:1130).

The main intention of the Programme of Action is to improve gender equality and women's rights as it was acknowledged that a poor societal status of women significantly increased their risk of dying from obstetric complications (WHO, 2004b:6). It was stressed that service providers cannot effectively care for women without addressing their social environment, and that prevailing family planning services need to include neglected areas of reproductive health care such as unwanted pregnancies, complications of abortion, postnatal care, HIV/AIDS and obstetric fistula. Furthermore, the importance of men's responsibility in improving women's reproductive health was emphasized. Altogether with the adoption of the programme of action, the so far neglected issue of reproductive and women's rights became priority in the international population agenda (Haberland and Measham, eds., 2002:1, 8, 12; WHO, 2004b:1-2). Similar to the SMI; the ICPD programme of action acknowledges maternal death as a multi-

Sectoral problem (Starrs, 2006:1131). This was confirmed six years later at the United Nations (UN Millennium Assembly.

2.2.7.4 Millennium Development Goals

At the UN Millennium Assembly in 2000, 147 state leaders signed the Millennium Declaration, which resulted into eight comprehensive, specific and interrelated Millennium Development goals (MDGs). These aim to address the challenges of prevailing extreme poverty, inequality, epidemic diseases, environmental degradation and conflicts (Sachs,2005:211-212). Safe Motherhood was reaffirmed a crucial element of development and became the fifth goal (UNFPA, 2004:9). Again the aim to reduce MMRs by three quarters between 1999 and 2015 was reassured and the achievement of an additional objective, skilled attendance for 90% of all births within the same time period, was emphasized. The importance of gender equality was embraced in the third goal, which aims to eliminate gender disparities in primary and secondary education by 2015 (Millennium Development Goals Report 2006:8-12). Altogether, it was recognized that questions of reproductive health and women's right are crucial to the achievement of all the MDGs (in RFPD, 2006, accessed 11/6/2007).

Similar to the SMI and ICPD, the MDG agenda is a time-bound global commitment made by a great number of governments and powerful international stakeholders such as the WHO, several UN agencies and the World Bank (Freedman, 2003:106). The Millennium Declaration stresses the contribution of health to overall poverty reduction and claims the MDGs to be a package of

interrelated goals that can only be achieved through improved collaboration (WHO accessed 27/5/2007). It therefore states that the main challenge will be to promote "a comprehensive approach and a coordinated strategy, tackling many problems simultaneously across a front board" (Boston University School of Public Health, accessed 27/5/2007).

Altogether, the multi-dimensional aspects that contribute to maternal mortality have been acknowledged and addressed by the SMI, the ICPD programme of Action and the MDGs. In the next section it will be discussed which strategies were promoted by those initiatives and other experts in recent years and whether they were able to improve maternal health in the developing world in the past 20 years.

2.2.8 Strategies to Improve Maternal Health

2.2.8.1 Demand Side Strategies

Improving Women' Status and Financial Access to Care

The above named initiatives and goals focus on a number of strategies to improve maternal health. Most of them explicitly address the several demand and supply side barriers women face to receive care. As stated earlier, factors such as cultural influences, low levels of education or income often represent demand side impediments to individuals to invest in health and use related services, and therefore contribute significantly to delays in seeking care (Grossmann 2000 in Ensor and cooper, 2004:69-71).

In many developing countries, a large number of women still die in pregnancy because they are not educated and do not even know about their right to receive education, Information and care (DFID, 2005:1). Hence, maternal mortality is strongly correlated to female education and empowerment and it has been shown that low income countries with high female secondary school enrolment rates have a significantly lower MMR than countries where female education is low (Shiffman, 2000:280-285). This is because education improves women's knowledge about general and reproductive health care, nutrition and disease treatment and thus increases their ability to better control their own lives and that of their children. Therefore, educating women and informing them about the availability and necessity of health services has been found essential to improve maternal health (Obuekwe et al, accessed 25/5/2007), for example through behaviour change communication (BCC) and information, education and communication (IEC) strategies. Considering the respective local and cultural context, these approaches aim to increase people's knowledge about reproductive health, to promote and maintain a change of attitude for a healthier behaviour, and to increase demand for services as well (FHI, UNFPA, both accessed 25/6/2007). This includes raising women's awareness about their right to receive care (WHO, 2003:17). Likewise, women's situations can be improved and maternal deaths reduced through policies that support later marriage, delayed childbearing and the improvement of economic and occupational prospects for girls and women (Senderowitz 2000, in Ransom and Yinger, 2002:24).

Furthermore, as in many developing countries men are still the ones who make decisions about their wife's health care, most programmes emphasize the role of men in reducing maternal mortality. Several studies have found that most men lack knowledge about pregnancy complications and therefore make poor decisions about seeking care during their partner's pregnancy and delivery. Consequently, educating men and husbands about reproductive health plays an important role in achieving safer motherhood as well (Ransom and Yinger, 2002:22).

However, as discussed earlier, even if women are enabled and encouraged to seek care, often they are constrained by financial costs. Many poor households still pay a lot of money for maternal health services, mainly through out-of-pocket payments (WHO, 2006c:11). Often people do not seek care because they cannot afford the costs due to insufficient levels of income. Therefore, interventions to reduce financial barriers have been stated as crucial as well. Some countries have approached this problem through, for example, the abolishment of costs for poor pregnant women funded by government revenues (Ghana), social health insurances (Bolivia), voucher schemes and cash transfers, or community-based financing for transport and emergency transport services (Borghi, et al, 2006:1463; Ensor & Cooper, 2004:74).

Altogether, demand side interventions such as removing women's educational, cultural and financial obstacles to maternal health services have been confirmed to significantly improve maternal health and hence remain crucial

(ELDIS, accessed 29/5/2007). The removal of supply side barriers through adequate provision of care services (Freedman et al, 2005:7) is equally important, as shown below.

2.2.8.2 Supply Side Strategies

(i) Family Planning

Reducing maternal mortality largely depends on the reduction of the probability that a woman becomes pregnant (McCarthy and Maine, 1992:23). Therefore, one of the most critical supply side interventions to address maternal mortality that was also recommended by the SMI and ICPD programme of action is the provision of family planning services. Costello et al (2004:1167) estimate that the adequate supply of family planning services could lessen maternal deaths in developing countries by at least 20%. Obuekwe et al (accessed 25/5/2007) also found that maternal mortality ratios have decreased in countries where use of contraception has increased. However, due to several supply side and demand side constraints such as unavailability and high costs of services, cultural barriers and lack of knowledge, many women in the developing world are still denied the access to family planning (Key, 1987:61). It is assumed that 200 million women have an unmet need for contraception today (Singh et al, 2003, in Freedman et al, 2005:73). Accordingly, worldwide more than 75 million pregnancies annually are unwanted (UNICEF, 1998:1), and approximately 22% of them lead to abortion (The Alan Guttmacher Institute, 1999:7). It is estimated that between 25% and 40% of all maternal deaths can be avoided by preventing unwanted pregnancies

(Campbell and Graham, 2006:1295). Thus, increasing the availability of contraceptive information and services is regarded as one of the main strategies to reduce maternal deaths, especially those from unsafe abortions (Liljestrand: 1999:879). By using contraceptives, women are also enabled to delay motherhood, space births, and protect themselves from sexually transmitted diseases (STDs) such as HIV/AIDS. The provision of emergency treatment for abortion complications, family planning counselling and post abortion care services have also been found to contribute to reduced maternal mortality and morbidity (Ransome and Yinger, 2002:3, 8).

Despite the importance of family planning to achieve better maternal health, it is acknowledged that family planning services cannot represent a substitute for obstetric care services, as they will not avert complications in pregnancy (Obuekwe et al, accessed 25/5/2007. Preventing pregnancy complications was promoted as one of the main strategies to reduce maternal mortality by the SMI, as discussed in the following section.

(ii) Antenatal Care and Traditional Attendants

Although the SMI includes a broad range of approaches, in the earlier years of the initiative, donors, UN agencies and governments mainly focused on two elements of the safe motherhood strategy – antenatal care (ANC) and training of traditional birth attendants (TBAs) (Starrs,2006:1130). Antenatal care programmes were believed to prevent maternal deaths through screening for risk factors or the detection and treatment of complications. However, it was increasingly realized

that most obstetric complications can neither be foreseen nor prevented (Maine and Rosenfield, 1999:481) and that every woman is at risk of complications. Consequently, the "risk approach" was soon no longer favoured (Villar et al 2001, in Ransom and Yinger, 2002:10). Nevertheless, ANC is still considered effective in identifying and treating causes of maternal deaths such as anaemia, hypertension and infections. Jowett (2000:215) estimates that ANC interventions altogether can prevent about 26% of all maternal deaths today. Likewise, ANC has been found useful for the provision of information about services for obstetric emergencies or health care during pregnancy (Tsui et al, 1997:124).

Apart from ANC, the second major strategy promoted by the SMI in earlier years was the training of TBAs,. This was believed to advance delivery care at the community level, as it was realized that many births in developing countries take place at home supervised by TBAs such as relatives only (Starrs, 2006:1130; Freedman, et al, 2005:91). However, because TBAs lack the necessary medical proficiency to deal with obstetric complications and usually do not belong to the formal health-care system, in many countries the strategy was not successful (UNFPA, 2004: 10). Consequently, training of TBAs was soon no longer regarded a priority as well (Graham, 2002:703). Nevertheless, research has shown that TBAs often offer psychological support and advice to pregnant women in their communities and therefore have a major influence on women's decision making regarding health care (Jowett, 2000;210, Ensor and Cooper, 2004:73). For example, studies revealed that training of TBAs is associated with an increase of

women using ANC services by 38% (Sibley et al, 2004:298). Moreover, due to the lack of health professionals in many developing countries, especially in rural areas, TBAs are likely to remain birth attendants for some time (Galadanci et al, 2007:452). In countries where maternal mortality is high and use of TBAs common, programmes hence often support the social role TBAs play in women's health care. For instance, they collaborate with them to promote reproductive health education and to diminish delays in seeking care (UNFPA, 2004:6).

Despite some advances, altogether training of TBAs and providing ANC services have not been found to reduce maternal mortality significantly, for example at the Technical Consultation of Colombo, Sri Lanka (1997), where the progress made since the initiation of the SMI was evaluated (Graham, 2002:701). This brought about a change in the focus of the SMI strategies.

(iii) Skilled Care and Emergency Obstetric Care

As it was increasingly realized that MMR are highest in countries where women are not supervised by professional care during childbirth, skilled attendance at delivery was soon promoted priority within most maternal health strategies (Graham, 2002:702; WHO, 2004b:2). A skilled attendant is defined as a medically qualified provider (a midwife, nurse or doctor) who has the professional midwifery skills to manage normal deliveries, to diagnose complications, start treatment and carry out essential interventions accordingly. Besides, he organizes the referral of mother and baby for treatments he is not able to perform or which are not operable in a particular setting (WHO, 1999:31). In comparison, most

TBAs have not received any formal training and therefore are not regarded as skilled health personnel (AbouZahr and Wardlaw, 2001:563).

According to UNFPA (2004:15), the MMR is lower in countries where assistance of trained medical personnel at childbirth is high. This is also stated in the Millennium Declaration, where this indicator is used to measure progress towards achieving the fifth MDG (Ransom and Yinger, 2002:18).

An equally important strategy to decrease maternal deaths is seen in treating pregnancy complications and therefore ensuring the access to quality emergency obstetric care (EOC) (WHO 1996, in Liljestrand, 1999:879). EOC includes the provision of special drugs and the conduction of lifesaving treatments such as caesarean section deliveries and blood transfusions (Ransom and Yinger, 2002:14) Jowett (2000:215) estimates that the universal availability of EOC services can reduce maternal mortality by 74%.

Furthermore, as a majority of maternal and newborn deaths occur within six weeks after delivery, the provision of postnatal care – the handling of complications occurring after childbirth as well as the provision of health care information for the mother and her child – is acknowledged crucial to reduce maternal morality (Nigeria DHS 2003, 2004:125). Postnatal care is especially important within the first four hours of delivery, as 90% of maternal deaths that are caused by postpartum haemorrhage the most common cause of maternal death, arise within that time (UNFPA, 2006:12). Altogether, in recent years particularly the provision of skilled attendance at births, quality emergency obstetric and

postnatal care has been promoted essential to improve pregnancy outcome and save mothers lives.

(iv) Access to and Quality of Care

Nevertheless, the supply of maternal case services can only be effective if pregnant women are guaranteed access to this care (Ransom and Yinger, 2002:3). Apart from removing financial and cultural barriers, it is also critical to provide sufficient referral and transport systems to women who have birth complications to ensure they receive lifesaving EOC in time (Freedman, 2003:102). In some countries and regions where geographical constraints hamper emergency referral, maternity waiting homes have been established close to health institutions (UNFPA, 2006:11). These provide a place near to professional care where women can stay in the final weeks of pregnancy and allow immediate interventions in case of complications (WHO, 2003:22).

However, as discussed above, even when women reach a health centre in time, they often do not receive the health care services they need, as many health facilities, especially those in poor and geographically remote areas, face a severe shortage of skilled staff, medical and technical equipment (Lule et al, 2005:17, 38). Services are often not available 24 hours and seven days a week (Freedman et al, 2005: 85). Because of inadequate salaries and unfavourable working conditions, health staff is also often unmotivated and disorganized (Macfarlane et al, 2000:844). A study from Bangladesh revealed that almost 40% of patients who were asked for the reason of not seeking care did not receive the required medicine

due to unavailability. Another 25% stated the absence of the doctor, and 6% the unfriendliness of staff (Piet-Pelon et al 1999, in Ensor and Cooper, 2004;70). Therefore, the improvement of health staff capacity, skills and morals as well as health centre equipment has been regarded significant to address maternal mortality (Macfarlane et al, 2000:844).

Altogether, maternal mortality strategies today are increasingly aiming to improve women's status and make skilled care at births and EOC financially, cultural and geographically accessible for all women who experience complications. It has also been acknowledged that these services need to be supported by an enabling environment that includes adequate quality and capacity of health personnel, equipment and supplies, reliable systems of transport, sufficient roads and infrastructure (Freedman et al, 2005:16, UNFPA, 2004:17).

However, the provision of sufficient maternal health care today is also limited by further weaknesses and constraints in the health system. The next paragraph will give an insight into the challenges many health systems face today to delivery appropriate maternal care services.

(v) Health Systems

Despite the manifold efforts made in recent years with the introduction of the above mentioned strategies, maternal health services cannot reduce maternal mortality if the overall health system is weak (Graham, 2002:703). Several health systems in developing countries today suffer from the negative consequences of the curtailing of social service provision due to Structural Adjustment

Programmes. The numerous economic reforms policies, persistent poverty, heavy foreign debts, corruption and a poor overall government performance have a negative impact on health systems in many countries (Freedman, 2003:103-4, Leonard, 2002:74, 62).

Therefore, in many low-income countries the strengthening of the weak health care system is a major challenge to achieve safer motherhood (Lule, et al 2005:19). The WHO (accessed 27/5/2007) has estimated that widespread provision of comprehensive, effective and equitable health systems could meet 70 to80% of the fifth MDG. This is increasingly recognized and several developing countries have initiated health sector reforms in the past years (Graham, 2002:703). Apart from the lack of human resources, equipment and quality, many health sectors also suffer from an absence of coordination among the numerous donors and non-governmental organizations (NGOs) involved in health interventions. The result is an uneconomical duplication of services (for example, parallel drug-delivery systems), which hinders the implementation of coherent health programmes. In recent years, stakeholders of health projects therefore have tried to improve coordination between them – for example through participation in sector-wide programmes (Freedman et al, 2005:149, Global Health Watch:2, (accessed 8/6/2007).

(vi) Sector-Wide Approaches

The sector-wide approach (SWAP) to health development is a partnership led by a government and involves donors, NGOs and civil society organizations

(Cassels 1997, in Hill, 2002:30). It promotes a joint development of sector policies and strategies, the establishment of a common management system, and institutional improvements and capacity building in the sector. SWAPs aim to reinforce national leadership and transparent decision making and facilitate financing by channeling funding into a single expenditure scheme (Walt et al, 1999:216; Hill, 2002:31-33).

Although SWAPs can facilitate the planning, financing and organization of health systems and increase investments into the health sector, they have yet not shown to markedly improve health care services provision or the health status of deprived populations (Toole et al 2003, in Freedman et al, 2005:151). Because a SWAP is a relatively new strategy, introduced in the late 1990s, and due to the weakness of health sectors in many countries where SWAPs are implemented, this approach probably requires another decade of continuous implementation before significant improvements can be confirmed. Moreover, the success of SWAPs is still hindered by a lack of consensus and collaboration between some international stakeholders (Hutton and Tanner, 2004:893, Hill, 2002:31). Goodburn and Campbell (2001:919-920) are also concerned about the lack of focus on maternal mortality in SWAPs, even in countries where maternal death numbers are high. They still advocate for continued support of maternal health programmes through SWAPs, because donors often grant large amounts of funding to these approaches, which might increase the investment for maternal health programmes as well.

Likewise, SWAPs are more likely to be successful than single, separately financed programmes (ibid).

(vii) Decentralization and the Role of NGOs and Community Based Interventions

Another strategy increasingly proposed to improve health sector performance is decentralization, which redistributes authority from central to district or community level (Tsui et al, 1997:163). The reason, as for example shown in the World Bank World Development Report (2000), is that a great number of poor people are dissatisfied with the deficient quality of often highly centralized and unaccountable governmental health and social care services (Macfarlane et al, 2000;842). Likewise, the private sector often lacks quality or does not reach low-income population groups. Many people therefore prefer the work of NGOs as those play an important role in advocacy for health services and often offer a considerable share of health care services (Leonard, 2002:63, UNFPA, 2004:14). However, as some NGOs lack the financial and technical resources to provide comprehensive care (Lule et al, 2005:39), it is suggested that the collaboration of governments and NGOs in the provision of services could both enhance quality and diminish costs (Leonard, 2002:75),

However, community-based interventions often provide the best way to improve the health of the poor (ELDIS, accessed 29/5/2007), yet they have been "neglected and undervalued' (Costello et al, 2004:1166). Freedman et al (2005:78) state that the most successful maternal mortality reduction strategies give highest

priority to local problem solving within health institutions and communities. Community-based strategies are more sensitive to women's culture and needs, facilitate the understanding of existing local situations and restrictions faced in providing services, and promote local based solutions (WHO, 2003:24). Likewise, the involvement of religious and community leaders helps to address the issues of reproductive health and safe motherhood within the cultural and religious context of the population group. Through education and awareness-raising community involvement can diminish delays related to decision making and reinforce utilization of maternal health services (UNFPA, 2006: 1517). Hence, "instead of jumping from one intervention to the other", the international health community is advised to focus on improving community based approaches (Kamala 1997 in Stekelenburg et al, 2004:396) and help to enhance regional and national capacities through technical support (WHO, 2006c:5).

In recent years, the involvement of communities in health interventions is increasingly promoted. For example, the WHO Making Pregnancy Safer (MPS) initiative launched in 2000 fosters the improvement of access to professional health services for women and their babies by working closely with communities (WHO, 2003:v). Evidence from several countries has shown that health institutions supporting community health strategies initiated by local government are more successful and sustainable than "top-down efforts" (Veneraction 1994, in MacFarlane et al, 2000: 85). Moreover, Tsui et al (1997:146) found that most developing countries already have some existing infrastructure to provide maternal

and child health services. Therefore, they argue that the improvement of health service delivery can primarily be achieved through enhancing coordination, cooperation and incorporating and diversifying available services before building new ones.

Altogether, it is acknowledged that maternal mortality can only be reduced if maternal health services and safe motherhood strategies are embedded into a well functioning, coherent and coordinated health system, which puts the needs of local people and their involvement in provision and improvement of care first. However, despite the increased efforts made to improve the effectiveness of the above discussed approaches, there has been almost no progress in reducing maternal mortality in the past 20 years. This research was therefore embarked upon to find out the type of strategies which Rotary International employed towards finding solution to the problem.

2.2.9 Lack of Progress in Reducing Maternal Mortality

Despite 20 years of international promotion of safe motherhood, which was launched in 1989, and the WHO estimation that "88-98% of maternal deaths are preventable" (in Campbell & Graham, 2006:1297), approximately 10 million women have died in pregnancy and childbirth during that period. Compared with other MDGs, the goal of reducing maternal mortality has made the least steps forward and it is the one which is most unlikely to be achieved (Freedmnan et al, 2005:77; Galadanci, et al, 2007:452).

Although the proportion of deliveries attended by skilled health care in Southeast Asia rose from 38% in 1990 to 68% in 2000, from 40% to 71% in Northern Africa and from 51% to 79% in Eastern Asia; in Sub-Saharan Africa, there were still only 46% of births attended by skilled care in 2000 compared to 42% in 1990, and in South Asia, coverage also just increased from 30% to 36%, despite the fact that almost all of the worlds maternal deaths occur in these two regions. Likewise, the presence of trained care at delivery is inequitably distributed within countries. In sub-Saharan Africa, urban women are over three times more likely to deliver with health personnel than women in rural areas, and women in the wealthiest fifth of the population are six times more likely to give birth supervised by a health professional than those in the poorest fifth (Millennium Development Goals Report 2006:12-13). Overall, the average annual increase in skilled care at birth was only 1.7% between 1989 and 1999 (AbouZahr & Wardlaw, 2001:564).

At the current rate of progress, less than 50% of women in sub-Saharan Africa will give birth attended by a health professional in 2015 (ELDIS, accessed 29/5/2007). It is also estimated that still 60% of births in developing countries do not take place in a health facility today (WHO in Stekelenburg et al, 2004:390).

Why has there been so little progress, although the medical, economic and societal interventions that are needed to address maternal mortality are widely known (Lule et al, 2005:18). There are several reasons. Not only social, cultural and economic problems and health system weaknesses hinder progress in bettering

maternal health, but political and technical factors as well. One of them is the lack of data about maternal mortality ratios and cost effectiveness of intervention strategies (Graham, 2002:701).

2.2.9.1 Lack of Data

A major challenge in improving maternal health is that many national MMRs are underreported (Liljestrand, 1999:879). Experts believe that most MMRs of poor nations are probably double or triple as high as those reported. In many developing countries where population figures are large, population-based investigations of maternal mortality are expensive and time-consuming (Ransom & Yinger, 2002:16) Likewise, health information and civil registration systems that record live births and deaths by cause are absent or unreliable (AbouZahr & Wardlaw, 2001:561-2). This makes it difficult to assess progress and rate the impact of health interventions (Starrs, 2006:1131). This is actually true in Nigeria, because deaths are regarded as sorrowful occurrences, hence most people do not bother to register it officially.

Moreover, in some less developed countries, maternal causes are not recorded as a death reason in official statistics. Similarly, deaths occurring in early pregnancy and from complications of induced abortion often remain unreported, and therefore, many deaths are unrecorded or miscategorized. Consequently, many national and international safe motherhood strategies lack data, which often causes doubt and resignation among the stakeholders involved because there is no

solid evidence for decision-making (Ransom and Yinger, 2002:16; Graham, 2002:702-703).

Partly due to the difficulty to obtain MMRs, the Millennium Declaration also proposes to measure progress by the skilled-attendant indicator, from which data are more available for most developing countries through Demographic and Health Surveys (DHS) (AbouZahr and Wardlaw, 2001:563). Moreover, it was realized that maternal health is inseparably connected to reproductive health and that related services promoted by the ICPD Programme of Action, such as family planning, are of fundamental importance to achieve the fifth MDG (Freedman, 2003:99). Hence, the goal was augmented to promote universal access to reproductive health services by 2015. This includes the coverage of emergency obstetric care, the proportion of family planning needs satisfied, the adolescent fertility rate, contraceptive prevalence rate and HIV prevalence among 15 to 25 year old pregnant women as relevant indicators (Freedman et al, 2005:17). Initially, reproductive health was not included in the Millennium Declaration document because of the conservative attitude of the U.S. and some other nations on this sensitive issue (German, 2004:65).

Altogether, the contribution of comprehensive information is crucial to the reduction of maternal mortality. Evidences from countries that have achieved improvements in maternal health; such as Sri Lanka, shows that data on maternal deaths reveal the seriousness of the problem and force governments to react and invest in maternal health (Graham, 2002:701). Investigating the causes and

circumstances of maternal deaths and referring them to decision makers is therefore an important way to make politicians take action (Liljestrand, 1999; 879). Although this should be the way it should be handled, most politicians in Nigeria may not necessarily be interested in research findings or to study research reports.

Yet another main reason why progress is uneven or declining in a number of regions is because political commitment has been lacking in some countries (Starrs, 2006:1132).

2.2.9.2 Lack of Commitment and Funding

Ransom and Yinger (2002:10) argue that maternal mortality would be significantly lower if the access to maternal health services would be governments' main concern. However, many nations have yet mostly neglected women's needs and their right to health (Germain, 2004:65) - mainly because maternal mortality is often considered a "women's issue" only (Starrs, 2006:1132). Likewise, at the G8 summit in Genoa in 2001, compared to HIV/AIDS, tuberculosis and malaria, maternal mortality was not regarded a global health priority (Graham, 2002:701). Accordingly, present funding for safe motherhood is inadequate to achieve the fifth MDG (Borghi et al, 2006:1457). Although the WHO recently estimated that a comprehensive maternal health programme using available resources in a less-developed country would cost just US$ three per person per year (in Ranssom and Yinger, 2002:11), maternal health programmes lack funding since many years. A few months after the ICPD

conference in1994, the newly elected U.S. President arranged his country to reduce its aid contribution to certain reproductive health areas. Since then, inadequate funding meant that millions of women did not gain access to family planning services, resulting in almost unchanged high maternal deaths due to complications of unsafe abortions (Rosenfield & Schwartz, 2005:647). Moreover, the main donor countries contribute still less than the promised 0.7% of their gross domestic product (GDP to official development assistance (Borghi et al, 2006:1463). Similarly, approximately only 5-11% of the aid budget of all donors and 4-12% of national health expenditures is contributed directly to maternal health services (Graham, 2002:703). However, it is estimated that the missing funding for maternal health care requires an increase of just 0.01% of the GDP of all main donors (Borghi, et al, Ibid). Therefore, enhancing international and national political commitment is believed a major component "to overcome this avoidable tragedy" (Shiffman, 2000:286).

However, missing political will is also reflected in the unwillingness of some participating stakeholders in safe motherhood interventions to coordinate their actions.

2.2.9.3 Lack of Coordination and Collaboration

At the five year review conference of the ICPD (ICPD + 5) in 1999 it became obvious that the SMI's goal to reduce maternal mortality by 50% by 2000 will not be achieved. The failure was mainly accredited to the great number of policies, funding – schemes and programmes implemented by the SMI and ICPD

participants such as Ministries of Health, NGOs and civil society groups (Haberland and Measham, 2002:1). This caused a lack of common agreement regarding appropriate interventions and hindered the implementation of focused, coordinated and realistic strategies for improving maternal health (Starrs, 2006:1131-2). Likewise, discrepancies arose due to the unawareness about the respective responsibilities and comparative advantages of the different groups participating in safe motherhood programmes (Graham, 2002:702). For example, communication has often been missing because many governments did not accredit the work of NGOs and community-based organizations (Lule et al, 2005:42).

However, in recent years, donors and NGOs have increasingly acknowledged the significant burden on low-income governments of negotiating and implementing different programmes and therefore increasingly collaborate on large public health initiatives. As stated earlier, some stakeholders have started to support SWAPs (Lule et al, 2005:42, Bhatia and Mossialos, 2004:181). Likewise, global partnerships between Ministries of Health, organizations and donors are considered to help to find joint solutions for the achievement of the fifth MDG (WHO, accessed 27/5/2007, WHO, 2003:28). Altogether, it is increasingly recognized that united efforts for maternal health programmes would be more effective than competing agendas (ELDIS, accessed 29/5/2007).

Tsui et al (1997) also stated the importance of inter-sectoral partnerships for the implementation of strategies, as most programmes to address maternal

mortality are ineffective as "single-agency mission". (1997:166). It is realized that maternal health services alone cannot reduce maternal mortality and therefore need to collaborate with programmes that promote the education and empowerment of women and communities (WHO, 2003:3). Maternal health strategies also need to be connected to other major health and development problems, such as child health, HIV/AIDS and poverty reduction (Starrs, 2006:1132). In most of the countries where maternal mortality has decreased, partnerships between Ministries of Health, NGOs, Professionals, academics, community based groups, international organizations and different sectors have made a vital contribution to this progress (UNFPA, 2004:2).

Therefore, the promotion of more harmonized strategies between different partners is critical for greater effectiveness and sustainability (Bhatia and Mossialos, 2004:181). Enhanced collaboration between varying stakeholders and sectors at national and regional levels is regarded essential to ensure quality and to avoid duplication of services (Starrs, 2006:1132, UNFPA, 2006:15). However, yet diverse ideologies and policy strategies towards health have made successful partnership difficult and many organizations are still not coordinating their activities (Bhatia & Mossialos, 2004:197). Therefore, greater efforts are needed to foster cooperation between the different sectors and stakeholders that are involved in the fight against maternal mortality (Lule et al, 2005:42).

Altogether, the diverse maternal health programmes of the past years could yet not succeed because of the absence of clear and complete data and insufficient

funding and political commitment. Likewise, lack of consensus and coordination among stakeholders has hindered achievements in safer motherhood in many countries.

2.3 Non-State Actors and their Roles in the Development Process

The development process of most nations of the world involves efforts by both the state and non-state actors. Prominent among the non-state actors, are the Non-Governmental Organizations.

2.3.1 Meaning of NGO

According to Asamoah (2003), "Non-Governmental Organization is a term that encompasses a wide range of similar and dissimilar organizations. NGOs are private and pursue a variety of activities that enhance the general welfare of the communities they serve. They may be secular or religious, and often work in tandem with national and local governments, regional groups and/or international bodies". The definition offered by Asamoah (2003) is a generalized one, it is broad-based, encompassing quite a wide spectrum of groups and activities, thereby highlighting the fact that NGOs are diverse and multi-faceted. Todaro and Smith (2006:822) gave a rather microscopic definition as "non-profit organization often involved in providing financial and technical assistance to Less Developed Countries (LDCs)". Theirs seems to be more direct and implies a kind of cooperation between the advanced countries and the LDCs. This definition has therefore introduced an element of cooperation in the process of development, between unequal parties: LDCs and advanced countries.

Turner and Hulme (1997:200-201) describes NGOs as those organizations, which are private in nature, in which the common value that members and trustees claim is the pursuit of development. This definition is a progressive one because in this case, the NGOs have a focus: development. They exist for the purpose of working towards the development of their host society. It is in an effort to drive home this point that Swanepoel and De Beer (2006:18) describes NGOs as stakeholders in development and that they are "organisations not in any way dependent on or responsible to either public or private sectors … NGOs come into existence to address specific problems, for example health, education or housing. More often, they address a number of problems in the field of development". This shows that NGOs are partners in the field of development and as De Beer and Swanepoel (2007:38-39) pointed out, they are role players in community development in African countries because "due to the failures of governments on the political and economic levels ... it was hoped that NGO activity would help to mitigate the negative effects of the macroeconomic policies on poor and vulnerable groups …". They, concluded by agreeing with Peng (1983) that "NGOs can contribute towards enhancing the lives of the poor and protecting their basic rights ... prevent communities from being displaced and impoverished by so-called development programmes".

Non-governmental organizations (NGOS) have become quite prominent in the field of international development in recent decades. But the term NGO encompasses a vast category of groups and organizations.

The World Bank, for example, defines NGOs as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development:. A World Bank Key Document - Working - With NGOs, (2010) adds, "in wider usage, the term NGO can be applied to any non-profit organization which is independent from government. NGOs are typically value-based organizations which depend, in whole or in part, on charitable donations and voluntary service. Although the NGO sector has become increasingly professionalized over the last two decades, principles of altruism and voluntarism remain key defining characteristics".

Different sources refer to these groups with different names, using NGOs, Civil Society Organizations (CSOs), Private voluntary Organizations (PVOs), charities, non-profits charities/charitable organizations, third sector organizations and so on.

These terms encompass a wide variety of groups, ranging from corporate-funded think tanks, to community groups, grassroots activist groups, development and research organizations, advocacy groups, operational, emergency/ humanitarian relief focused, and so on. While there may be distinctions in specific situations, this section deals with a high level look at these issues, and so these terms may be used interchangeably, and sometimes using NGOs as the umbrella term.

The conclusion here is that NGOs are private but mostly non-profit organisations, who are partners in development through their activities geared towards assisting the vulnerable groups, by employing the community strategy to carry out their development activities.

2.4 Origin of NGOs

Development and its administration has evolved over the years, through a process of roles and actions of organizations that are either part of the state apparatus (public) or are market-based (private). This reflects the dominant orientations of development policy. There are however other groups of organisations that are "neither prince (state) nor merchant (market). These are associations formed within civil society bringing together individuals who share some common purpose … this 'third sector', as it is sometimes called, has a wide array of members – formally registered … non-governmental organizations .." (Turner and Hume, 1997:200).

NGOs have been considered as the 'third sector' of society, but in order to understand fully what they are, it is quite necessary to know their origins, in terms of how they came into being and what necessitated or led to their emergence. It is in an attempt to shed light on this, that Turner and Hume (1997;201) stated further that:

> The origins of NGOs vary. Many of them, especially those that function exclusively at the local level, have deep historical roots within indigenous society and have operated, and evolved, over centuries (for example water-user societies, revolving savings and

> credit associations). Other NGOs have their origins in the colonial period. This is particularly the case of those with missionary bases that provide health and education services and often promotes local economic development (for example Caritas). Finally, there are a growing number of formally registered NGOs in developing and developed countries that have been created in the last two decades to pursue a developmental mission. Despite differences in origin, specific objectives, philosophy, scale (of operations, staff and budget), location and structures a perception has arisen that such organisations may represent a development alternative that makes the achievement of progress more likely than in the past.

The above account of the origin of NGOs is more of categorization of NGOs, the origin in terms of the historical account of the emergence of NGOs was not discussed. A more historical account was given in the NGO Handbook (http://www.ngohandbook.org/) which stated as follows:

Non-governmental organizations (NGOs) as we know them today are generally thought to have come into existence around the mid-nineteenth century. It was only about a century later that the importance of NGOs was officially recognized by the United Nations. At the UN Congress in San Francisco in 1968, a provision was made in Article 71 of the Charter of the United Nations framework that qualified NGOS in the field of economic and social development to receive consultative status with the Economic and Social Council.

The development of modern NGOs has largely mirrored that of general world history, particularly after the Industrial Revolution, NGOs have existed in some form or another as far back as 25,000 years ago. Since 1850, more than

100,000 private, not-for-profit organizations with an international focus have been founded. The growth of NGOs really took off after the Second World War, with about 90 international NGOs founded each year, compared with about 10 each year in the 1890s. Only about 30 percent of early international NGOs have survived, although those organizations founded after the wars have had a better survival rate. Many more NGOs with a local, national or regional focus have been created, though like their international counterparts, not all have survived or have been successful.

This article presents an overview of the history of modern day NGOs, with particular emphasis on international organizations. It looks at the different causes that have been championed by NGOs as the events in world history have unfolded, from the aftermath of the Industrial revolution to the World Wars and through the aftermath of the Cold War. It also looks at the evolution of the structure and purpose of NGOs as they have matured over the years.

The World Bank (http://www.ngohandbook.org/) gave another account of the origin of NGOs by stating that: Since the 1970s, it has been noted how there are more non-governmental organizations than ever before trying to fill in the gaps that governments either will not, or cannot.

The above-mentioned World Bank document points out that "since the mid-1970s, the NGO sector in both developed and developing countries has experienced exponential growth … It is now estimated that over 15 percent of total overseas development aid is channeled through NGOs." That is, roughly $8

billion dollars. Recognizing that statistics are notoriously incomplete, the World Bank adds that there are an estimated 6,000 to 30,000 national NGOs in developing countries alone, while the number of community-based organizations in the developing world number in the hundreds of thousands.

Such organizations must operate as a non-profit group. While in that respect, NGOs are meant to be politically independent, in reality it is a difficult task, because they must receive funding from their government, from other institutions, businesses and/or from private sources. All or some of these can have direct or indirect political weight on decisions and actions that NGOs make.

Professor of Anthropology, Richard Robbins, in his book, Global Problems and the Culture of Capitalism (Allyn and Bacon, 2002, second edition), suggests a few reasons why NGOs have become increasingly important in the past decade or so amongst them (Allyn and Bacon, 2002: 128-129).

1. The end of the Cold War made it easier for NGOs to operate.
2. Communications advances, especially the internet, have helped create new global communities and bonds between like-minded people across state boundaries
3. Increasing resources, growing professionalism and more employment opportunities in NGOs
4. The media's ability to inform more people about global problems leads to increased awareness where the public may demand that their governments take action of some kind.

5. Perhaps most importantly, Robbins suggests, is that some believe NGOs have developed as part of a larger, neoliberal economic and political agenda. Shifts in economic and political ideology have lent to increasing support of NGOs from governments and official aid agencies in response.

2.5 Types of NGOs

The origin of NGOs seems to be linked with a wide array of activities which they get involved in. This array of activities shows that there are different NGOs, and it is therefore necessary to explore the various types and how they have been categorized by scholars.

Just as political scientists have attempted to categorize interest groups by membership and function, or insider versus outsider status, so development scholars have tried to divide the broad spectrum of NGOs into categories. One writer (Constantino-David, 1992) cynically, but perhaps informatively refers to BINGOs (big NGOs), GRINTOs (government-run or inspired NGOs), BONGOs (business-oriented NGOs), and COME 'NGO's) (NGOs which are established for opportunistic reasons, and do not last long).

Another way of looking at NGOs is provided by Clark (1991) who uses a dynamic typology, dividing NGOs into six schools, reflecting their historical evolution.

1. Relief and welfare agencies, including missionary societies, providing services routinely and in emergencies.

2. Technical innovation organizations, which promote new or improved approaches to problems (for example, the intermediate Technology Development Group in the UK)
3. Public service contractors, NGOs contracted by aid agencies to implement parts of official aid programmes because of their special expertise (for example, the US NGO called CARE is entirely funded by the government and distributed by the US Food Aid);
4. Popular development agencies which are northern NGOs and their southern counterparts which focus on self-help and social development (for example, Oxfam, BRAC);
5. Grassroots development organizations which are locally based, southern NGOs, which may or may not receive funding from popular development agencies (for example, Musasa in Zimbabwe, or TASO – the AIDS Support organization of Uganda);
6. Advocacy groups and networks, which are groups which do not necessarily have field projects, but which exist primarily for education and lobbying.

Many differing typologies have been drawn up for NGOs or, as they are commonly termed in the USA, private voluntary organizations (PVOs). In this section attention is drawn to a number of the main criteria that have been used for classification to help the reader appreciate the range of agencies included in this

chapter and their heterogeneity in terms of scale, location, objectives relationships and strategies.

A primary distinction can be made between organizations that are based in one country (or several countries) and seek to assist in the development of other countries. These are International NGOs (INGOs). Most of these are based in OECD member states, although a number of Third World networks based in the south are evolving (for example World Rainforest Movement). Below these, in terms of geographical coverage, are what Carroll (1992) has called 'intermediate NGOs' which operate across a developing country or a region of a country. In this chapter these are termed Southern NGOs (SNGOs). Closest to the practice of development are grassroots organizations (GROs) that operate within only a limited area, such as in a group of villages or in parts of a city. In general, higher levels of this NGO continuum (for example INGOs) seek to provide assistance, in terms of finance, resources, or technical assistance to those at lower levels (for example, GROs).

At all levels a fundamental distinction can be drawn between NGOs that seek to provide mutual benefits (benefits to members only) and those that seek to provide public benefits (that is to people who are neither members nor workers of the NGO, or to society at large). This distinction is significant as while the accountability structures for mutual benefit agencies are relatively straightforward (with leaders accounting to members at least in principle), those of the public-benefit (NGOs are often much less clear. This has led Uphoff (1995) to argue that

public benefit NGOs are not part of a 'third sector', but are part of the private sector.

Clark (1991: 41-50) has suggested a useful alternative categorization. He distinguishes between NGOs in terms of their strategic orientation, differentiating between those that focus on relief provision, those that follow the aid market (public service contractors), mutual benefit and public benefit NGOs, and, those that concentrate on advocacy, policy-lobbying and empowerment (see box). Although many NGOs blend a mix of these positions, or change their position over time, the typology gives the reader an idea of the very different objectives and methods that NGOs may utilize.

Non-governmental organizations (NGOs) play a significant role in the social development process in all regions of the world. They are particularly critical in circumstances where State funds are limited, political situations are fluid, natural disasters resulting from both predictable and unpredictable environmental circumstances occur, ethnic strife in rampant, and the level of per capita income severely restricts the ability to purchase needed goods and services – social, educational and economic.

Many of the world's poorest countries are the hardest hit by conditions described above. In addition, gross human rights violations continue worldwide, and silent killings resulting from poverty and its consequences still stalk millions.

Fortunately, a host of local, national, and international NGOs operating throughout the world have made tremendous strides in helping nations meet and

sustain their development objectives in the face of momentous challenges. They have helped to facilitate achievements in basic human development as measured by the United Nations Human Development Index (HDI) (UNDP 2000). They have also been on the front lines in the fight for human rights, equality, freedom and social justice. They will certainly play a key role in the implementation of the goals outlined in the Millennium Development Compact plan of action to end human poverty (UNDP, 2003). Areas targeted for achieving sustainable growth-governance, health, education infrastructure and access to markets – are areas in which NGOs are already working. Mobilizing grass-roots support (in this case for the Millennium Development goals) is already a major component of the mission of many successful NGOs.

A nation need not be poor to benefit from the contributions made by NGOs. While individual governments are responsible for meeting the needs of its citizens, there is a limit to what central government is willing and able to do in both rich and poor countries. NGOs play a vital role in complementing government efforts in meeting human need in nearly all countries. Very few countries have reached the ideal of sustaining the human condition at an optimal level, whatever the GNP and other indicators of wealth, through dependence on government action alone. NGOs help fill in the gaps while systematically prodding government will and the collective conscience.

Characteristics that differentiate the range of organizations operating under the NGO banner include: size, organizational structure, nature of national and

international affiliation, mission, operational programme areas, geographic location, administrative efficiency, accountability, financial resources and funding sources, level of coordination with government and other NGOs, and membership criteria. Strategies used range from grass roots/local community organizing, education, leadership development, policy development and implementation, empowerment through local and national coalition building, to human rights and social justice promotion and monitoring

Target populations include specific categories of the poor and disenfranchised; age and gender-specific groups: selected occupational groups (e.g. farmers and fishermen); and persons adversely affected by disease, natural and man-made disasters, ethnic strife and forced migration. Many NGOs work together as a team locally and nationally, especially in programmes aimed at poverty alleviation, sustainable development, and disaster relief. They may be a part of a larger effort coordinated by an international body such as the United Nations and its specialized agencies (UNICEF, WHO, UNHCR) or by multinational organizations, such as the International Committee of the Red Cross, Oxfam, Save the Children Federation, and Medicins sans Frontieres, Large NGOs have offices in many countries, employ paid staff, and do organized fund-raising. They often cut across populations and are multi-task oriented if their mission includes relief and humanitarian aid, social development, advocacy, education and empowerment, health care and general welfare promotion. NGOs specializing in technological innovation are invaluable team members for many social

development projects. Small NGOs may depend entirely on voluntary efforts for programme supplementation and membership contributions for funding, which may limit their impact.

The body of literature reviewed has revealed the fact that until the late 1970s there was little appreciation of the potential role of NGOs in implementing development projects and influencing policy. However, the 1980s have witnessed a remarkable change in the scale and significance of NGOs. They have now moved into centre-stage in terms of both development practice and debate. This therefore leads us to the question of the role of NGOs.

2.6 The Role of NGOs

2.6.1 International Politics

The role of NGOs has been viewed and discussed from different perspectives, they have been discussed mainly according to the purpose for which they were established. They include:

i. They endeavor to influence international politics (Bestill and Correll, 2001). This reveals the fact that NGOs even though they are supposed to be apolitical also get involved in politics indirectly, through negotiations. This view was corroborated by Knoke (1990:3).

ii. They act as agents of change. This is the view of Klugman (1997), who asserted that even though NGOs come in many shapes and forms, with differing goals and activities, some concern themselves directly or indirectly with policy, while others do not. She carried out a study on

the roles played by NGOs as agents of change by describing NGOs as "the grouping of organizations that function between state and community – some at local level, some at regional or national levels (Klugman, 1997:110).

iii. The NGOs play monitoring role. Al-Jufr (2010) is of the view that through NGOs, people with opinions relating to development can push for actions such as donor-policy debates, sound macroeconomic policy, the opening of industrial country markets, the strengthening of bilateral assistance, or better environmental management of World Bank projects. Their influence can also include their ability to monitor governments and international organizations and thereby help allocate scarce resources efficiently.

2.6.2 General Roles of NGOs

Karunwi (2004), while trying to discuss the role of NGOs in Gender Awareness (Akinboye, 2004:188-203) opined that the general roles of NGOs are:

(1) Service delivery: This is usually done in partnership with international donors, especially UN agencies, to provide goods and services such as water and sanitation.

(2) The promotion of social development in the area of developing the capacity of individuals and communities to help themselves.

(3) Using development as leverage in changing the broader social, economic and political structures of the state.

Williams (1991) however, gave a more comprehensive list of roles played by NGOs as follows:

(i) Development and Operation of Infrastructure

Community-based organizations and cooperatives can acquire, subdivide and develop land, construct housing, provide infrastructure and operate and maintain infrastructure such as wells or public toilets and solid waste collection services. They can also develop building material supply centres and other community-based economic enterprises. In many cases, they will need technical assistance or advice from governmental agencies or higher-level NGOs.

(ii) Supporting Innovation, Demonstration and Pilot Projects

NGOs have the advantage of selecting particular places for innovative projects and specify in advance the length of time which they will be supporting the project – overcoming some of the shortcomings that governments face in this respect. NGOs can also be pilots for larger government projects by virtue of their ability to act more quickly than the government bureaucracy.

(iii) Facilitating communication

NGOs use interpersonal methods of communication, and study the right entry points whereby they gain the trust of the community they seek to benefit. They would also have a good idea of the feasibility of the projects they take up. The significance of this role to the government is that NGOs can communicate to the policy-making levels of government, information about the lives, capabilities, attitudes and cultural characteristics of people at the local level.

NGOs can facilitate communication upward from people to the government and downward from the government to the people. Communication upward involves informing government about what local people are thinking, doing and feeling while communication downward involves informing local people about what the government is planning and doing. NGOs are also in a unique position to share information horizontally, networking between other organizations doing similar work.

(iv) Technical Assistance and Training

Training institutions and NGOs can develop a technical assistance and training capacity and use this to assist both CBOs and governments.

(v) Research, Monitoring and Evaluation

Innovative activities need to be carefully documented and shared – effective participatory monitoring would permit the sharing of results with the people themselves as well as with the project staff.

(vi) Advocacy for and with the Poor

In some cases, NGOs become spokespersons or ombudsmen for the poor and attempt to influence government policies and programmes on their behalf. This may be done through a variety of means ranging from demonstration and pilot projects to participation in public forums and the formulation of government policy and plans, to publicizing research results and case studies of the poor. Thus NGOs play roles from advocates for the poor to implementers of government

programmes; from agitators and critics to partners and advisors, from sponsors of pilot projects to mediators.

Both assertions by Williams (1991) and Karunwi (2004) could be seen as indeed a wide variety of roles that NGOs play. They however seem to run the risk of generalization, because the ability of NGOs to play such roles successfully depends on the environment in which they operate, their objective, their source of funding among others.

Karunwi (2004) however, emphasized that "most NGOs develop their programmes at the community level, which allows them to address the issue of community empowerment". From this assertion, it could be deduced that those roles are more adaptable to NGOs, that are community-focused. She concluded by stating that for effective performance of their roles, NGOs should:

1. Include all beneficiary groups in project planning.
2. Regularly visit and contact beneficiary groups at the household level.
3. Focus on narrowly defined target groups, which enable specialization.
4. Create an atmosphere for the formation of innovative and established relationships with other NGOs and community-based organizations (CBOs)
5. Have a strong and politically-astute leadership.
6. Have a long-term funding perspective from donors who are prepared to support the development of civil society.

The NGOs have the potential of a strong impact on the redefinition of politics and political agendas since its very nature is 'counter-hegemonic'.

2.7 NGOs as Partners in Development

In the past fifty years, NGOs have made a tremendous impact in the areas of international governance and the formation of international policy in numerous areas, ranging from the environment to human rights. In the 1990s they frequently made their mark at major United Nations conferences devoted to key aspects of development (e.g. the 1992 Rio Conference on the environment, the 1993 Vienna Conference on human rights, the 1994 Cairo Conference on population, and the 1995 Social Summit in Copenhagen).

A mix of forces has fuelled the rapid rise to prominence of NGOs. In particular, the ideological ascendancy of neo-liberalism in the late twentieth century has created a global environment conducive to the 'third sector' (Salamon, 1993). The perceived poor performance of the public sector in developing countries has led to a search for more effective and efficient organizational forms for the delivery of goods and services especially amongst aid donors. The latter have reappraised their programmes and have placed greater emphasis on linkages with NGOs. For example, in the UK the fastest growing part of the official aid programme in the early 1990s was the Joint Funding Scheme with NGOs, and the Government's Overseas Development Administration (ODA) is now keen to work directly with SNGOs.

It must be noted, however, that a doctrine of assumed effectiveness has grown around NGOs much of which is either erroneous or unsubstantiated. There is very little evidence that NGOs are more cost-effective than government agencies (Robinson, 1992; Riddell and Robinson 1995) as is often believed, and the data available on performance are very limited (Edwards and Hulme, 1995 and Hulme and Edwards, 1997). NGOs are often able to work with the poor, but their capacity to assist the poorest of the poor is limited (Farrington and Bebbington, 1993: 120). Aid agencies have been reluctant to observe the limitations of NGOs; 'small size,' restricted impact, distance from policy decisions, professional and technical limitations, poor coordination, problems of representativeness and accountability' (Ibid, p. 25).

Since 1989, neo-liberal economics have been harnessed alongside Western notions of liberal democracy into what has been called the New Policy Agenda (Robinson, 1993), NGOs and GROs have been viewed by donor nations as vehicles for democratization and the strengthening of civil society. Indeed, they have been rechristened civil society organizations (CSOs) that may act as a counterweight to the state, opening up channels for communication and participation, providing a training ground for activists promoting pluralism and protecting human rights (Blair, 1997). Thus, Western donors have pushed for a greater role for NGOs not merely to improve developing country economies but also to improve their politics.

Macroeconomic forces have also been important in encouraging the increase in NGO numbers and activities. IMF and World Bank conditionalities on structural adjustment, loans, national indebtedness and further adverse movements in the terms of trade have meant that many countries, and particularly those in Africa, have seen vast reductions in public expenditure. This has led to the withdrawal of state-provided services. Local organizations and higher level NGOs have stepped into these vacuums in an attempt to maintain basic levels of service.

Some of the reasons for the growth of NGOs in Africa were linked to the search for funds for development activities. Yiman (1982) while commenting on the actions that should be taken in order to meet the development needs of Africans, stated that:

> The implementation of the above measures will, undoubtedly, require an enormous amount of financial, technical and specialist inputs. Where do we get these resources from? As a result of unfavourable terms of international trade, and the mismanagement of scarce financial resources, African countries have not been able to generate enough domestic capital. To this effect, about 60% of African development programmes are estimated to be run with the help of aid. A World Bank special paper on the Economic Development Problems of sub-Sahara Africa (1982:19) concludes with a set of recommendations to donors … that aids to Africa should double in real terms to bring bout renewed African development and growth in the 1980s.

Sholes and Covey (1996:5) reported that "USAID direct funding to local NGOs grew by 40% from $184 million to $307.8 million between 1991 and 1995, and that African NGOs have been receiving the majority of USAID funding (35%

overall in the five year period), followed by Latin America and the Carribbean (LAC) with 27%; and Asia Near East (ANE) with 18% of total funds. The Europe/Newly Independent States (ENI) region received only 2% of all funding to NGOs …"

An IMF official, Sergio Perara Leite (2001:2) stated that "the IMF cannot win a war on poverty alone … to be successful, poverty reduction strategies require a level of commitment that can only be developed by debate … A question that is often asked is what should we do if the national government, which should be in the driver's seat, pays only lip service to the participatory process. My answer is that we should push the government gently in the right direction; in the end, it is the civil society that will have to demand more participation in the development process".

Leite (Ibid) explained further that IMF recognizes the contribution that NGOs are making in the poverty reduction process but that NGOs should join forces with the IMF so as to move decisively towards their shared objectives. Leite (op. cit) listed such roles which had been played by NGOs in that direction, as:

(i) Advocacy – bringing poverty and debt issues to the forefront of the political agenda.

(ii) Design – developing proposals that are effective and yet realistic in their demand for resources.

(iii) Identification – Identification of development bottlenecks, as well as possible causes and regional distribution of poverty.

(iv) Project implementation – NGOs carry out projects in low-income countries, which are financed both by their own resources and by multilateral and industrial countries' contributions to NGOs.

(v) Monitoring and evaluation – NGOs can and do play an important role in the area of monitoring progress against targets, to allow stakeholders to evaluate progress.

Examples of other international organizations which partner with NGOs for the purpose of development are UNICEF, UNFPA, WHO, Rotary International, DFID, USAID, Pathfinder International, COMPASS, among others.

2.8 The Comparative Advantage of NGOs/Strength of NGOs

NGOs have generally been considered to be more efficient and more effective in their service delivery. It is therefore necessary to explore those areas of strength and to examine what actually gives them such comparative advantage.

Turner and Hume (1997:207-209) in their analysis tried to assert that: Alongside the influences described above one can also discern a set of micro level arguments that have been developed to explain the comparative advantage of NGOs. Why might NGOs be able to succeed in circumstances where other forms of organization, and particularly public services, have floundered?

Students of organizational behaviour and management have identified a range of features that differentiate NGOs from government agencies pursuing

similar goals. These include flexibility, responsiveness, the capacity to experiment and learn from experience, linking processes to outcomes and the NGO ability to enlist the energies and commitment of intended beneficiaries. Fowler (1988: 11) attributes these features to two distinctive characteristics of NGOs.

1. NGO relationships with intended beneficiaries are based upon principles of voluntarism, rather than those of control which typify government agencies.
2. NGOs have a task-oriented approach that permits them to achieve 'appropriate organization … [as] development, change and diversity, rather than maintenance, control and uniformity, can be their guiding image and organizational design'.

The first of these has been elaborated on in great detail by many writers, under the label of 'participation' (Korten, 1980; Oakley and Marsden, 1984). It is argued that when beneficiaries are involved in programme design and management, then programmes are more relevant and attractive to beneficiaries who take a much greater interest in them. The latter principle has only recently become a major topic for analysis, but is receiving a great deal of attention as even mainstream management theorists search for the secrets of NGO effectiveness (Drucker, 1989).

If one accepts the explanatory power of these two factors (and there is by no means a consensus on this), then an immediate and fundamental problem for NGOs becomes apparent: the dilemma of 'scaling up' (Edwards and Hulme,

1992). The qualities associated with these two characteristics may be incompatible with organizational growth (Tendler, 1987) as they may be lost if growth occurs. They may also lead to NGOs managing their growth poorly (Dichter 1989; Hodson, 1992) with a consequent reduction in efficiency. Views as to whether NGOs can grow and remain operationally effective differ markedly. David Korten (1990), whose work has been very influential, has recently revised his earlier ideas and now argues that the organizational expansion of NGOs will mean they become unresponsive bureaucracies.

A second set of concepts that seeks to explain why voluntary organizations perform well has been derived from work on the sociology and politics of local organizations. Empirical work by Easman and Uphoff (1984) on the ways in which environmental factors and internal variables influenced the performance of GROs indicated that, at least at the local level, there was no optimal organizational model for a GRO and that some form of contingency theory was acquired to relate objectives, environment and organization to outcomes. A set of complex findings emerged (summarized in Hulme and Turner, 1990: 194-197) including evidence that GRO performance was positively correlated with (i) a participatory orientation; (ii) horizontal linkages with other GROs, and (iii) vertical linkages with intermediary (NGOs or unions of GROs.

Asamoah (2003:3) gave a catalogue of this comparative advantage of NGOs, by stating that:

> "The major advantage of NGOs include their flexibility, ability to innovate, grassroots orientation, humanitarian versus commercial goal orientation, non-profit status, dedication and commitment, and recruitment philosophy. Many are made up of volunteers so deeply committed to the NGOs mission that they are willing to undergo considerable hardships and no monetary compensation in order to carry out that mission. In addition to supporting innovation, NGOs may serve as pilots for larger anticipated projects, help to motivate and involve community based organizations whose constituents may be the primary beneficiaries of a larger project, serve as advocates or ombudspersons, and are in a unique position to share communication both horizontally and vertically. A close look at the implementation strategy of any given country's development plan will reveal the nature and extent of NGO activity in relation to its current circumstances. Relief for families and children affected by the AIDS pandemic, local social development, environmental protection, gender equality, the protection of children's rights and freedoms and promoting the positive and fighting against the ill effects of economic globalization, feature, prominently in the list of NGO activities through the world today.

Efforts to manage the AIDS crisis in many countries hit by this pandemic would not be successful without the dedication of local, national and international NGOs. Local NGOs have played a vital role in tailoring government and private response to the cultural practices of local populations. The extent to which information and efforts to change behaviour are geared to the cultural beliefs of the local population can make or break a development, relief or prevention programme. Because many development programmes especially health, focus on KAB (knowledge, attitude and behaviour), it is critical at the design stage to

understand the psychological components of attitude development and change within a given cultural context. International NGOs with national and local counterparts have the advantage of input and feedback from their local affiliates in designing culturally appropriate programmes. This input should not be overlooked or minimized.

However, one characteristic these diverse organizations share is that their non-profit status means they are not hindered by short-term financial objectives. Accordingly, they are able to devote themselves to issues which occur across longer time horizons, such as climate change, malaria prevention or a global ban on landmines. Public surveys reveal that NGOs often enjoy a high degree of public trust, which can make them a useful – but not always sufficient-proxy for the concerns of society and stakeholders (Business and sustainable Development, bsdglobal.com).

As was argued by Klugman (2001) while discussing the role played by NGOs, in affecting policies, she stated that it is the non-profit status of NGOs that actually enhances their ability to do so. She stated further that; it is not, however, the existence of certain types of NGOs, alone, that facilitates policy change. NGOs operate within a political, economic and social context that may be more or less favourable to change. This context substantially influences NGO goals and activities. For this reason, it is appropriate to begin by asking how policy change occurs.

The conventional wisdom in many sectors is that policy changes are decided on the basis of a rational assessment of possible options, given existing human and economic resources. This perspective is particularly espoused by those most directly responsible for policy development, that is government technocrats, who define themselves as those with the technical expertise to advise government. Likewise many transnational put money into research for policy, and argue policy perspectives on the basis of research or international experience. This approach, described by policy analysts as a 'rational' approach, formed the basis for early frameworks for understanding the policy process. Initially articulated by Laswell in the 1950s, it presents a chronological set of decision-making stages or phases that usually include identification of the policy problem, agenda-setting formulations of policy proposals, adoptions of policies, implementation and lastly evaluation (Porter, 1995:9).

This approach of course defies the conventional public perception that policies reflect the party-political aims, at best, and the personal ambitions, at worst, of politicians. Moreover, as policy analysts now recognise there is a wide range of forces that influence the process of decision-making around policy, in which the rationality of research findings may carry little weight. For this reasons, today it is accepted by policy analysts that while all the various 'stages' must occur, the phases may occur simultaneously. Walt and Gilson (1999) suggest that policy is a product of the interaction of the possible policy content with the overall policy context, the process of policy-making, and the actors in each phase. Ham

and Hill (1993) refer to the environment of the political system in which policies are made noting that there is an interaction between the social, economic and political contexts that must be analysed in order to understand the way in which problems are addressed (or not addressed). Thus policy content can be further broken down to include the situational or transient context; structural aspects of the political and economic system; the cultural context or values of groups or the community as a whole; and exogenous or international factors. The process includes all the phases of decision-making described above. The actors can be identified in terms of their relationship to the policy-making process. Reich and Cooper's (1996) method of political mapping, for example, proposes that actors should be analysed by among other factors – position (support or non-support of policy), strength of position, power and concentration of power type of organisation, and type of sector (Reich and Cooper, 1996).

This view challenges the idea that content alone – that is, the technical factors influencing policy development is the primary determinant of policy outcomes.

Taking this even further, Kingdon (1995) argues that three streams of processes – namely, problem identification, solution identification and the political process – occur independently. The factors influencing each stream differ. In order to bring about policy change, there needs to be an interaction between all three streams, HIV/AIDS provides a good example. While first the threat and then the reality of HIV/AIDS epidemics have been with many African countries for

years, the extent of the illness and the means with which different countries have responded to the crisis have differed. In the problem identification stream, the issue was identified to a lesser or greater degree in different countries by different sources, in particular, health services, those with HIV and their families, the media, researchers, and donors.

A number of different solutions have been developed in response to the perceived problems, including:

a. Welfare responses to support those with HIV/AIDS or their families in some cases from NGOs, in some cases within communities
b. Efforts by researchers, in some cases supported by the pharmaceutical industry in search of new products and markets, and by service-provision or advocacy NGOs to understand the virus and how it spreads in order to develop technical means of prevention, such as vaccinations, female condoms or microbicides, means of treatment, or means of preventing spread through social interventions, such as providing information and promoting changes in social behaviour.
c. Efforts at containment such as prison policies to separate those who are HIV positive from other prisoners, or immigration policies denying entrance to people who are HIV positive.

How the processes of problem identification and solution development have interfaced with the political process has also differed from country to country. In

some cases mobilization of organisations in civil society has forced government to respond, if only by supporting the direction of multi-national and bilateral aid towards NGOs addressing the problem. In some cases, such mobilization of organisations in civil society has forced government to respond, if only by supporting the direction of multi-national and bilateral aid towards NGOs addressing the problem. In some cases, such as in Zambia, a past president's personal experience of loss of a family member to AIDS has led to the recognition of HIV/AIDS as an issue to be addressed by government. In other cases multinational or bilateral agencies have made HIV/AIDS an area of financial support, thus influencing national policy towards provision of services, social marketing or health promotion activities that were not previously on the agenda.

As the HIV/AIDS example illustrates, there are indeed separate streams of problems, solutions and politics in society. Their interaction is the critical process for policy development and implementation. Kingdon talks of the need for 'policy entrepreneurs' who make connections across streams. By identifying the forces required to bring about an interface between all three streams, and developing strategies to strengthen these forces, such entrepreneurs can play a key role in facilitating policy change. This is therefore the major site for NGOs' interventions in the policy process although their non-profit motive leads us to describe them as 'policy activists' rather than entrepreneurs. Moreover, it is their role as non-profit organisations that make them particularly able to foster both policies and processes to promote equity.

Policy activism can engage with the political process or the bureaucratic process, so that policy activists can help not only to get an issue onto the policy agenda, and influence its content, but to advocate for implementation as well as influencing the nature of implementation through advocacy, operational research or other interventions that influence the bureaucracy.

The Establishment of Coalitions

Another critical factor determining the success of NGOs as policy activists is their ability to work with others. In the case of the women's rights NGOs lobbying the ICPD, they won recognition as those with the necessary knowledge because they drew upon the experience of groupings from all over the world. In addition, they operated in unison. Whatever the ideological or organizational difference between those NGOs that chose to lobby the ICPD, they developed consensus on wording. The importance of ensuring unity in relation to one specific goal, irrespective of other areas of difference, cannot be overemphasized as a critical factor in successfully influencing a policy process.

Klugman (2000), Karunwi (2004) and Asamoah (2003) all agree that part of what accounts for the success or strength of NGOs, is in the fact that most of them have the trust and legitimacy needed. Most of them have built a good name for themselves and for their staff. NGO legitimacy is won primarily out of their demonstratable competence at all these levels. Working with others in networks and coalition builds trust in the NGOs style and integrity, and one success builds further confidence in their ability.

At the same time, it is usually NGOs who take on the role of facilitating for the most disadvantaged in society to express their own views. Thus, while the legitimacy of NGOs does not reside in being representative organizations (Van Roog, A., 1997: 93-114), it is enhanced by their commitment to ensure that the experiences and concerns of advantaged or oppressed constituencies influence the policy agenda process and outcome.

NGOs also help in getting gender-disaggregated data to assess gender disparities and monitor gender consequences of policies (Karunwi, 2004); which often provide data for scholars engaged in research.

These strengths or comparative advantages of NGOs notwithstanding, NGOs have received criticisms from different quarters.

2.9 Criticisms/Weaknesses of NGOs

Shah (2005) opines that:

> There is plenty of evidence that the growth in size and number of NGOs is fed by increased governmental contributions along with greater contributions from multilateral developmental organizations such as the World Bank. On the one hand, these conditions have created additional monies for NGOs and GROs (Grassroots Organizations) to develop; on the other hand, they risk becoming so dependent on governments that they have been co-opted and their independence threatened.

This shows that some NGOs, due to fund contribution by government, may end up losing their "non-governmental" status, and may end up losing their independence.

Shah (2005), ibid) further stated that:

> In the past, many development NGOs gained a bad reputation with developing countries because they were seen as arrogant and going into poor countries and telling people how to do things, or doing things for them. They have also been described by some as the modern missionaries, referring to the imperial and colonial times, where things like converting people to Christianity was considered the moral thing to do by European and American missionaries.

Some NGOs, aid organizations and development institutions from the "North" have been described sometimes as being tools or part of the objectives of the foreign policy aims of the 'northern nation' from which they come. But Howell and Pearce (2000) noted that civil society cannot really be grown from 'outside', it comes from within society; it reacts to specific historical, social and cultural contexts. It is not that donor programmes are entirely negative. Howell and Pearce add, but that they are certainly not neutral. By making various assumptions they conclude that donor agencies risk becoming 'creations of the outside, embodiments of external norms and goals, and materially dependent on outside rather than local sources".

David Rieff, writing in The Nation expands those ideas suggesting that strengthening the civil society sector goes in line with the neoliberal idea of reducing the role of the state:

> That this emphasis on local capacity building, to use the bureaucratic term of art, and on fostering civil society arose at exactly the moment when development aid from most major donor countries was plummeting (n many countries, including the United States, they are now at historic lows) may, of course, be coincidental. But in the development sphere, at least, ideological commitment to making states "responsive" to civil society seems to have been accompanied by a determination to cut funding. When pressed development specialist s who favour this new approach insist that a robust civil society will open the way for the integration of the poor world into the global economy – supposedly the first step toward prosperity.

There has also been criticism on how NGOs have used their funding and other monies received or raised. Criticisms range from pointing out that only small percentages go to people in need, that a lot goes to recover costs, and some have even been used to pay very high salaries of the people at the top of these organizations.

In some cases, this is fair criticism. In other cases, these arguments have been used by those who wish to paint a dark picture of NGOs in general because NGO research may ultimately criticize their practices. It has to be expected that NGOs need to pay for expenses, for permanent staff and for various other costs incurred.

Due to the pressures of obtaining and maintaining funding, much effort is spent on marketing, and the already constrained budgets require many NGOs to ensure optimal efficiency, similar to private corporations. Sometimes then, the actual activity can be affected due to the need to raise funding.

It is easy to think of NGOs as one group. However, the interests and perspectives are so diverse, that summarizing and generalizing criticisms that can be valid to all NGOs and similar organizations is obviously unfair. Indeed there are many NGOs now that do not really work in tune with government and corporate interests as suggested above, but seriously challenge and criticize. As Lewis and Wallace (2000) write in an introduction to their book on development NGOs:

"The new attention being given to NGOs as actors in "civil society' unleashes a new set of difficult conceptual and terminological problems, partly because non-governmental organization" is in many ways a virtually meaningless label.

i. For some analysts the term is synonymous with the "aid industry." In which NGOs are viewed as effective tools or channels for donors to provide international development funds to low-income countries.

ii. Conversely, they are seen as vehicles for privatizing foreign assistance, making it less accountable to either government authorities or local people because of a lack of clear governance structures for NGOs

iii. Some see NGO as a term strongly associated with grassroots action and community organizing, which may exist outside the domain of the formal development world.

iv. Others see NGOs primarily as service contractors, able to work more efficiently and more effectively than government agencies but with

comparatively little legitimacy with which to challenge policy or represent people.

Inadvertently Doing More Harm than Good?

Another type of criticism for some NGOs is that despite good intentions, they may be doing more harm than good, without realizing it. For example, many food aid groups where, in non-emergency situations, food is delivered from rich countries for either free, or virtually free, end up under-cutting local producers and hence have a negative effect on local farmers and the economy (as shown in this website's poverty sub-section on hunger and food dumping (http://www.globalissues.org/issue/9/food dumping). As another example, many organizations working on population-related issues risk doing more harm in other societies due to either misconceptions about over-population, or misunderstandings about family and community structures in those societies. (See this website's section on population for more details).

Aid has often been seen as an altruistic action often coming from religious roots and therefore seen as a moral thing to support. However, sometimes, what gets lost is the type of aid that is administered. While many wealthy countries are cutting back on their already low aid contributions, the discussion/criticisms and debates should also focus on the types of aid.

A lot of official aid, raised and distributed by NGOs, in the past had been based intentionally or unknowingly on foreign policy objectives, or the interests of

the lenders, less of the recipients. Aid has often led to excessive dependency or reliance on aid rather than helping nations move away from this.

It is not that the poor are unable to do things themselves, but with the aftermaths of colonialism, corruption, conflicts and so on, rebuilding and developing often requires outside assistance. The form of assistance that would be preferred is one that allows the recipient to help them help themselves, along the lines of the famous age-old quote: "Give a man a fish; you have fed him for today. Teach a man to fish; and you have fed him for a lifetime".

Shah (2005) reported that the special Dutch ambassador to Ethiopia and Eritrea, Pieter Marres (May 16, 2001) has stuck his neck out by publicly questioning the use of development aid. He says its keeping people dependent and less self-reliant. It's a situation perpetuated by the way international aid is organized. Every donor has its own priorities, procedures and regulations. Satisfying donor demands requires great effort and energy on the part of developing nations. Many have adopted a wait-and-see attitude, says Mr. Marres.

Reliance on Philanthropy May Reveal More fundamental Issues

We hear more and more about philanthropic organizations set up by mega-successful business elites, where millions of dollars are donated to seemingly worthy causes. However, the fact that such donations are needed also serves as an indication that development policies and globalization policies in their current form are not sustainable! The following quote summarizes this notion quite well.

It is all very well for Bill Gates to charitably donate $750m to pay for immunization programmes for certain diseases, as he recently announced he would do, and for James Wolfenson to urge transnational companies setting up in poor countries to contribute financially directly to local education services. Societies which depend on such largess to meet their basic health and education needs are neither sustainable, democratic nor equitable, yet new dimensions of power are ceded to large companies (Brendan Martin, 2000).

And as Noreena Hertz (2001) points out in the UK's Observer paper, when there is economic downturn, corporate help and charity diminishes and so we should not become more and more reliant on it alone. Dr. Stella Goings of UNICEF also points out that "laying a foundation for a strong economy and not reliance on charity is a start to poverty reduction (http://www.oneworld.net). David Rieff (1999) mentioned above, also adds that the belief that civil society will be able to cope where nations have failed is "a counsel of despaire" as civil society does not have the ability that state would have. The ideal of civil society has been most coherent when applied to nations where citizens needed protection from a repressive state, as was the case in the Soviet empire. But in other parts of the world, this paradigm is either irrelevant or of distinctly secondary importance. There are parts of Africa where a stronger state, one that could bring the various bandits and insurgents to heel, might be of far greater value. Its tempting to add that the United States, after more than two decades of seemingly inexorable

privatization, is a country where strengthening the state' role would be preferable to hoping that NGOs will somehow be able to take up the slack.

The suggestion that civil society can cope where nations have failed is, in fact, a counsel of despair in such instances. Without a treasury, a legislature or an army at its disposal, civil society is less equipped to confront the challenges of globalization than nations are, and more likely to be wracked by divisions based on region and the self-interest of the single-issue groups that form the nucleus of the civil society movement.

NGOs as a Weak Third Sector Compared to Governments and Corporations

Some have observed that in a way then, the complex group termed NGOs are seen as the weaker part of a triumvirate, or "third sector": to counter the other two actors, the state and the market.

It is suggested that NGOs are a natural outcome of a free democratic and capitalistic society. The idea is that as market forces require more and more relaxations of rules and regulations for their benefit, society will naturally demand social justice to balance out negative aspects of market forces such as exploitation and environmental degradation.

This leads to a romantic notion of what Adam Smith, regarded as a father of capitalism, described as a "hidden hand" in his 1776 book, Wealth of Nations, where through the pursuit of self-interest, hidden forces would automatically help balance things out.

Yet NGOs are typically weaker because they are not as financially independent as the other two actors, and are often dependent upon them. Or, when independent, they typically do not have the resources and political power that the other two wield (for example, both states and corporations can own large influential media organizations) and are not as well and long established as the other two.

Other criticisms of NGOs according to Shah (2005) include the following:

i. Undemocratic nature of NGOs – Some people are of the opinion that NGOs are undemocratic, this is because as they claim, nobody chose them, yet they claim to be fighting for various issues for the people. This however, is debatable because even some governments (which claim to be democratic) can be faulted for becoming less democratic in a variety of ways, from concentrating power, to bending to corporate and corporate funded influences, among others. Even many of the mega corporations from the business world which wield enormous influence and power, cannot be said to be democratic either.

ii. The growth of NGOs have been attributed to the failures of state and markets to provide all the requirements of society.

iii. That NGOs have problem of accountability. This, according to Shah (2005, ibid) led to a UK organization, One World Trust, embarking on a project called the Global Accountability Project, to try and compare

accountability of various bodies such as transnational corporations and NGOs.

In continuation of the criticisms leveled against NGOs, Al-Jurf (2010) listed the following:

i. That the increase in NGO power in the 1990s caused some developing nation governments and international organizations to fear the encroachment upon their sovereign power. Their status was consequently closely regulated by the vast majority of developing country governments. For example, the Arab and Asian countries were reported to have often limited NGOs ability to take a public stance on human rights and other issues that they held to be vital national interests. Even at the international level, representatives of NGOs were allowed to observe departmental meetings, but were not given the power to vote at such meetings. They were essentially relegated to consultant status.

ii. NGOs had limited effectiveness and performance because they failed to see the big picture of the problems of the developing countries, they usually operate within the mandates tied to their funding. They therefore, have been regarded as having a narrow focus (Tunnel Vision).

iii. That NGOs act as political platforms for a few executives of the NGOs. Such executives make the organizational policies for the NGO, without

much real or extensive input from their members. This tends to result in arbitrary decision-making by the executives.

The claim that NGOs represent a humanitarian alternative, and that they can and do represent the poor and the marginalized, rests on a number of assumptions:

i. Decisions made and activities pursued by inter-governmental organizations will improve, be fairer and more effective if NGOs are part of the decision making process.

ii. NGOs do not act out of self-interest.

iii. Governments and inter-governmental institutions are uncivilized whereas civil society is civilized, homogenous and in agreement.

iv. It is possible to transmit demands and standpoints from below without distortions.

v. NGOs are immune to corruption whereas politicians and public employees are not.

Today, there is a heated and somewhat worried discussion about the future governance of an increasingly interdependent world. Many are of the opinion that while governments pursue narrow, egoistic interests, NGOs have a global consciousness and therefore they should be allowed to have a say in global decision making. The answer to that claim is not self-evident, as indicated by the following two statements. On the one hand, it is claimed that "NGOs participate vitally in the international system … and generally increase the accountability and

legitimacy of the global governance process (Paul, 1999a). On the other hand, NGOs have been viewed as "unelected and unaccountable special-interest groups [which] disrupt global governance' (Economist, 1999).

While the debate on the role which NGOs should play or do play continues, it is pertinent to note that even though the body of literature which exists as regards the comparative advantages or the limitation of NGOs, appear more like individual tales of isolated cases, they seem to lack proper scientific investigation whose methodologies can either be questioned or replicated. For such to be accepted, it would be necessary to have case studies of different NGOs, taking into consideration their size, goal, environment of operation among other factors, in order to have verifiable evidence.

It is in order to do this that this study has selected a specific NGO, with the aim of carrying out an indepth study that could be replicated or verified, hence the focus on the activities of Rotary International in Maternal Health Care in Northern Nigeria.

2.10 Summary

Maternal mortality remains one of the major health challenges for politicians today. About half a million women annually still die in pregnancy and childbirth, and another 15 million women suffer long-term disabilities – 98% of them in developing countries. The publication of high maternal death numbers in the mid-1980s forced numerous politicians and maternal health experts to address and research the issue of maternal mortality in the following years. The Safe

Motherhood conference and Initiative in1987, the ICPD programme of Action 1994 and the Millennium Declaration 2000 all acknowledged maternal mortality as a multi-sectoral problem. They have promoted initiatives to fight maternal death by addressing financial barriers, educating and empowering women, providing maternal and reproductive health services such as family planning, ANC, skilled attendance at birth and EOC. Several programmes have been implemented to improve the overall functioning of the health systems into which maternal health services are embedded, such as upgrading human resources and infrastructure, better coordination of programmes through SWAPS, and increasing community-based service provision.

It has also been shown that despite the proven effectiveness of these interventions; maternal mortality remains an enormous challenge in many developing nations. Deficient data about maternal deaths numbers makes decision-making difficult for the stakeholders involved. Moreover, a lack of funding for maternal and related health programmes and insufficient political commitment in many countries still seriously hamper improvements in safe motherhood. Besides poor coordination and collaboration among donors, governments and NGOs often result into lack of agreement on appropriate strategies and duplication of programmes, which contributes to the weakness of health systems. Consequently, many developing countries today are still far from reducing their MMRs by 75% by 2015 compared to the 1990-level, especially in Africa and South Asia.

2.11 Theoretical Framework

A theory is a set of ideas that provides an explanation for something. But it must be noted that no amount of theory can hope to explain everything, or account for the infinite amount of data that exists, or encompass the endless ways of viewing reality. Theories are therefore selective in terms of their priorities and perspectives and the data they define as significant (Haralambos and Holborn, 2004).

There are quite a wide range of theories that could be adopted for this study; however, two theories have been selected, they are: structural-functionalism and the Programme theory of Evaluation.

2.11.1. Structural- Functionalism

This is a theory that has its root in sociology. The theory began from the works of Auguste Comte (1798-1857) and Herbert Spencer (1820-1903). It was further developed by Talcott Parsons (1902-1979). Other contributors to the theory are Marion Levy, Gabriel Almond, David Apter and Fred Riggs. Structural-Functionalism views society from a macro point of view, it analyses the way society as a whole fits together harmoniously. It views society as a system, that is, as a set of interconnected parts which together form a 'whole'. The basic unit of analysis in the theory is society and its various parts are understood primarily in terms of their relationship to the whole that is, the maintenance of the society. They believe that in order to survive, society has basic needs that must be met if it is to continue to exist.

Levy (1952), and Davis and Moore (1967) emphasized what they called 'functional prerequisites' which they regard as necessary conditions of existence, as well as to ensure the development of society. They stated for example, that "to ensure that members of society do not become extinct, a system for reproducing new members and maintaining the health of existing members is essential…in order for these essential services to be maintained, individuals must be sufficiently motivated…the social system would collapse through lack of effort…"(Haralambos, et al, 2004).

2.11.2 Application of Structural-Functionalism

Nigeria as a country could be viewed as a 'whole' or a 'system'. This theory of structural-functionalism is adopted for this study because Nigeria which is an 'entity', a 'whole' or a 'social system', has many parts. Each of the parts can be called the sub-systems, and each of those parts or sub-systems must work towards maintaining the entire society. This means that society can only develop if its various parts or sub-systems can work together harmoniously.

The health sector and maternal health care service delivery in Nigeria must be likened to one of the 'parts' or 'sub-systems' of Nigeria, which must function properly in order to ensure the health of the human capital in society, as well as ensuring an efficient health care delivery system. Women constitute part of the human capital in Nigeria because they play significant role in agriculture as well as in other sectors of the economy; in addition to this, women also play a reproductive role. As part of the measures to promote development in Nigeria, it is

incumbent upon the government at all levels to provide and maintain and sustain good health care services. It was however observed that there are gaps in the delivery of health care services and this led to the emergence of NGOs willing to complement the efforts of the government. One of such NGOs is the Rotary International, which attempted an intervention in the maternal health care service delivery in six states of Nigeria. This study is focused on assessing the programme of intervention by Rotary International.

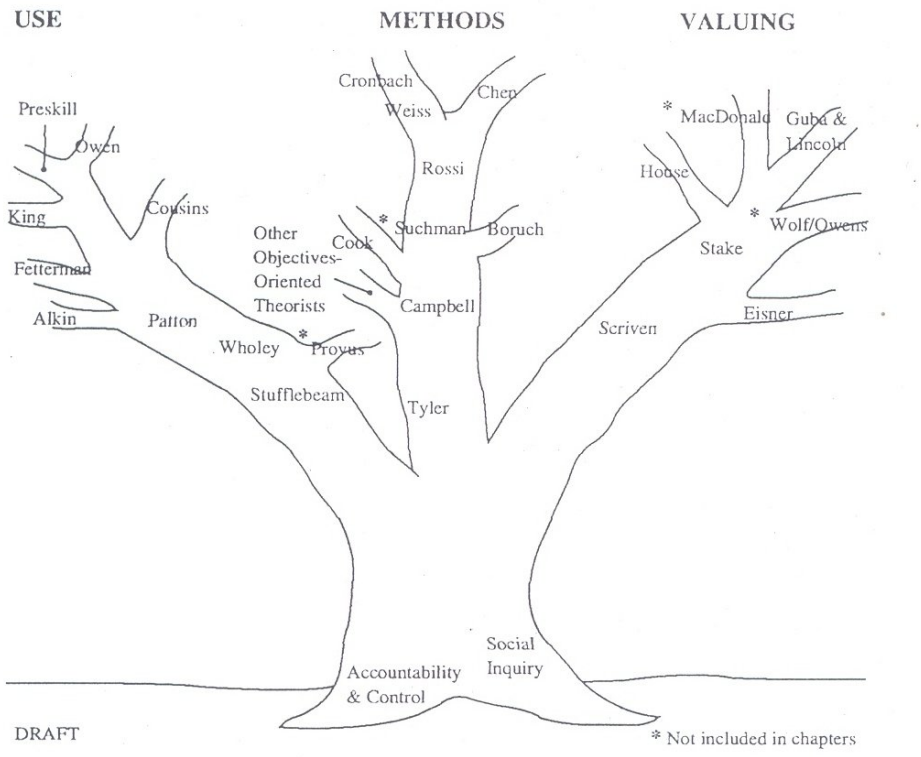
In order to carry out an assessment of the intervention by Rotary International, the programme theory as propounded by Weiss (1997) has been adopted. Its adoption for the study is because this study is an assessment of a particular programme, and programme assessment is embedded in the field of programme evaluation study.

2.11.3 Programme Evaluation

The field of programme evaluation has its roots in the 17th century, but widespread systematic evaluation research became prominent in the 20th century (Rossi, Lispsey and Freeman, 2004).

Programme evaluation has been defined as "the use of social research methods to systematically investigate the effectiveness of social intervention programmes in ways to inform social action to improve social conditions" (Scriven, 1991).

In order to shed more light on the origin and development of the field of programme evaluation as a design in social science research, Alkine and Christie (2004) designed an "Evaluation Tree" which could be seen in figure 2.1:



Source: Alkine and Christie 2004

Fig. 2.1: Evaluation Theory Tree

The tree has a trunk and three primary branches:

i. The trunk is built on a dual foundation of accountability and systematic social inquiry. Accountability is designed to improve and better programmes and society. The social inquiry root of the tree emanates from a concern for employing a systematic and justifiable set of methods for

determining accountability. While accountability provides the rationale, it is primarily from social inquiry that evaluation models have been derived. It has to do with goal accountability, process accountability and outcome accountability.

ii. The main branch of the tree is a continuation of the social inquiry trunk. One of the branches is the "Method" branch. This deals with obtaining generalizability, or "knowledge construction (Shadish, Cook, and Leviton; 1991).

iii. The valuing branch: This was initially inspired by the work of Scriven (1967). This branch firmly establishes the vital role of the evaluator in valuing.

iv. The use branch theorists here (Stufflebeam and Wholey) focus on the way in which evaluation of information will be used and also focused on thos who will use the information.

The purposes of evaluations according to Rossi (2004) are:

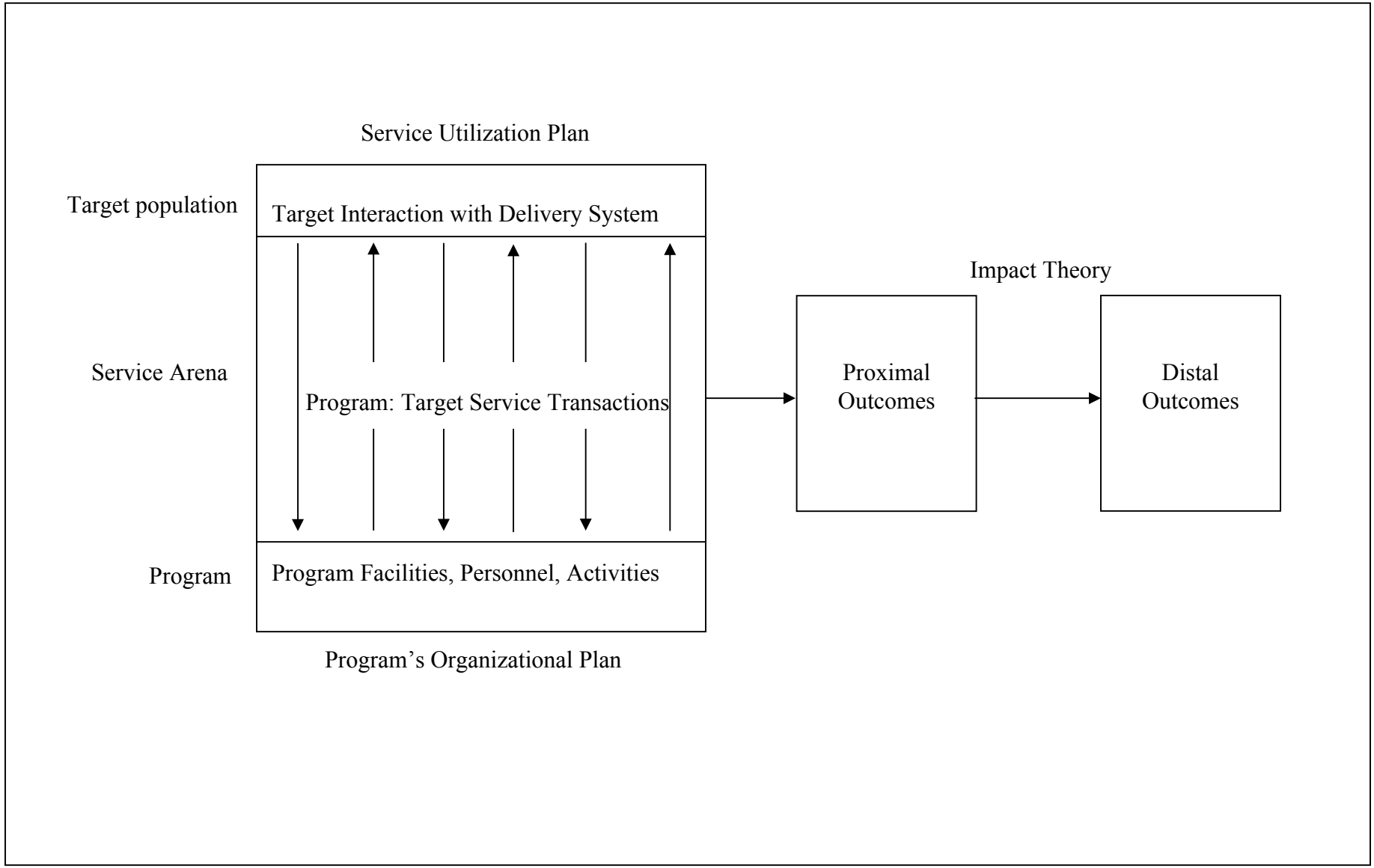
a. To help management improve a programme
b. To support advocacy by proponents or critics
c. To gain knowledge about the programme's effects
d. To provide input to decisions about the programme's funding, structure, or administration
e. To respond to political pressures.

The purpose of this study is to gain knowledge about the effects of Rotary International 3-H Project in the area of Maternal Health. To do this, the program theory of programme evaluation has been adopted for this study.

2.11.4 Programme Theory

The program theory is important because it is a basis for formulating and prioritizing evaluation questions, designing evaluation research, and interpreting evaluation findings (Bickman, 1987; Chen and Rossi, 1980; Weiss, 1972; Wholey, 1979). Rossi, Lipsey and Freeman (2004) therefore designed a scheme to explain program theory. This can be seen in Figures 2.2

Fig. 2.2: Program Theory



Source: Rossi, Lipsey and Freeman – 2004

The scheme highlights three interrelated components of a program theory:

a. The program impact theory – this is a cause theory which describes a cause and effect sequence in which certain program activities instigate causes and certain social benefits are eventually produced (Chen, 1990; Lipsey, 1993; Martin and Kettner, 1996). Programmes according to Rossi (2004) rarely exercise direct control over the social conditions they are expected to improve, they must generally work indirectly by changing some critical but manageable aspect of the situation, which, in turn, is expected to lead to more far-reaching improvements.

b. The programme service utilization plan – This has to do with the way the programme is organised in such a way that it can actually provide the intended services. It constitutes the programme's assumptions and expectations about how to reach the target population with the programme's activities.

c. The programme's organizational plan – This refers to the propositions that: If the programme has certain things, such as resources, facilities, personnel, and so on; and if it is organized and administered in a particular way, and if it engages in particular activities and functions, then a viable organization will result that can operate the intended service delivery system. This has to do with program management which encompasses both the functions and activities the programme is expected to perform and the human, financial, and physical resources required for that performance. Central to this

scheme are the program services, those specific activities that constitute the program's role in the target – programme transactions that are expected to lead to social benefits.

The programme theory has been described and used under various names such as: Logic Model, Programme Model, Outcome Line, Cause Map, and Action Theory (Rossi, 2004).

2.11.5 Application of Programme Theory to the Study

This study is geared towards gaining knowledge about the R.I.3-H Project and the effects or outcomes which it has been able to produce in the area of maternal health care delivery in Nigeria, this is why the programme theory has been adopted. Its application in regard to figure 2.2 can be seen as follows:

i. Programme's Organizational Plan: This has to do with the management structure of the R.I 3-H Project. This can be broken down into, how the project was managed, the different cadres of people involved in its management, the monitoring system, the reporting system and the line of authority as well as strategies adopted in carrying out project activities.

ii. The Service Utilization Plan: This means the type of services rendered and the way services were delivered to the clients.

iii. The Target Population: The target population for the R.I. 3-H Project is women of reproductive age. It was to provide such services that will assist them to live healthier reproductive lives.

iv. Service Arena: This has to do with the way reproductive health services are rendered at the service delivery points, that is, the health facilities.

v. The Program Arena: This relates to what programme facilities are available, the personnel and the activities. In the R.I.3-H Project, the facilities included the project offices at the state level and at the District level. The project had one District Office in Nigeria (an equivalent of a National headquarters) and six project offices, one in each of the project states.

The personnel comprised of the Rotarian volunteer team in both Nigeria and Germany. This comprised of parallel District Committees in Nigeria and Germany, and State Committees in each of the project states. There were the independent Medical Managers at both the District and State levels. There were also the project paid employees at District and State levels, the External Auditor and the employees of government who constituted the clinical service providers.

Activities – The activities were centred aroud the project strategies comprising of Advocacy, Awareness and Sensitization, Training of the clinical service providers, the supply of commodities and the provision of basic medical equipment to the service points.

In order to further explain the link between a programme's activities and the expected outcomes, a Programme Impact Theory is applied to show the link. Programme Impact Theory is a causal theory which describes a cause – and – effect sequence in which certain programme activities are the instigating causes

and certain social benefits are the effects they eventually produce (Rossi, Lipsey & Freeman, 2004). This can be seen in Figure 2.3. It is an illustration of the Programme Impact Theory of the Rotary International Maternal Health Programme. This provides a visual representation of what the programme is, the effects or outcomes which it is supposed to produce, both immediate and on the long term. The expanded one is seen in figure 2.4.

Fig. 2.4: Programme Impact Theory Showing Expected Programme Effects or Proximal and Distal Outcomes

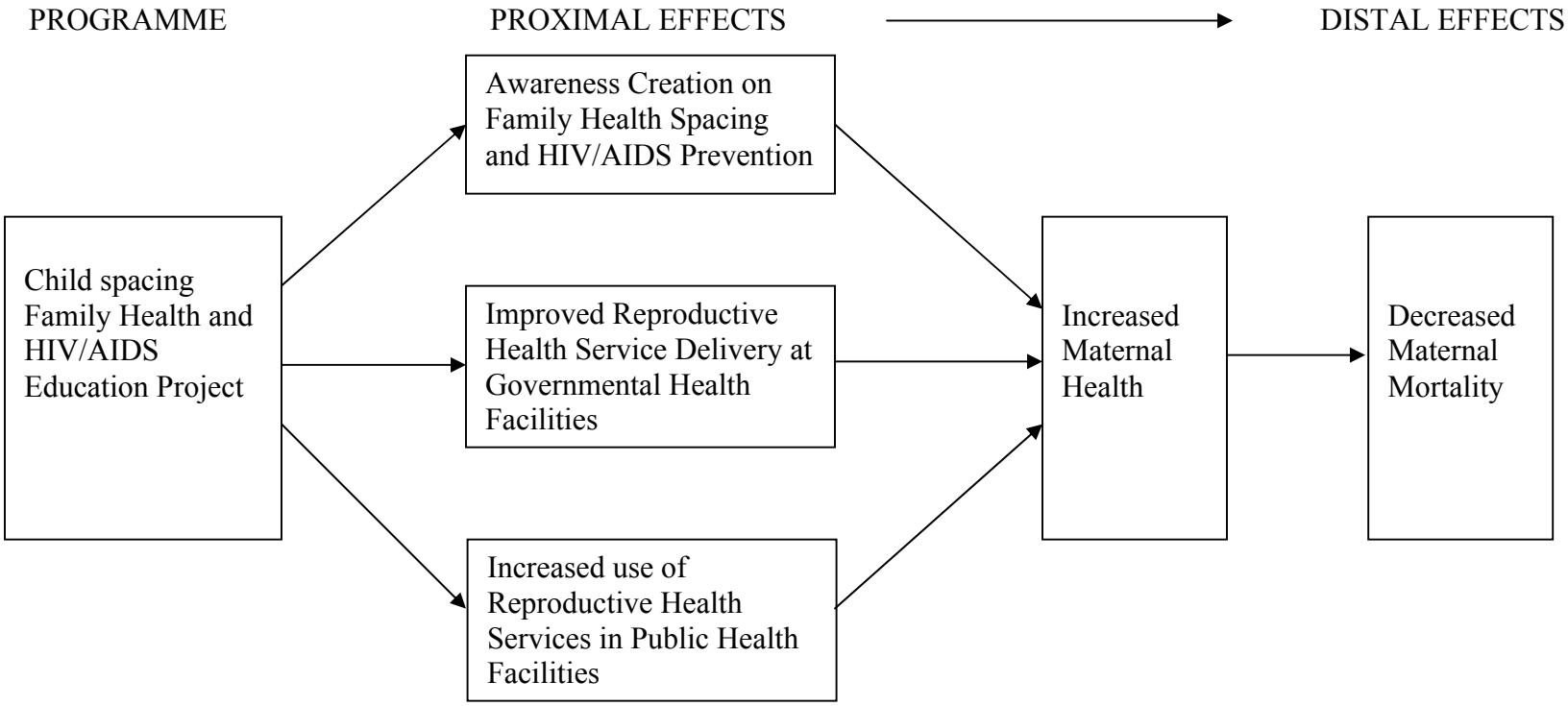


Figure 2.5 PROGRAMME IMPACT THEORY OF ROTARY INTERNATIONAL 3-H PROJECT (CHILD SPACING, FAMILY HEALTH AND HIV/AIDS EDUCATION)

PROGRAMME	PROJECT COMPONENTS	INPUTS	STRATEGIES	ACTIVITIES	OUTPUTS	PROXIMAL OUTPUT OUTCOMES	DISTAL OUTCOMES
Improvement of Maternal Health	Child Spacing Family Health HIV/AIDS Education	**A. People** - Foreign Rotarian Partners - Nigerian Rotarians - District Medical Manager - States Medical Managers - External Auditor - KPMG - Government Service Providers **B. Money** - TRF - PF - EU **C. Facilities** - Government-owned health Facilities - Offices - Vehicles - Office equipment	**A. Advocacy** **B.Awareness Creation** **C. Training** **D. Commodities Supply** **E. Equipment** **F. Clinical Service Provision**	**A. Visits** - Heads of Ministries and P arastatals - Traditional Rulers - Opinion Leaders - Heads of Institutions - Media Houses etc. **B. Awareness Campaigns** - Men and Women - Youths - In and out of school youths - Prostitutes, etc **C. Development of IEC Materials** **D. Training Workshops** - Doctors - Nurses/ Midwives - CHEWs / CHOs - TBAs **E. Procurement and Supply of Commodities** **F. Donation of Equipment** - Ultrasound - Sphygmomanometers etc.	- Rulers, opinion leaders and Heads of Institutions and Establishment Visited with advocacy messages. - Men, women, youths and others sensitized. - Health Personnel Trained - Child spacing commodities procured and distributed to Health Facilities - Basic medical equipment sourced and donated to service delivery points - M & E. Undertaken	Awareness creation of family health, child spacing and HIV/AIDs preventions Improved Reproductive Health Service Delivery at Government Health Care Facilities Increased use of Reproductive Health Services in Public Health Facilities	Increased Maternal Health Decreased Maternal Mortality

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter contains the research design, the research method and the procedures as well as techniques used in collecting the data, and the method adopted for analysing the data. The population of study, sample and sampling method are also included.

3.2 Programme Background

The Rotary International 3-H Project was a programme of intervention aimed at addressing the poor state of maternal health in Nigeria and specifically in northern Nigeria. This programme of intervention was implemented in six states namely: Adamawa, Jigawa, Kaduna, Kano, Katsina and Plateau States. It was a programme of social intervention, and according to Babbie, Mouton, Vaster and Prizesky (2001:342-343) all interventions must have the following core features:

i. Clearly defined goals and objectives

ii. The target group (intended beneficiaries)

iii. Explicit measures of success (outcome measures)

iv. Programme components (the means to achieve the goals)

v. The management and implementation system (programme infrastructure)

vi. The human resource base (who drives the programme?)

vii. The stakeholders that have a direct or indirect interest in the programme

viii. The context (or setting) of the programme

All these have been taken into consideration in this study.

3.3 Research Design

This study was designed using the evaluation research design. The purpose of evaluation according to Rossi, et al (2004), include among others: creation of knowledge about the programme's effect, to document programme accomplishments, and the creation of knowledge about social intervention and social problems.

The objectives of this study are the same as the purposes of evaluation as listed above. Hence, we proceeded to use the Quasi-experimental design. This choice was premised on the work of Louw (2011:5) which stated that the quasi-experimental design should be used when "it is necessary to prove impact and attribution, pilot project was done to serve as model for wide multiplication; and to test hypothesis."

This R.I. 3-H project was preceded by a pilot project, this study was embarked upon in order to test some hypotheses, and to prove some kind of attribution. The quasi-experimental design was used because it was not possible to do a 'true' randomization that is required in a classical experimental method. In this quasi-experimental design, there was a treatment and a comparison, in the form of a comparison, between the Baseline data and the post-intervention data of the programme. Also, there was a matching of the programme objectives with the outcomes, in order to be able to ascertain whether the R.I. maternal health

programme has been able to achieve its objectives or not, and to make the information available to the academia.

This falls within the 'valuing' branch of the evaluation tree. "Theorists on this branch believe that what distinguishes evaluators from other researchers is that evaluators must place value on their findings" (Alkin and Christie, 2004:32). In fact, as Scriven (1976:220) puts it: "the evaluator , in valuing must fulfill his or her role in serving the 'public interest'. By public interest, Scriven does not restrict the evaluator's responsibility simply to clients, users, or stakeholders, but to all potential consumers.

This principle of evaluation design was what guided this study from the beginning to the end.

3.4 Sources of Data

Data for this study was sourced from both primary as well as secondary sources. This is because the unit of analysis here is the R.I. Maternal Healthcare Programme, hence, it was necessary to focus on the programme's objectives, the processes and the outcomes. Specifically, data for the study dwelt more on the programme's objectives, the inputs, the outputs, the outcomes –both proximal and distal.

3.4.1 Primary Sources

A triangulation of primary data sources were used, this included the use of the interview method, questionnaire method in some cases key informants. The

use of these methods enabled us to obtain information on the objectives, the processes and the outcomes in the project states. Site visits were also conducted.

3.4.2 Secondary Sources

The secondary sources were: textbooks, government policy and official documents, seminar and workshop materials. Others included the R.I. 3-H project documents such as the Basic Document, Baseline Report, Project Monitoring Reports, Project Training Reports, Project Correspondence.

This study used a lot more of existing data because of the free access granted to the researchers to the project documents; this was complemented with other data generated from the primary sources. The existing or available data enabled the comparison of data from pre-project implementation with that of the post-project implementation. This enabled the measurement of the level of project achievements in terms of proximal and distal outcomes.

3.5 Population

3.5.1 National Level/International Level

At these levels, there was one Chairman in Nigeria, and one Chairman in Germany = 2 Chairmen (Rotarians).

3.5.2 State Level

At the state level, there was one Rotarian State Chairman per state = 6 state chairmen (Rotarians).

3.5.3 Project Staff

The project staff employed and paid by the project were:

a. At the District level

District Manager	=	1
Field Manager/Research Officer	=	1
Accountant	=	1
Administrative Officer	=	1
Liaison Field Worker	=	1
Drivers	=	2
		7
		=

b. At the State level

State Manager (1 per state)	=	6
Administrative Officers (1 per state)	=	6
Liaison Field Workers (12x4 states)	=	48
Liaison Field Workers (in Kano State)	=	14
Liaison Field Workers in Jigawa State	=	10
Drivers (1 per state – 1x6)	=	6
		90
		==

3.5.4 District Management

Apart from the District or National Chairman and the Managers in Nigeria, there was a District Management Committee made up of 8 members who were non-paid Rotarian volunteers, as well as a District Medical Manager and an External Auditor. There was also a replica of this committee in Germany with 8 Rotarian members also.

3.5.5 Government Officials

Rotary International did not erect buildings for the health care services. Rather, government-owned existing health facilities were used for the project. Hence services were carried out through government employed clinical staff. However, the government officials who were involved in decision-making and monitoring of project activities were as follows:

a. The State Reproductive Health (RH) Coordinators in each state (1 x 6) = 6

b. The Maternal and Child Health (MCH) Coordinators in the 166 LGAs (1 x 166) = 166

3.5.6 Beneficiaries

Beneficiaries of the services of the project can be categorised as follows:

a. Trainees which included:
   i. Medical doctors trained in ultrasonography
   ii. Medical doctors trained in child spacing, HIV/AIDS Prevention and other reproductive health issues
   iii. Nurses/Midwives
   iv. Community Health Extension Workers/Community Health Officers
   v. Traditional Birth Attendants

b. Community at large

3.6 Sample and Sampling Method

The sample for the study was drawn using the following procedures:

3.6.1 At the National/International Levels

The 2 Chairmen: Nigerian and German Chairmen were interviewed. This provided information on the planning of the project.

3.6.2 District Level

Out of the 7 project staff at this level, 3 of them were interviewed namely: The District Manager, the Research Officer, and the District Accountant. This is because they constituted key informants as regards the implementation of every aspect of the project; they were the ones who coordinated the implementation and reporting processes.

3.6.3 State Level

The purposive sampling method was adopted in the selection of the sample at this level. According to Babbie and Mouton et al (2010:166) "sometimes, it is appropriate for you to select your sample on the basis of your own knowledge of the population, its elements, and the nature of your research aims: in short, based on your judgement and the purpose of the study". The purposive sampling method was adopted because the study is that of assessing a programme using a programme theory which focuses mainly on the objectives and outcomes of a programme. The essence was to ascertain the level of achievement of the programme, based on its objectives. Also, because the programme has been implemented, it was not possible to contact or reach every individual involved in the project, hence, the choice of this sampling method, in view of the limitations of time and financial resources.

The sample at the state level was selected as follows:

i. The 6 Project States Chairmen, the 6 Project States Managers, were interviewed. A total of 3 Liaison Field Workers (LFWs) per state, representing one-quarter of the LFWs were given questionnaires to fill. These categories of people were the ones who monitored project activities at the local level on the Rotary Side. This amounted to a total of 30 people.

ii. Government Officials: Questionnaires were administered to the 6 State Reproductive Health Coordinators.

iii. Local Government Level: There were a total of 166 MCH coordinators, 10% of this were selected and questionnaires were to be administered to them. This would have given 16 MCH coordinators on the whole. We later changed it to 16 MCH coordinators per state, this meant that questionnaires were administered to 96 MCH coordinators at the local government level. This was in order to obtain as much information as possible within the limited resources of the researchers.

iv. District/State Management Committees: The information needed from these committees was obtained from the District/Nigerian Chairman, the District Manager, and the State Managers as key informants. It was therefore not necessary due to time constraint, to interview them.

3.6.4 Beneficiaries

The beneficiaries of the project were in two categories as follows:

i. Healthcare personnel – attempts were made to select 10 health personnel per state = 60 health personnel.

ii. Communities – the target group for the project was women of reproductive age, women between 15-59 years. In order to obtain information on the outcomes of the project in terms of how beneficial or otherwise the project was, questionnaires were administered to 100 per state = 600 beneficiaries. The grand total of respondents was 791.

3.7 Methods of Data Presentation and Analysis

3.7.1 Data Presentation

The data gathered for the study were presented using tables, charts, percentages, as well as averages and frequency distribution.

Each component of the intervention was assessed focusing on the objectives, the process and the outcomes. The data considered on outcome indicators were such as: number of health care facilities that have become "fully" or "partially" functional, quantity of basic equipment supplied, competence of service providers (measured by qualifications and training, received), record keeping ability, record keeping tools, monitoring and evaluation tools, availability of commodities and training, staff attitudes and behavioural change training, advocacy visits, sensitization training, categories of people sensitized (Araoye, 2004).

3.7.2 Data Analysis

The data gathered in the course of the study were ordered, categorized, tested statistically and summarised in a logical manner; this is what has been referred to as data analysis in the context of this study. The research hypotheses were tested using the chi-square test. The reason for the choice of the chi-square is that we were interested in finding out the extent of significant contribution which the R.I. 3-H Project made to maternal health care in Northern Nigeria. This was measured by comparing the Baseline information which constituted the pre-implementation situation with the post-implementation or intervention information. Also, the expected outcome of project indicators were measured against the observed outcome indicators, and the chi-square test is normally used for such a test.

The following procedure was adopted in this study:

i. Computation of the test statistics using the data collected to find the arithmetic average or mean score.

ii. The chi-square test (X^2) was applied.

iii. The Decision Rule, that is, the condition under which the null hypothesis (H_o) was rejected. The decision rule in this study was that if the calculated value is greater than the critical value at 5% level of significance, then the null hypothesis should be rejected. Also, if the calculated value is less than the critical value at 5% level of significance, then the null hypothesis (H_o) should be accepted.

iv. The formula used for the computation of the chi-square (X^2) in this study is as follows:

$$X2 = \sum_{i=1}^{K} \frac{(0i - ei)^2}{ei}$$

Where

0i = observed frequency

ei = expected frequency

k = summation of all cells

The degree of freedom (df) was obtained using the formula:

N = (r-1) (c-1)

Where

N = Number of periods/occurrences

r = row

c = column

(Araoye, 2006)

CHAPTER FOUR

4.0 HISTORY, STRUCTURE AND FUNCTIONS OF THE ROTARY INTERNATIONAL 3-H PROJECT IN NORTHERN NIGERIA

4.1 Introduction

This section focuses on what Rotary International is, as well as a brief historical background of Rotary International. This will help to give a proper understanding of the background to the activities of Rotary International.

4.2 What is Rotary?

Rotary is an organization of business and professional persons united worldwide who provide humanitarian service, encourage high ethical standards in all vocations, and help build goodwill and peace in the world. This is exemplified in the official Rotary International (R.I.) motto: "Service Above Self" (Rotary, 2003).

4.3 History of Rotary

Rotary was founded in Chicago, Illinois, U.S.A. 23 February, 1905. Its founder was Paul P. Harris, an attorney. On that day, Paul met with three friends - Silver Schiele, a coal dealer, Gustavs E. Loehr, a mining engineer, and Hiram E. Shorey, a merchant tailor.

Originally, Paul's idea was to promote fellowship among business acquaintances. Soon there developed the higher purpose of service to others. The men met in rotation at each other's places of business, hence the name Rotary. To make the club representative across the sections of the business and professional

community, only one representative of each business or profession was admitted. This was the beginning of the classification principle of members. Rotary has since spread around the world and has more than one million members.

4.4 What is a Rotary Club?

A Rotary Club is an organisation of business and professional leaders (e.g. proprietors, partners, corporate officers, managers of a business or profession, or who hold important positions with an executive capacity therein) within a defined community (e.g. city, borough, or municipal area). Its purpose is fellowship and service. It has a president and a board of directors. Club members are adult persons, who must be of good character and good reputation.

4.5 What is a Rotary District?

A Rotary District is a geographical territory in which Rotary clubs are associated for Rotary International administrative purposes. Each district is headed by a District governor, an officer of R.I. whose job is to assist clubs in the district. District Governors are nominated by their district and elected for one year at the R.I. International Convention (which is held annually in April, May or June in a major city such as Tokyo, Rome, Chicago, Toronto and so on).

4.6 What is Rotary International?

Rotary International is an association of Rotary clubs throughout the world. It is administered by a Board of directors consisting of the president and president-elect of Rotary International and 16 other directors from around the world.

The world headquarters of Rotary International (R.I.) is located in Evanston, Illinois, U.S.A., a suburb of Chicago. It has an international staff headed by the general secretary. Branch offices are located in Sydney, Australia; Sao Paulo, Brazil; Delhi, India; Tokyo, Japan; Zurich, Switzerland; Buenos Aires, Argentina; Seoul, Korea; and Manila, Philippines.

4.7 The Hallmark of Rotary

The hallmark of Rotary is service. There are four "avenues of service" in Rotary, they are Club service, and International service. These are based on the four parts of the object of Rotary. Each club channels its projects and service activities into these "avenues".

4.8 The Object of Rotary

The object of Rotary is to encourage and foster the ideal of service as a basis of worthy enterprise and, in particular, to encourage and foster:

i. The development of acquaintance as an opportunity for service;

ii. High ethical standards in business and professions, the recognition of the worthiness of all useful occupations, and the dignifying by each Rotarian of his occupation as an opportunity to serve society.

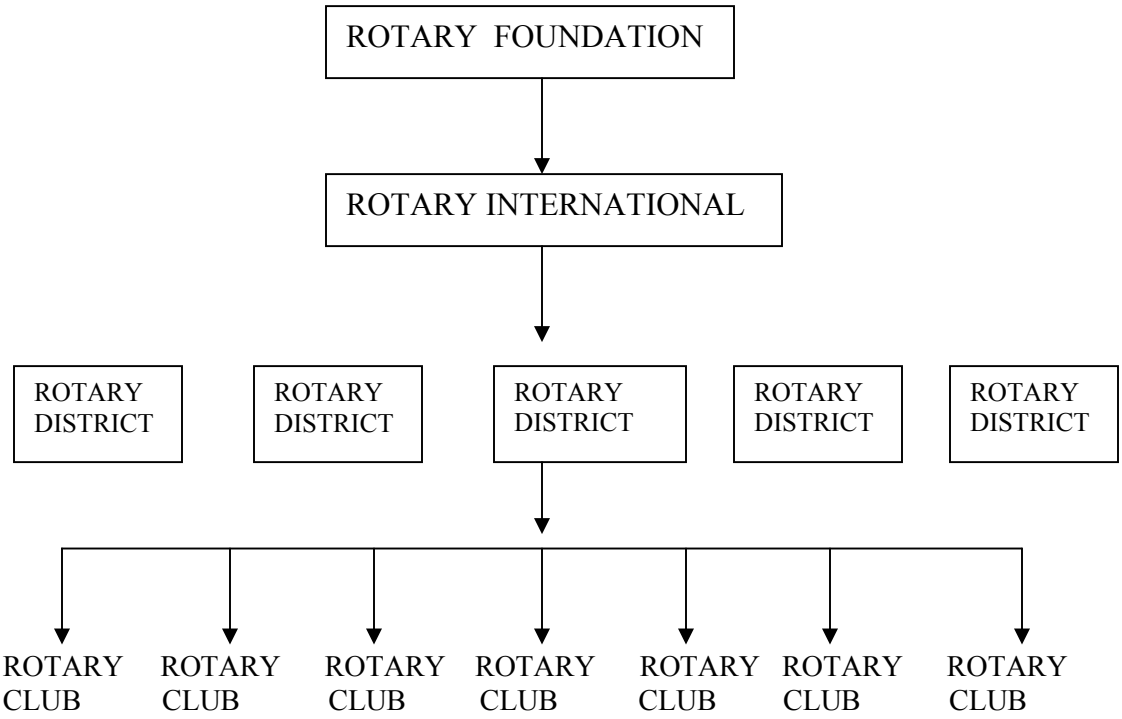
iii. The application of the ideal of service by every Rotarian to his personal business, and community life

iv. The advancement of international understanding, goodwill and peace through a world fellowship of business and professional persons unified in the ideal of service.

There are a number of special activities in Rotary, they include: the World Community Services; Rotary Foundation Ambassadorial Scholarships; World Fellowship Activities; Youth Exchange; Interact and Rotaract; Rotary Youth Leadership Awards (RYLA); Polio Plus Program; and Health, Hunger and Humanity Program (3-H).

The Health, Hunger and Humanity Program (3-H) undertakes major projects which are too large for any single club. An example of this is the 3-H Project designed to improve maternal health in Northern Nigeria, on which this study is based.

FIGURE 2.5: ORGANISATIONAL CHART OF ROTARY



4.9 The R.I. 3-H Project

The activities of Rotary International in Maternal Health care in Northern Nigeria were a 3-H Project (Hunger, Health and Humanity). It was however a health project. It has three components: child Spacing, Family Health and HIV/AIDS Education.

It was a project jointly executed by two R.I. Districts: Districts 9120 – Nigeria and District 1860 – Germany.

4.10 Rotary Organisational Features Relevant for Project Implementation

Rotary International (R.I.) is organized in the form of Districts. A Distrct may cover several administrative-political regions of a country; there are many

Rotarian Districts all over the world. In Nigeria, as at the time when the 3-H project was executed, there were 4Rotary Districts in the country. A District is therefore the operational unit of R.I. at the national level, it is usually headed by a District Governor; the decision making body of the district project is the District Committee.

The R.I. 3-H Project of "Child Spacing, Family Health and HIV/AIDS Education" was implemented within a District in Nigeria, which is District 9120 – Nigeria. The Project was however, that of cooperation between two R.I. Districts, which is: District 9120- Nigeria and district 1840- Germany.

In Nigeria, District 9120 covers the whole of Northern Nigeria, which encompasses 16 States of the Federation. The project was however executed in 6 states out of the 16 due to constraints of funds.

The 3-H Project "Child Spacing, Family Health and HIV/AIDS Education" was carried out within the broader framework of development, in relation to a kind of "North-South| cooperation between Germany and Nigeria. The relevance of the project is in relation to its need – orientation, its support to implementing the country's policy, its capacity building approach at the institutional and personal levels, and its support in terms of participation and decentralized decision-making.

4.11 Historical Background of the 3-H Project

The R.I. 3-H Project has its roots in the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt. At that conference, there was a declaration that in order to reduce maternal deaths, every government has to:

> Develop a comprehensive national strategy to ensure universal access to all individuals and couples of appropriate ages throughout the life cycle to a full-range of high quality, affordable sexual and reproductive health services, which includes family planning, through the primary health system as soon as possible and no later than 2015 (ICPD I, 12 7.2)

Also, the Nigerian Health Policy also has the aim to:

> Improve the standards of living and the quality of life of the people (of Nigeria) to promote their health and welfare, especially through preventing premature deaths and illnesses among high-risk mothers and children; to achieve lower population growth rates through reduction of birth rates by voluntary fertility regulation methods that are compatible with the attainment of economic and social goals of the nation.

4.11.1 Background of Child Bearing in Nigeria

As Shittu (2004) observed, the attitude of Nigerians to child bearing can be summarized as follows:

i. Child bearing is the ultimate goal of marriage union

ii. It is assurance of economic and social prosperity in old age

iii. Infertility is taken as a fruitless marriage

iv. Accolades and honors are conferred on women with the most children.

Hence high premium is placed on:

i. Early marriage

ii. High fertility rate

iii. Child bearing in old age

But research findings according to Shittu (2004:34-40) show that usually pregnancy and child birth can be hazardous to mother, baby and family when:

i. Age of mother is below 18 years

ii. Age of mother is above 35 years

iii. Mother gets pregnant after having 5 childbirths

iv. If interval between childbirths is below 2 years

The consequences of unplanned conception as enumerated by Shittu (ibid) are:

i. Pregnancy-related death of a woman for every 100 live births

ii. For every such death, 15 other women incur permanent damages such as Obstetric Fistula (VVF or RVF).

iii. One out of 10 newborn babies do not survive to their first birthdays.

iv. Low life expectancy

v. Persistent poverty, poor nutrition and illiteracy.

4.11.2 The Rotary Challenge

In view of the above, Rotary sought to make a difference in Nigeria by bringing to bear its human and material resources, its network of professionals, access to all stakeholders in Reproductive Health (RH) and its organizational and Advocacy skills. Hence the conception of the Rotary International 3-H Project (R.I. 3-H Project) of "Child Spacing, Family Planning and HIV/AIDS Education".

4.11.3 Rotary International 3-H Project

The project was first conceived in 1994 by past District Governor (PDG) Professor Robert Zinser of R.I. District 1860 – Germany and PDG Professor

Emmanuel Adedolapo Lufadeju of R.I. District 9120 – Nigeria. The concept was developed by Gynecologists in Giessen and Rostock (Germany) and Ahmadu Bello University Teaching Hospital, Zaria (Nigeria).

4.11.4 The project first began with a pilot project funded by R.I. Districts 1860 Germany and 9120 - Nigeria from 1995 to 2000. The Pilot Project was implemented in two local government areas (LGAs) in Kaduna State, Nigeria, namely: Lere and Zaria LGAs.

The Pilot Project (1995-2000): Target Communities

CHARACTERISTICS	LERE	ZARIA
Population	221,058	277,187
Population Density	144/sq km.	299/sq. km.
Headquarter	Saminaka	Zaria
Religion (Predominant	Christianity	Islam
Occupation	Farming	Farming
Ethnicity	Kurama	Hausa
	Jaji	Fulani

Source: Rotary International Presidential Celebration (2003: Population Concerns, Abuja, Nigeria, August 9, 2004. Page 34.

4.11.5 Objectives of the Pilot Project

The overall objective of the pilot project was to reduce maternal mortality and improve the quality of life of the target population

i. Raise awareness on effective child spacing methods

ii. Establish effective child spacing services

iii. Improve access to high quality comprehensive reproductive health services

4.11.6 Strategies and Methodology of the Pilot Project

The strategies and methodology of the Pilot Project (1995-2000) were:

i. Targeting of two contrasting populations

ii. Involvement of as many Rotarians as possible

iii. Use of title "Child Spacing" instead of "Family Planning"

iv. Advance personal and family benefits of contraceptive use rather than population

v. Process of exploratory flexibility

vi. Strong and sustained advocacy to political, traditional, opinion and religious leaders.

vii. Baseline survey in target communities

viii. Establishment of partnership with all reproductive health institutions in project areas.

ix. Adaptation of existing healthcare facilities for project implementation.

x. Extensive public awareness campaigns.

xi. Supply of ultrasonography machines, laparoscopes and colposcopes to improve RH care. Training in their use.

xii. Supply of subsidized child spacing commodities to all service points.

xiii. Training of Town Announcers (Town Criers).

xiv. Training Nurses, Midwives, CHEWS and TBAs. They also formed drama groups.

4.11.7 Results of the Pilot Project (General)

The general results of the Pilot Project were that:

i. "Child Spacing" title facilitated acceptance of the project.

ii. There was uniform program acceptance and patronage

iii. There was active participation of Federal, State and Local Government health facilities, staff and TBAs

iv. There was enthusiastic participation of town announcers and TBAs in public awareness.

4.11.8 Results of the Pilot Project (Training)

In the area of Training, the pilot project recorded the following results: that the following categories of people were trained.

i.	Doctors	=	8
ii.	Service providers (Nurses and Midwives)	=	164
iii.	Traditional Birth Attendants (TBAs)	=	750
iv.	Village Health Workers (VHW/CHEWs)	=	500
v.	Town Announcers	=	105.

4.11.9 Results of Child Spacing Services

The clinics offering child spacing services were as follows:

NUMBER	LERE	ZARIA
Number of clinics in 1995	11	4
Number of clinics in 1999	28	25

Another result was that Contraceptive Prevalence Rate (CPR) increased from 3.5 in 1995 to 27% in year 2000 in the two LGAs.

4.12 The 3-H Project – Child Spacing, Family Health and HIV/AIDS Education

Based on the Final Evaluation of the Pilot Project conducted by the German Foundation for World Population – Deutsche Stiftung Weltbevolketung (DSW) in October, 2000, Rotary International decided to consolidate the achievements of the Pilot Project by expanding it to cover six states of Northern Nigeria: Adamawa, Jigawa, Kaduna, Kano, Katsina and Plateau States.

The 3-H Project commenced in October, 2000 to December, 2003 in the 6 northern states with an approximate population of 31 million and a total of 166 LGAs. Another phase of the project commenced in January 2004 to December, 2006. This second phase was called to "Sustainability Project" of the 3-H Project. The essence was to ensure a "smooth landing" of the 3-H Project, that is, to ensure that its achievements could be sustained and to hand over successfully to the state

and local governments in each of the six states. This second phase was from January to December, 2007.

4.12.1 Project Components

The aim of the project was the same as that of the pilot project. The Project however, contains the following components.

i. *Advocacy:* Advocacy visits were to be paid to religious and traditional leaders at various levels, as well as governments.

ii. *Training*: Different cadres of health personnel were to be trained, including doctors, nurses, midwives, community health extension workers (CHEW), Traditional Birth Attendants (TBAs), among others.

iii. *Awareness Campaigns:* Awareness campaigns were to be used.

iv. *Capacity Building:* Apart from training of health care service providers, capacity building was to include basic equipment of health facilities.

v. *Implementation of the 'Field Phase':* The field phase was the implementation of services in the health care facilities at the local government, state and federal government levels.

4.12.2 Administrative Structure of the Project

Because the project is a Rotary International District project, a District Office was set up in Zaria as the head office in Nigeria. The work of the Project District Office is steered by the District committee; the members of the District Committee (DC) are mainly Rotarians, with a few non-Rotarian professionals. Each of the project states has a project office with paid employees, but the project

states are steered by the state committee of Rotarians having the same composition as the District Committee. The District Committee in Nigeria has a similar District Committee in Germany.

4.12.3 District Office

The District Office in Nigeria is headed by a District Chairman (a Rotarian) who is the overall head of the project in Nigeria. He is the financial controller.

The District Manager is the Administrative Head of the project and based at the district Office. The Research Officer is the one in charge of Monitoring and Evaluation of all project activities in all the 6 states and also based in the District Office.

Other District Office staff includes the project Accountant, Administrative Officer, a Liaison Field Worker (LFW) and two Drivers.

The District Manager, Research Officer, District Accountant, Administrative Officer, Liaison Field Worker and those 2 Drivers are the District Office staff and they are paid employees and are not Rotarians.

4.12.4 State Office

Each of the 6 project states has a state project office. The State Chairman (a Rotarian) is the financial officer at the state level and the administrative head.

The State Manager is the one in charge of operations at the state level, and is based at the state office, also a non-Rotarian, and a paid employee.

Other employees at the state office are the administrative officer and 12 Liaison Field Workers (LFWs) apart from Jogawa and Kano State 10 and with 14

LFWs respectively, and a driver each. All of them are paid non-Rotarian employees.

4.12.5 Rotarian Administrative Structure

Apart from the paid employees of the project at the District and state levels, there is also a parallel Rotarian administrative structure that steers the affairs of the project. This is illustrated as follows:

4.12.5.1 District Committee

The District committee is headed by the District chairman. The District Manager is the Secretary. Other members include all the state chairmen, the District External Auditor (KPMG), Internal Auditor, Treasurer, Awareness Manager, Medical Manager, State Managers and District Accountant.

This District Committee in Nigeria also has a parallel District committee in Germany.

4.12.5.2 State Committee

The state chairman is the head of the state committee. The members include the state manager, the state medical manager, state awareness manager, treasurer and accountant.

4.12.5.3 Rotary Clubs

The Rotary Clubs in each of the project states are expected to be actively involved in advocacy, awareness creation and monitoring visits to health facilities.

4.12.5.4 Project Executing Organisations

The executing organizations are the German Rotarian Districts – 1840 and the Nigerian Rotary District – 9120.

The project implementation is based on a contractual agreement between the 6 state governments of Nigeria and the 2 Rotary Districts.

The overall responsibility lies with The Rotary Foundation (TRF). The Rotary Germany Charitable Organization (Rotary Deutschland Gemein Dienst-tung RDG) to facilitate handling of contracts and money flow.

Auditing of the project accounts was done by the external audit firm of KPMG in Nigeria.

4.13 Project Funding

Funds for the project were from mainly 2 sources: The Rotary Foundation (TRF) in USA, and the David and Lucile Packard Foundation USA. Other sources included: the European Union (EU) in support of the Basic Equipment Component of the project; the Rotary Districts 1840 – Germany and 9120 – Nigeria.

Figure 3.1

Table 1: PROJECT ORGANISATION – MANAGEMENT COMMITTEES AND OFFICES

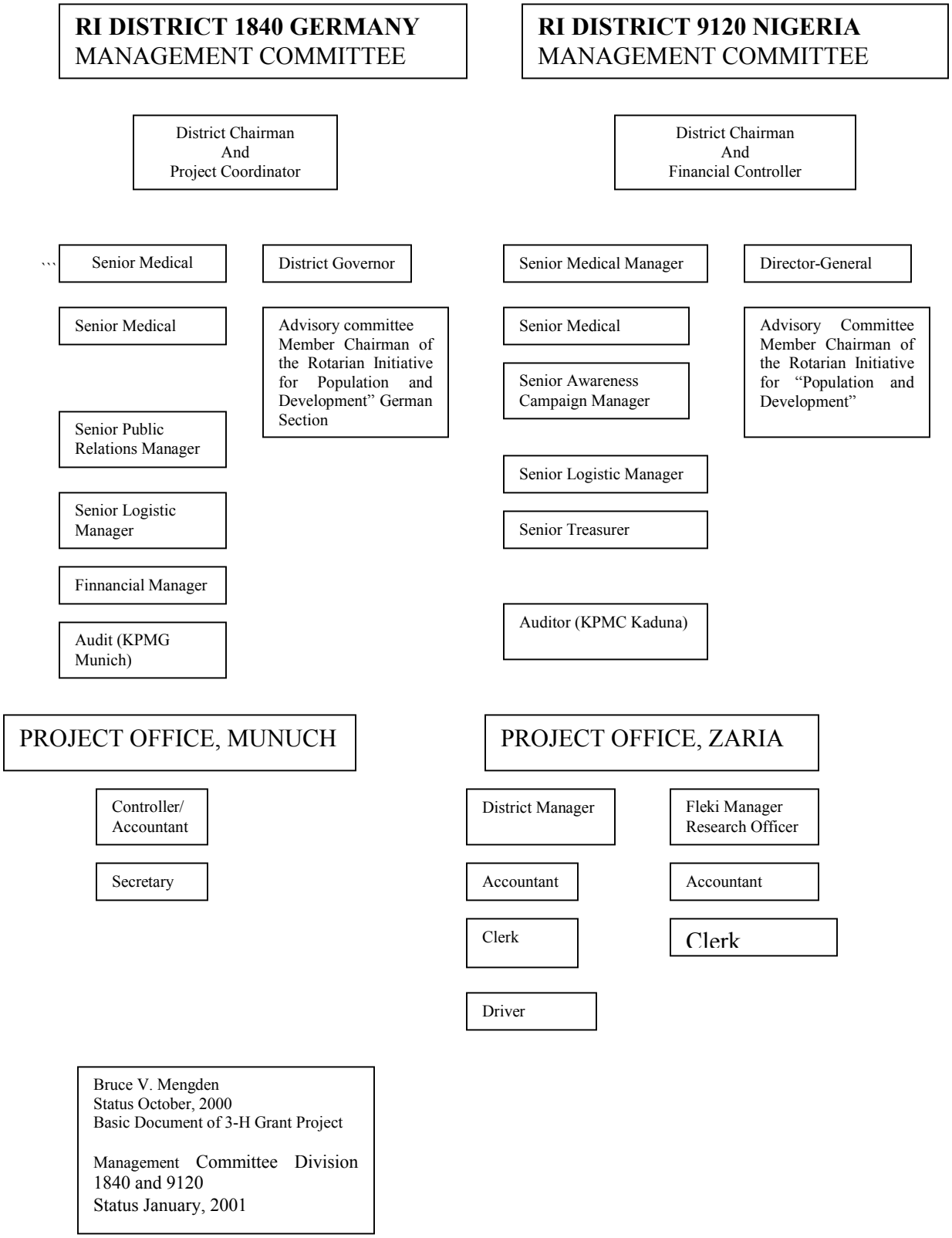
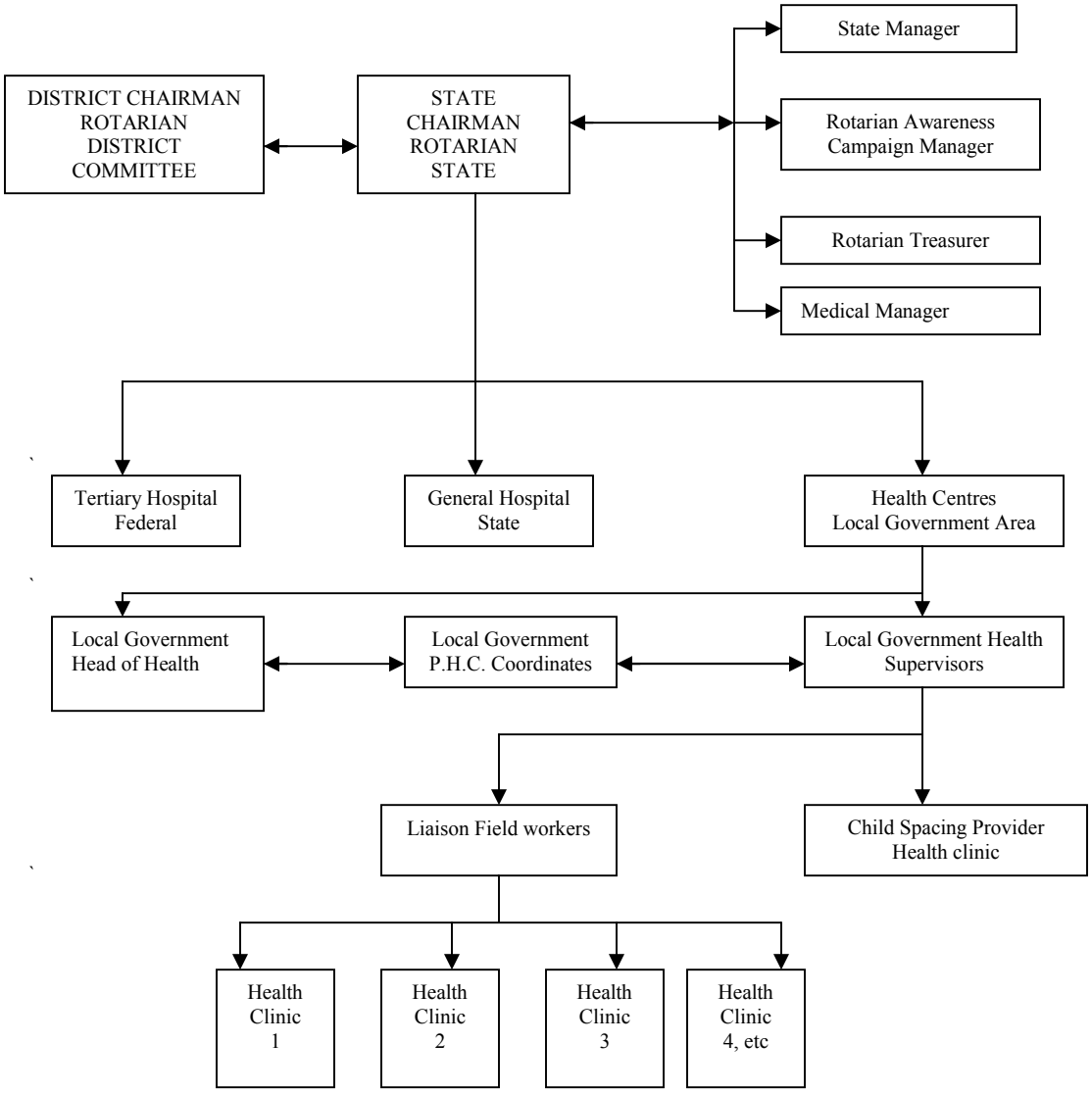


Figure 3.2

STATE COMMITTEE ORGANOGRAM



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CHAPTER FIVE

5.0 DATA PRESENTATION AND DATA ANLYSIS

5.1 Introduction

This chapter deals with the presentation and analysis of the data collected in the course of the field work. The data were gathered through primary and secondary sources.

The secondary sources used were textbooks, journals, newsletters, project reports, (Monthly reports, District Committee Meeting Reports, Report of Visits of Monitoring and Evaluation) Project Basic Document, Baseline Survey Reports, Internet materials).

The primary sources were from information from interviews, questionnaires and site visits.

The data derived from both secondary and primary sources were organized and presented using simple percentages, averages, tables and charts. The analysis was done using frequency distribution, and chi-square test statistics.

The statistical Packages for Social Sciences (SPSS) software version 15.0, was used for the computation. Tables were used for the data presentation, and the cross tabulation of the data analysed, were used to test the hypotheses.

5.2 Methods of Data Collection

The methods of data collection employed in the study included the following:

a. Interview Method

b. Questionnaire Method

c. Site Visits/Observation Method

d. Available data obtained from the Project's Service Registers; Weekly, Monthly Service Reports; Reports to Funders, and Internet Materials.

5.2.1 Interviews

A total of 29 respondents were scheduled to be interviewed; these were the International Chairman (Germany), the National/District Chairman (Nigeria), the District Manager, Research Officer, 6 States Managers and 18 Liaison Field Workers. Out of 29 respondents, 28 were successfully interviewed; the German Chairman could not be interviewed early enough, due to his extremely busy schedule. This gave us a 96.5% success rate in the interview schedule.

5.2.2 Questionnaire Administration

Questionnaires were administered to a total of seven hundred and sixty-two (762) respondents as scheduled:

State Reproductive Health Co-ordinators	=	6
Local Government Maternal and Child Health Coordinators	=	96
Beneficiaries: Health Personnel	=	60
Clients	=	600

The questionnaire administration yielded one hundred percent success (100%). This feat was achieved by engaging the services of 12 research assistants,

who were employed to follow up the respondents, this involved quite a number of repeated journeys to the service delivery points as well as several telephone calls. This eventually resulted in spending beyond the estimated budget.

The data analysed and hereby presented were based on the interview conducted and the questionnaires administered, as well as the data obtained from other sources as stated below.

5.2.3 Site Visits

Visits were made to some of the service delivery sites in order to make some observations, and to ascertain continuity of services and availability of equipment donated. Visits were also made to the District Office in order to peruse the project documents which included correspondences between the Nigerian project office and international office, Project Reports, as well as samples of materials used for Information Education and Communication (I.E.C. materials).

5.2.4 Internet

Some of the materials used were also obtained from the internet.

5.3 Data Presentation and Application of the Programme Theory

5.3.1 Introduction

In order to present the data in a logical manner using the programme theory, it is essential to do so by highlighting the following:

a. Goal of the project

b. Objectives of the Project

c. Strategies of the Project

d. How the project was implemented

e. The extent to which the project met its desired goal

f. The outcomes

The data on these from the research can be seen as presented below.

5.3.2 Goal of the Project

According to the Federal Ministry of Health (FMOH, n.d.) one woman in every 13 women face a life time risk of maternal death. In the United Kingdom (U.K.) it is 1 in 5,1000; while in Canada, it is 1 in 7,700. It is also estimated that 15% of pregnancies experience complications world-wide, but in Nigeria, it stands at over 40% (Zinser, 2007: 7, www.globalhealthtv.com)

According to the interview held with the Nigeria/District Chairman of the Rotary International 3-H Project (R.I. 3-H Project) "Rotary went around and found that the clinics were part of the problems, they were under-staffed and poorly equipped. Women did not have education on child spacing which is one important aspect. They were having more deliveries and yet not having more live children, because many of them died before they are five, 10-15% of the children died before they are 5 years old".

From the interview, as well as information gathered from the Project's Basic Document (2000), Rotary intervened because of:

i. The poor indices of maternal health in Nigeria, especially in Northern Nigeria. Nigeria constitutes only 2% of the world's population, it accounts for over 10% of the world's maternal deaths in child birth

(Adamu, 2003). Maternal deaths in Nigeria ranges from 165 per 100,000 birth in the south-west, to 1,549 in the north (Federal Ministry of Health,2008).

ii. Inadequate health facilities, poorly equipped and under-staffing of available health facilities, which also contribute to poor maternal health, which manifests in maternal mortality and morbidity.

iii. Lack of information and education on how to promote maternal health.

Rotary intervened to promote maternal health through the provision of information and education as well as clinical services. This was done through its 3-H Project (child spacing, Family health and HIV.AIDS education).

5.3.3 Objectives of the Rotary International 3-H Project (Child Spacing, Family Health and HIV/AIDS Education)

The interview and Basic Document revealed that the main objective of the R.I. 3-H Project was to address the poor maternal health statistics in Northern Nigeria through reducing the rate at which women were having children, but not in a forced manner, but convincing them about their health and about the health of their children.

Specifically, the objectives were:

i. To raise awareness on effective child spacing methods.

ii. Establish effective child spacing services

iii. Improve access to high quality comprehensive reproductive health services

5.3,4 Strategies Adopted by the R.I. 3-H Project

The strategies adopted were as follows:

i. Advocacy

Advocacy visits were made to Government officials, Traditional rulers, Religious and Opinion leaders, among others. Such visits were for the purpose of securing their support and cooperation for the project. Table 5.1 shows the number of visits made from 2001 to 2003.

Table 5.1a: Advocacy Visit by the Six States from 2001 to 2003

State	Federal Government Officials	State Government Officials	Local Government Officials	Traditional Rulers/Opinion Leaders	Armed Forces and Other Para-military Organizations	Federal Establishment Officials
Adamawa	-	6	34	612	4	-
Jigawa	-	6	27	5	2	-
Kaduna	-	26	486	368	158	35
Kano	-	4	44	6	5	-
Katsina	-	139	68	53	245	1
Plateau	-	26	2	7	1	3
Total	-	207	680	1051	415	39

Table 5.1b:

State	Head of Institutions/ Teachers/Other Officials	N.Y.S.C.	Religious Leaders	Head of Hospitals	Trade Union Leaders	Proprietors of Brothels	Heads of Media Organizations
Adamawa	11	-	-	2	-	-	-
Jigawa	-	-	-	2	-	-	2
Kaduna	46	500	260	28	16	-	-
Kano	2	-	-	2	-	-	4
Katsina	7	-	54	2	-	-	3
Plateau	135	-	-	2	-	2	-
Total	201	500	314	38	16	2	9

Source: R.I. 3-H Project Reports: 2000-2004

Advocacy visits were made mainly from year 2001 to 2003. This is because the activities of the project were in stages. Advocacy visits constituted the first phase of the project.

ii. Awareness and Sensitization

Different categories of people and communities were sensitized. The project produced a variety of information education and communication (IEC) materials and measures to create awareness for the project and the issues addressed by the project. Each state of the project area was given a free hand in the design of messages for the IEC materials and measures, bearing in mind the peculiarities and sensitivities of the states. Table 5.2 shows the number of such IEC materials and measures produced.

Table 5.2a: Number of IEC Materials Produced

State	Posters	Hand bills	Stickers	Exercise Books	Traffic Warden Jackets	Aprons	Megaphones
Adamawa	10,000	1,000	800	10,000	20	50	-
Jigawa	10,000	1,250	-	10,000	10	100	27
Kaduna	20,000	-	-	25,000	-	30	-
Kano	10,000	-	-	10,000	-	-	-
Katsina	10,000	75,000	-	10,000	170	-	68
Plateau	10,000	-	3,000	10,000	300	40	-
Total	70,000	77,250	3,800	75,000	500	220	95

Source: R.I. 3-H Project Report 2000-2004

Table 5.2b

State	T-shirts	Face caps	Polythene shopping bags	Bill Boards	Newspaper clips	Radio	TV
Adamawa	200	200	-	3	-	-	-
Jigawa	-	-	-	3	6 clips	64 slots	24 slots
Kaduna	-	30	5,000	3	-	-	-
Kano	-	-	-	3	4 clips	-	-
Katsina	500	500	-	3	-	18 slots 3 x a week at 2 stations	5 audio/video cassettes
Plateau	150	60	-	3	-	-	-
Total	850	790	500	18	10	82	29

Source: R.I. 3-H Project Reports: 2000-2004

iii. Training

Health personnel were trained to facilitate their capability to provide child spacing services and other allied services such as HIV/AIDS prevention. Tables 5.3a and 5.3b show the number of personnel targeted to be trained and the number actually trained.

Table 5.3a: Target for Health Personnel Training 2000-2004

S/No	State	Doctors	Doctors trained in Trasonography	Nurses/ Midwives	CHEWs	TBA s	Total
1	Adamawa	20	Nil	600	600	3,000	4220
2	Jigawa	20	Nil	600	600	3,000	4220
3	Kaduna	20	Nil	600	600	3,000	4220
4	Kano	20	Nil	600	600	3,000	4220
5	Katsina	20	Nil	600	600	3,000	4220
6	Plateau	20	Nil	600	600	3,000	4220
	Total	120	Nil	3,600	3,600	18,000	Grand Total 9,120

Source: Rotary International 3-H Project Basic Document (2001)

Table 5.3b: Number of Health Personnel Trained 2000-2004

S/No	State	Doctors	Doctors trained in Ultrasono-graphy	Nurses/ Midwives	CHEWs	TBAs	Total
1	Adamawa	9	4	686	600	1,375	2,674
2	Jigawa	14	2	314	335	824	1,489
3	Kaduna	20	16	600	625	1,610	2,866
4	Kano	18	4	600	600	1,167	2,389
5	Katsina	23	3	613	600	1,528	2,767
6	Plateau	22	16	599	635	1,569	2,841
	Total	106	45	3,412	3,390	8,073	Grand Total 15,026

Source: Rotary International 3-H Project Basic Document (2001)

iv. Equipment

Provision of minimal medical equipment to the health facilities to facilitate their capability to carry out child spacing services. Table 4.3 shows the number of medical equipment donated to health facilities.

Table 5.4: Medical Equipment Donated to Health Facilities in the Six States – 2000-2004

	Adult Weighing Scales	Sphygmanometers	Stethos-copes	Storage Cupboards	Ultra-sound Machines	Medical Examination Couches	Infant Weighing Scales	IUCD Insertion Kit
Target	3,000	3,000	3,000	3,000	12	Nil	Nil	Nil
Number donated	3,000	3,000	3,000	3,000	12	400	1,000	500

Source: Rotary International 3-H Project Basic Document (2001)

v. Affordable Contraceptives

Making child spacing services accessible involved the regular flow of contraceptive commodities. The project sourced for and supplied child spacing commodities to health facilities.

The availability at a health facility of trained or skilled personnel, minimal equipment and materials, and contraceptive commodities, all together, is what makes a clinic or health facility to be classified as "Fully Functional". Tables 5.5a and 5.5b show the number of fully functional health facilities before the intervention by Rotary, and the number after. Out of a total of 3,764 public health facilities in the 6 project states, only 305 of them were Fully Functional for providing child spacing services. On the other hand, after the intervention, health facilities had been increased to 4,374 and out of these, there was a total of 1,785 Fully Functional health facilities.

5.3.5 Extent to which Rotary International Met Its Desired Goal

The following tables reveal the pre-intervention statistics and the post-intervention statistics or health status of health facilities offering child spacing services.

Table 5.5a: Pre-intervention Statistics of Health Facilities

S/No	State	Total Number of Health Facilities	Number of Fully Functional Clinics
1	Adamawa	262	43
2	Jigawa	292	28
3	Kaduna	643	71
4	Kano	1,299	90
5	Katsina	679	38
6	Plateau	589	35
	Total	3,764	305

Source: Basic Document (2001) Rotary International 3-H Grant Project

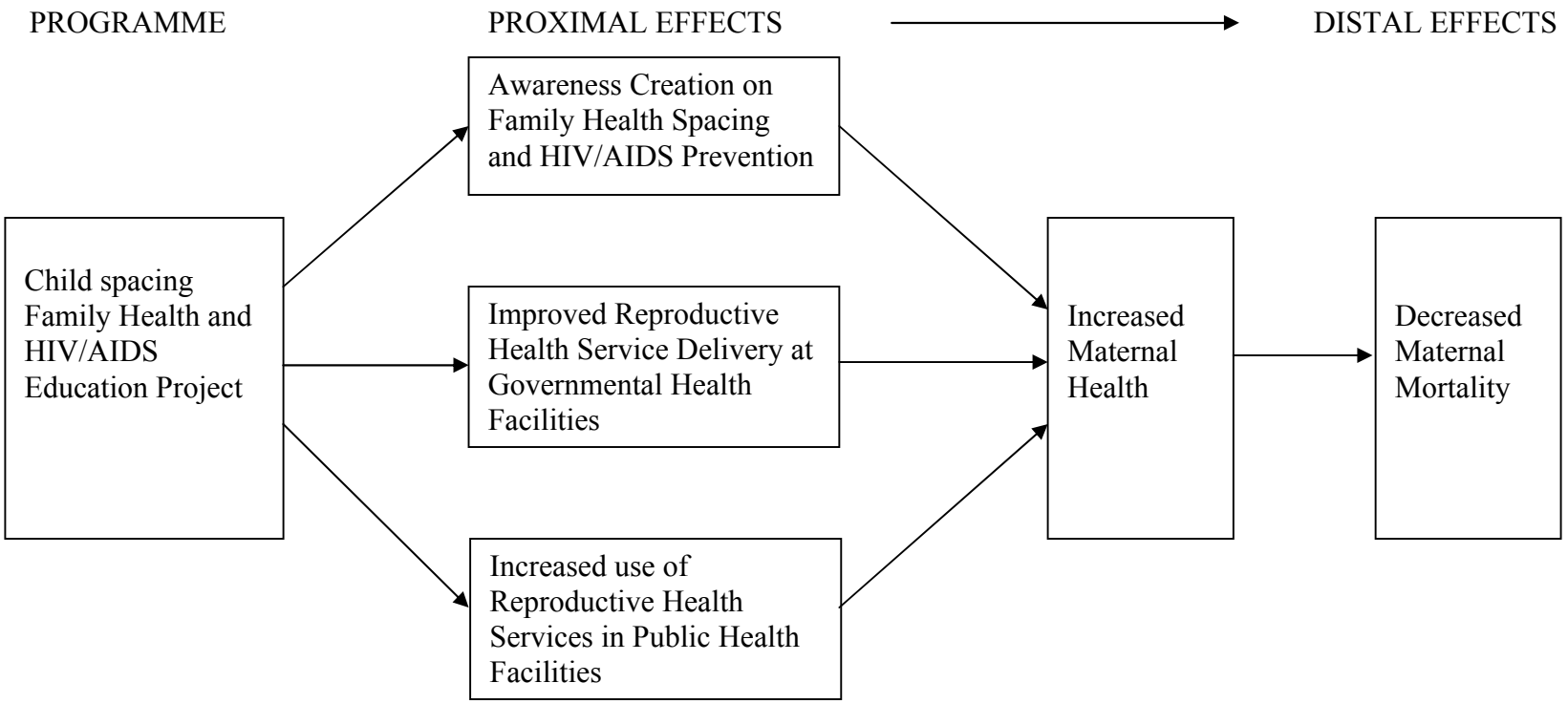
Table 5.5b: Post Intervention Statistics and Health Facilities 2000-2004

S/No	State	Total Number of Health Facilities	Number of Fully Functional Clinics
1	Adamawa	773	137
2	Jigawa	203	76
3	Kaduna	729	598
4	Kano	1,299	409
5	Katsina	724	246
6	Plateau	646	319
	Total	4,374	1,785

Source: Basic Document (2001) Rotary International 3-H Grant Project

The objectives of the Rotary International 3-H Project (R.I. 3-H Project) were to improve maternal health through the spacing of pregnancies and births, so that in the long run, there would be a reduction in maternal mortality. Hence, as the programme impact theory shows, it was expected that the programme (Rotary International 3-H project) should produce some proximal effects, as well as Distal effects. This can be seen on Figure 2.3 below

Fig. 2.3: Programme Impact Theory Showing Expected Programme Effects on Proximal and Distal Outcomes



The R.I. 3-H Project devised its own strategies to deal with the issues of poor maternal health care delivery. The programme identified women of child bearing age as its target population, designed the service utilization plan by embarking on advocacy sensitization and awareness creation, to establish the legitimacy of the project and to create information around it, in order to encourage the target population to utilize the services of the project. The service arena is where the programme services are organized and made available and accessible to the clients. The programme's organizational plan is the kind of plan made by the project for its management; it has to do with the interaction of the programme's facilities, the programme staff and the programme's activities. This is as shown on figure 5.2.4 and figure 5.2.5.

Figure 5.2.4: PROJECT ORGANISATION – MANAGEMENT COMMITTEES AND OFFICES

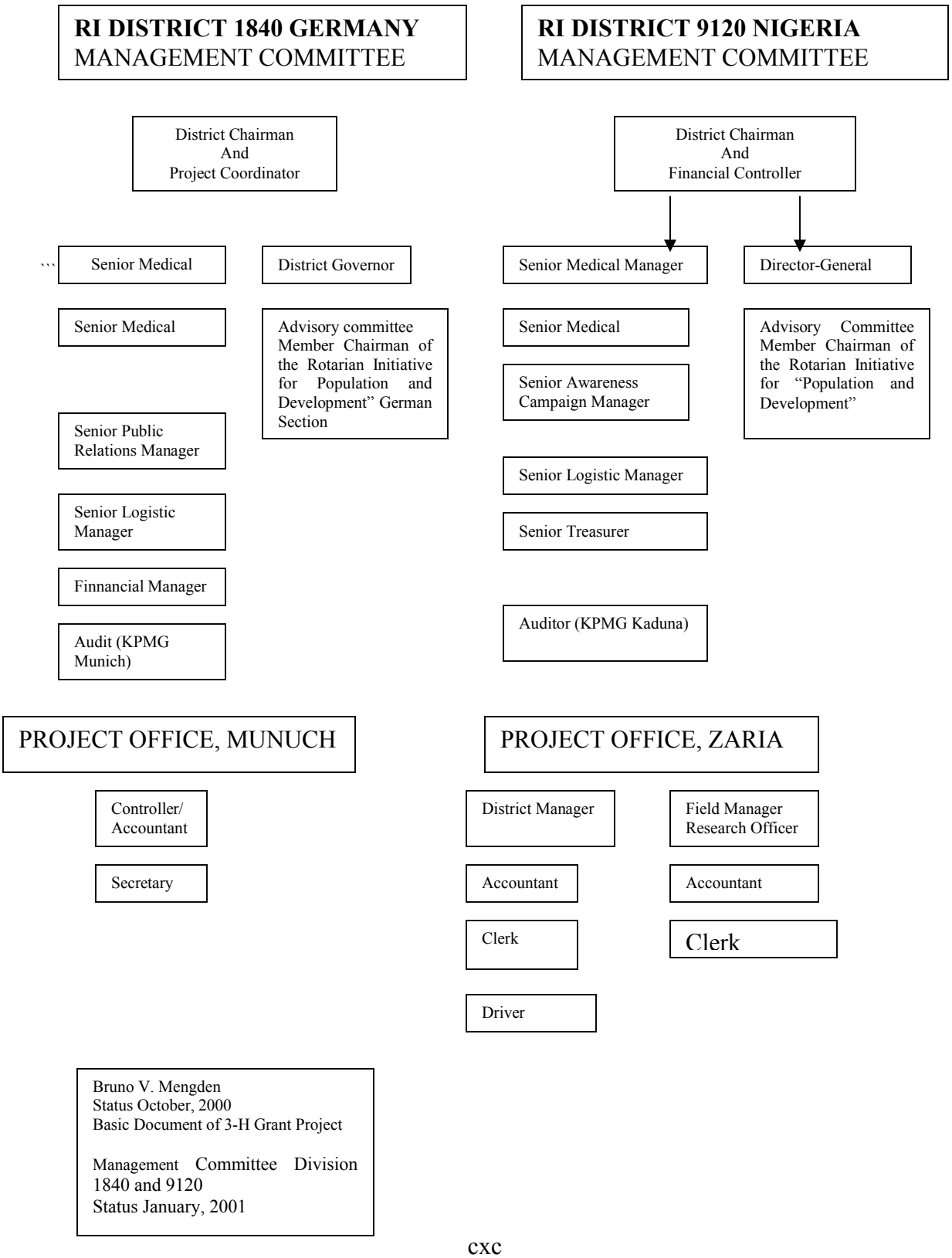
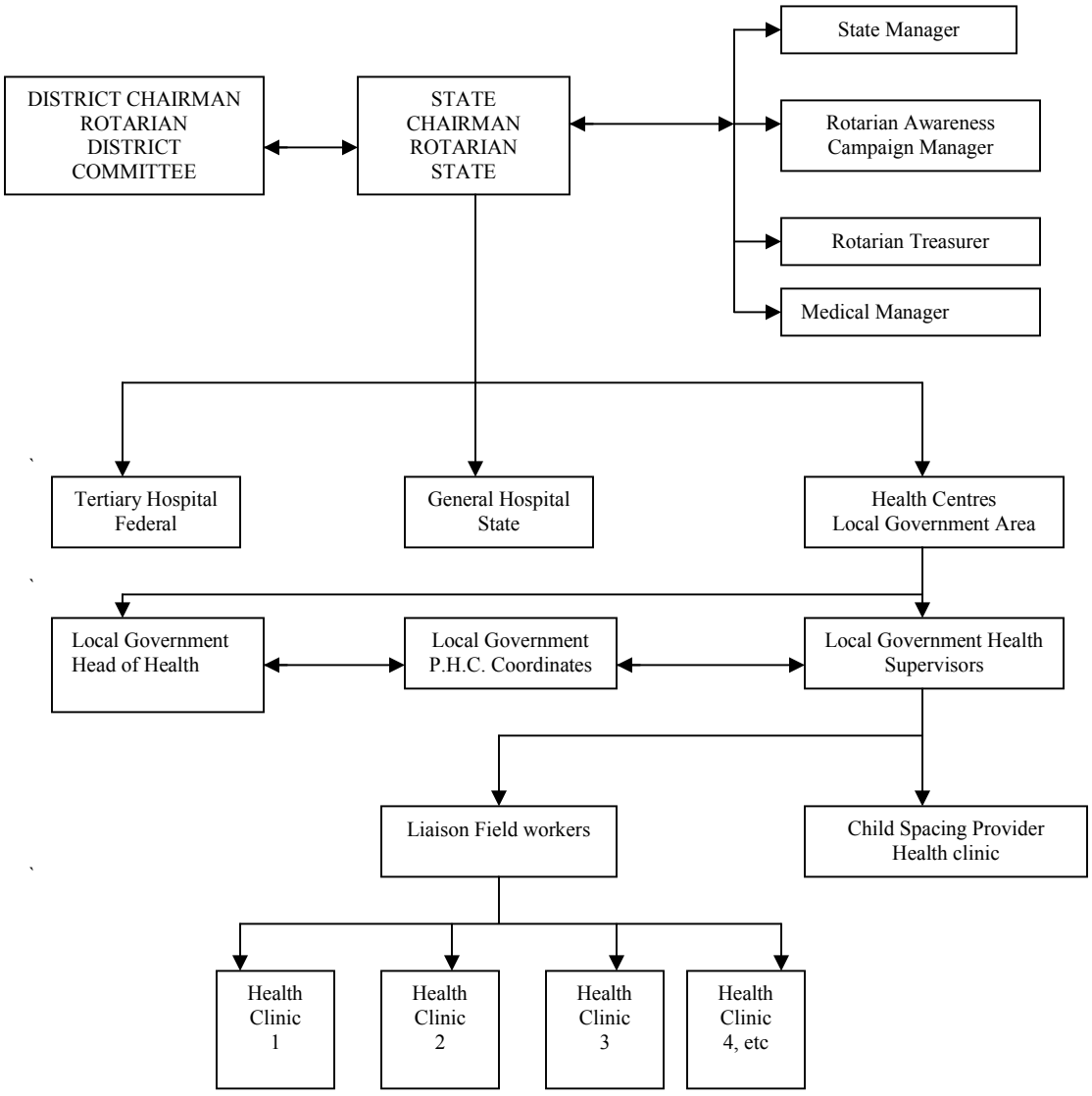


Figure 5.2.5: STATE COMMITTEE ORGANOGRAM



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5.3.6 How the R.I.3-H Project was Implemented

According to the Programme Theory, as shown on figure. 2.3, a programme must have two major plans:

a. The service utilization plan

b. The Organizational Plan.

a. The Service Utilization Plan must have the following components:

i. Target population

ii. Service Arena

iii. Service Delivery (Facilities, Personnel and Activities)

b. The Programme's Organizational Plan

The R.I. 3-H Project's organizational plan are as shown on figures 5.3.1 and 5.3.2 at District and State levels respectively. The two plans must interact in order to produce the desired outcomes.

The Target Population was women of reproductive age, which is women from 15-59 years.

The strategies employed in the intervention facilitates the achievements of the project.

a. Advocacy

The Rotarian organization could be adjudged to be well prepared for advocacy efforts, due to the fact that members of the organisation cut across a variety of professions in society. Many of them even occupy important positions in government, business and the different professions. This worked in their favour

when they had to pay advocacy visits to the federal, state, local government officials at the Ministry of Health, Ministry of Education, Ministry of Women's Affairs. Their status also assisted to facilitate visits to Traditional Rulers and Opinion Leaders (such as Unions, Armed Forces and Other para-military organisations, owners of brothels among others). The Rotarian involvement in the polio immunization campaign also helped them to gain the trust of those visited on advocacy. The result was that the government gave permission for the public health facilities to be used for the service delivery by the project and for their health personnel to be trained under the project. A total of 39 federal government establishment officials, 207 state government officials, 680 local government officials, 1051, traditional rulers/opinions leaders, 314, religious leaders, among others, were visited between year 2000-2004. These visits enabled the project to obtain a total of 67 letters of commitment from government at state and local government levels, to appreciate the efforts of the project and its activities, as well as a promise of commitment to ensure sustainability of the services even after Rotary's withdrawal.

b. Awareness and Sensitization

The project produced a variety of IEC materials and measures which included materials such as Billboards, Handbills, Exercise Books, Traffic warden jackets, shopping bags, radio and television messages; Town announcers were sensitized to take messages of child spacing to the villages and hamlets on market

days, during wedding and child naming ceremonies, among others. Health workers and health care clinical service providers were trained to provide counseling and sensitization on child spacing and HIV/AIDS prevention to clients at antenatal clinics. Sensitization was integrated into service delivery, the Liaison Field Workers who visited health sites at regular intervals (Daily and Weekly) also took the message of child spacing awareness to the rural areas. Even megaphones, were bought and given to the Town Announcers while Aprons were given to commercial motorcyclists to help in disseminating the information. A total of 75,000 exercise books, 95 megaphones, 18 billboards, 82 radio slots, 29 video and 24 television slots among others were produced. The localization of the materials to the cultural and religious sensitivities of each project state might be said to be quite encouraging, as each state might prefer to adopt messages suitable to their own environment. This must have enabled the populace to receive awareness regarding the maternal health programme.

c. Training

The findings of the Baseline Study (2001) revealed that out of the 3,764 available public health facilities, only 305 of them were fully functional. Fully functional here means that such health facilities had:

i. Health personnel qualified to offer child spacing services

ii. Regular flow of child spacing commodities (contraceptives)

iii. Basic equipment necessary to carry out child spacing services, as well as documentation materials.

Table 5.5c below shows the pre-intervention health facilities status.

Table 5.5c: Pre-intervention Status of Public Health Facilities

S/No	State	Total Number of Health Facilities	Number of Functional Health Facilities
1	Adamawa	262	43
2	Jigawa	292	28
3	Kaduna	643	71
4	Kano	1,299	90
5	Katsina	679	38
6	Plateau	589	35
	Total	3,764	305

Source: Basic Document (2001) Rotary International 3-H Grant Project

From Table 5.5c above, it could be seen that only 305 out of the 3,764 public health facilities, were fully functional. This represents 8% only. This prompted the project to embark on training of available health personnel so that they could increase their capacity to render child spacing services. Such trainings consisted of lectures, practical sessions, group discussions and presentations.

Table 5.5d: Training of Health Personnel in Six Project States 2001-2004

State	Doctors	Doctors in Ultrasonography	Nurses/Midwives	CHEWs	TBAs	Total
Adamawa	9	4	686	600	1,375	2,674
Jigawa	14	2	314	335	824	1,389
Kaduna	20	16	600	620	1,610	2,866
Kano	18	4	600	600	1,167	2,389
Katsina	23	3	613	600	1,528	2,767
Plateau	22	16	599	635	1,569	2,841
Total	106	45	3,412	3,390	8,073	Grand Total 15,026

45 doctors were trained in ultrasonography, 106 doctors trained in child spacing services, 3,412 nurses and midwives, 3,390 community health extension workers, and 8,073 traditional birth attendants were also trained.

In the 6 questionnaires administered to the state Reproductive Health Coordinators in the 6 states, all of them, representing 100% indicated that their states participated in the training programme. They also indicated that the training enhanced the performance of the health personnel. Out of a total of 96 questionnaires administered to MCH coordinators, 85 (88.5%) agreed that the training was adequate.

Out of the 60 questionnaires administered to health personnel who were beneficiaries of the training, 60 of them indicated that the training received had enhanced their work performance, representing 100%. However, in response to the question "How satisfied were you with the training content?", the responses were as follows: 20 (33.3%) extremely satisfied; 30 (50%) were very satisfied; while 10 (16.7%) were fairly satisfied. When further asked to rate the level to which they agreed that the training has enhanced their work performance, the responses were as follows: 10 (16.7%) strongly agree; while 50 (83.3%) agree. This can be interpreted to mean that the training received assisted the clinical service providers to be able to perform better at the service delivery points, as their knowledge and skills, had been improved.

d. Equipment

The service delivery points (SDPs) were equipped as follows:

i. Primary health care level – storage cupboard for contraceptives and other diagnostic and treatment items.:

- Sphygmomanometers

- Stethoscopes
- Weighing scales

ii. Secondary care level\

- The above items
- One ultrasound machine for one general hospital per state

iii. Tertiary level

* All the items as in the primary level
* One ultrasound machine for the Teaching Hospital or Specialist Hospital per state.

e. Contraceptive Supply

Project records revealed that contraceptives were sourced, procured and distributed to the service delivery points. This was said to be necessary because of the acute shortage of such commodities in the pre-intervention period. The reproductive health coordinators, MCH coordinators and the LFWs were involved in the distribution process.

Table 5.5e: Statistics of Contraceptives Distribution for the six project states 2002-2004

State	Oral Pills	Injectables	IUD	Spermicides	Condoms
Adamawa	6,842	1,279	97	599	7,906
Jigawa	3,972	1,147	15	-	393
Kaduna	15,960	3,498	260	7,200	217,672
Kano	11,500	4,293	277	280	13,200
Katsina	22,543	4,265	145	5,556	4,514
Plateau	22,646	22,983	9,636	10,414	58,282
Total	83,373	37,965	10,430	24,049	301,967

Source: R.I. Project Reports 2000 – 2007

Table 5.5f: Number of New Acceptors Per Type of Conceptive

Period	Pills	IUCD	Condom	Noriterat	Depo Provera	Vaginal Jelly	Nor Plant	Tubal Ligation	Vasectomy
Year	135,650	17,940	130,927	67,257	60,552	8,581	13	69	0
2005									
Year	39,405	3,954	644,557	82,211	562,907	13,727	0	10	15
2006									
Year	69,915	7,748	55,440	96,907	24,816	51,038	0	1,984	0
2007									
Total	244,970	29,642	274,612	246,375	648,275	73,346	13	2,063	15

Source: R.I. 3-H Project Reports 2000-2002

Table 5.5g: Number of Revisit Clients Per Type of Contraceptives

Period	Pills	IUCD	Condom	Noriterat	Depo Provera	Vaginal Jelly	Nor Plant	Tubal Ligation	Vasectomy
Year	216,150	19,171	196,089	111,712	87,969	15,551	55	34	
2005									
Year	97,868	13,747	1,544,554	289,967	841,59	75,720	0	0	
2006									
Year	112,233	4,583	154,965	120,077	311,692	26,221	0	89	
2007									
Total	426,251	37,501	1,895,608	451,756	483,820	143,713	55	123	

Source: R.I. 3-H Project Reports 2000-2002

Table 5.5d shows that from year 2002 to year 2004, the following contraceptive commodities were distributed:

Oral pills - 83,373 cycles

Injectables - 37,965 vials

IUD - 10,430 units

Spermicides - 24,044

Condoms - 301,967 packs

Table 5.5e and 5.5f show the annual number of child spacing clients recorded by year 2007. The tables revealed that there were a total of 1,566,757, new acceptors, and a total of 3,547,249 revisit clients.

From all the above, it could be said that Rotary was able to meet its desired goal, there was improvement in service provision, service utilization and capacity building.

5.4 Analysis of Data and Test of Hypotheses

5.4.1 Analysis of Data

Analysis of both primary and secondary data is as presented below

Hypothesis One

1. Hypothesis One

Null Hypothesis

H_o: Rotary International 3-H Project did not make any marked contribution to improve maternal health care service delivery in northern Nigeria.

Alternate Hypothesis

H_1: Rotary International 3-H Project has made marked contribution to improve maternal health care service delivery in northern Nigeria.

To be able to analyse and test this hypothesis, it is necessary to consider what happened before Rotary's intervention and after the intervention. Therefore, clients of the services were sampled in order to find out their obstetric history, their knowledge about the services, as well as examining the service delivery of the Pre- and Post-intervention.

Hence, the data obtained were as presented below:

In order to find out the obstetric history of the respondents who became child spacing clients, the clients were asked questions on their age, the number of pregnancies they have had, where they delivered their first child, by whom, and the outcome of the delivery. The responses were as contained in Tables 5.6a, 5.6b, 5.6c, 5.6d.

Table 5.6a: Age of Respondents

	Age	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	3	.5	.5	.5
	50 years and above	2	.3	.3	.8
	40-49 years	10	1.7	1.7	2.5
	30-39 years	297	49.5	49.5	52.0
	20-29 years	286	47.7	47.7	99.7
	Less than 20 years	2	.3	.3	100.0
Total		600	100.00	100.0	

Source: Researcher's survey, 2011

Table 5.6b: Number of Respondent's Pregnancies

No. of Pregnancies		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	6	1.0	1.0	1.0
	2	52	8.7	8.7	9.7
	3	50	7.3	8.3	18.0
	4	71	11.8	11.8	29.8
	5	69	11.5	11.5	41.3
	6	96	16.0	16.0	57.3
	7	63	10.5	10.5	67.8
	8	94	15.7	15.7	83.5
	9	38	6.3	6.4	89.8
	10	25	4.2	4.2	94.0
	11	14	2.2	2.2	96.2
	12	22	3.7	3.7	99.8
	13	1	.2	2	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.6c: Place of Delivery of First Child

Place of Delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	12	2.0	2.0	2.0
	At home	298	49.7	49.7	51.7
	Government clinic	165	27.5	27.5	79.2
	Government hospital	93	15.5	15.5	94.7
	Private clinic	30	5.0	5.0	99.7
	On the way to Hospital/clinic	2	.3	.3	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.6d: Attendance at Home Delivery

Place of Delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	281	46.8	46.8	46.8
	Self	3	.5	.5	47.3
	TBA	188	31.3	31.3	78.7
	Mother/Mother in-law	50	8.3	8.3	87.0
	Grandmother	25	4.2	4.2	91.2
	Other relatives	35	5.8	5.8	97.0
	Trained Midwife	10	1.7	1.7	98.7
	CHEW	8	1.3	1.3	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.6e: Outcome of Home Delivery

Place of Delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	180	30.0	30.0	30.0
	Baby alive	149	24.8	24.8	54.8
	Baby dead	271	45.2	45.2	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

In tables 5.6a, 5.6b, 5.6c, 5.6d and 5.6e the modal age of the respondents is 30-39 years, which is 297 (49.5%). At that age, respondents had up to 6 pregnancies. About 298 (49.7%) of the respondents had their first babies at home,

attended by Traditional Birth Attendants, the outcome was that the babies died (45.2%).

When the respondents were asked how they came to know about the hospital/clinics where they had their subsequent child/children, the majority of them 222(37%) responded that friends gave the information, details were as contained in Table 5.7a. They also stated that at such hospital/clinic, they were attended to and delivered by doctor (204 representing 35%) or Nurse/Midwife (306, representing 51), this could be found on Table 5.7b, the outcome for most of them, 497, representing 82.8% as seen on Table 5.7c. was live babies. This shows that when pregnant women utilize the services of the hospital/clinic, they are attended by skilled health care personnel, and they tend to have live babies and the mothers too have safe delivery, which reduces the death of mothers. This conforms with the first specific objective towards the reduction of maternal and newborn mortality towards the attainment of the Millennium Development goal Number 5, as stated in the Fact Sheet on Safe Motherhood (Federal Ministry of Health, n.d. 22).

Table 5.7a: Source of information about where to deliver child

Source of Information		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	33	5.5	5.5	5.5
	Friends	222	37.0	37.0	42.5
	Neighbours	110	18.3	18.3	60.8
	Husband	149	24.8	24.8	85.7
	Other relations	48	8.0	8.0	93.7
	TBA	38	6.3	6.3	100
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.7b: Who took delivery in hospital/clinic

Personnel		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	35	5.8	5.8	5.8
	Doctor	204	34.0	34.0	39.8
	Nurse/Midwife	306	51.0	51.0	90.8
	CHEW	54	9.0	9.0	99.6
	No response	1	2	.2	100
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.7c: Outcome of hospital/clinic delivery
a

Outcome		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	80	13.3	13.3	13.3
	Baby alive	497	82.8	82.8	96.2
	Baby dead	23	3.8	3.8	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Knowledge About Child Spacing/Current Use

Tables 5.8a and 5.8b are the responses of the respondents on the questions of whether they were currently using contraception and who introduced them to child spacing, while Table 5.8c contains their responses on the question "when did you first use a modern method of contraception?"

Table 5.8a: Currently Using Contraception

Responses		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	41	6.8	6.8	6.8
	Yes	500	83.3	83.3	90.2
	No	59	9.8	9.8	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.8b: Who Introduced you to child Spacing

Responses		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	56	9.3	9.3	9.3
	Friends	276	46.0	46.0	55.3
	Husband	160	26.7	26.7	82.0
	TBA	42	7.0	7.0	89.0
	Relation	36	6.0	6.0	95.0
	Others	30	5.0	5.0	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.8c: Time of First Use of Modern Contraception

Response		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	50	8.3	8.3	8.3
	Above 9 years	206	34.3	34.3	42.7
	6-8 years	145	24.2	17.3	66.8
	4-5 years	104	17.3	15.8	84.2
	2-3 years	95	15.8		100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Tables 5.8a, 5.8b, and 5.8c reveal that 500 (83.0%) of the respondents indicated that they were currently using modern contraception, 206 (34.3%) of them had been using it for over 9 years, 145 (24.2%) had been using it for between 6 to 8 years. On how they got information about child spacing, 276 (46.0%) and 160 (26.7%) responded that they got the information from their friends and husbands, respectively. This shows that most of them started using child spacing methods during the time of the project and have sustained their use of it. They got the information from friends, supported by their husbands. This in turn shows that there was a chain reaction of friends getting the information and passing the information to other women, also. Men might have heard about child spacing

probably from the awareness campaigns or sensitization measures, and informed their wives about it.

Table 5.8d: Approval by Husband

Response		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	25	4.2	4.2	4.2
	Yes	522	87.0	87.0	91.2
	No	53	8.8	8.8	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Table 5.8d reveals that 522 respondents (87.0%) had their husbands' approval to use child spacing methods. This shows that men had embraced child spacing even though culturally, men in northern Nigeria were perceived to be conservative.

Knowledge About Rotary Project

Table 5.9a: Knowledge About Rotary Project

Response		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	31	5.2	5.2	5.2
	Yes	539	89.5	89.5	94.7
	No	30	5.3	6.4	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

From Table 5.9a a total of 537 (89.5%) of the respondents expressed knowledge about Rotary International's 3-H Project. The respondents were further asked "if they had ever been informed about the activities of Rotary at the Public Health facilities which they attended", their responses were as shown on Table 5.9b.

Table 5.9b: Information about R.I. 3-H Project

Response		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No response	54	9.0	9.0	9.0
	Yes	527	87.8	87.8	96.8
	No	19	3.2	3.2	100.0
	TOTAL	600	100.0	100.0	

Source: Researcher's survey, 2011

Their responses show that 527 respondents (87.8%) indicated that they had been informed at the health facilities. This goes to show that since the service providers were able to offer the child spacing services to the clients, and also inform them about the activities of Rotary International 3-H Project, it then translates to the fact that such health personnel must have had evidence of the project's activities either through training, equipment donation, IEC material, or contraceptive commodities supply. This goes to explain the program service arena of the program theory (Rossi, Lipsey and Freeman, 2004).

5.4.2 Test of Hypothesis One

Hypothesis One was stated as follows:

1. Hypothesis One

Null Hypothesis

H_o: Rotary International 3-H Project did not make any marked contribution to improve maternal health care service delivery in northern Nigeria...

Alternate Hypothesis

H_1: Rotary International 3-H Project has made marked contribution to improve maternal health care service delivery in northern Nigeria.

Hypothesis one was tested with a paired sample t-test using the following formula:

$$t = \frac{X_1 - X_2}{SX_1 - X_2}$$

Where $SX_1 - X_2 = \frac{S_1^2}{n_1} + \frac{S_2^2}{n_2}$

Where X_1 = Mean of variable one

X_2 = Mean of variable Two

S_1^2 = Variance of One

S_2^2 = Variance of Two

n1 = Number of observations of One

n2 = Number of observations of Two

(Field, 2009:334-336)

The reason for using the t-test is because of the quantitative values involved in the two variables before intervention and after intervention, that is, the number of public health facilities that were of "Fully Functional" status (that could fully provide child spacing services using the parameters of availability of skilled personnel, basic child spacing equipment, and supply of child spacing commodities). Pre-intervention, and the number of "Fully Functional" Post-intervention.

The use of the paired t-test was informed by the equal number of states that were serving as replicates and the number of states involved in the project.

Table 5.10a: Paired t-test on contribution to maternal health care delivery in Northern Nigeria by Rotary International 3-H Project.

Health Facilities Status		Mean	N	Standard Deviation	Standard Error Mean
Pair 1	Health facilities Before	627.3333	6	375.54969	152.90927
	Health facilities After	729.0000	6	349.40693	142.64476
Pair 2	Fully functional Before	50.8333	6	24.24390	9.89753
	Fully functional After	297.5000	6	190.08919	77.60359

Table 5.10b: Test of Significance

Variable	X	SD	SE	t-value	df	P
Before	50	24.2439	9.8975	3.494	5	0.017
After	297.50	190.0892	77.6036			Sig.

The result of the test indicated significant contribution to maternal health care delivery at post-intervention within the states covered by the project. The observed T-value is 3.494 at 5 degrees of freedom, while the observed level of significance is 0.017 ($P < 0.05$) the critical value of P at 0.05 and at 5 degrees of freedom is 2.571, the observed T-value in the test is higher than the critical value. This means then that the Null hypothesis which states that "Rotary International 3-H Project did not make any marked contribution to improve maternal health care service delivery in northern Nigeria" is therefore rejected, because from the test, it

shows that significant contribution has been made. Hence, the Alternate hypothesis which states that "Rotary International 3-H Project has made marked contribution to improve maternal health care service delivery in northern Nigeria", is hereby accepted.

Hypothesis Two

Null Hypothesis

H_o: The Rotary International management structure did not enhance the performance outcomes of Rotary International 3-H Project.

Alternate Hypothesis:

H_1: The Rotary International management structure has enhanced the performance outcomes of Rotary International 3-H Project.

From the project basic document, project organizational framework and project reports, it was observed that the organizational structure was as presented in Figures 5.2.4 and 5.2.5. There were three (3) distinct arms:

a. The German Rotarian Arm (District 1840 – Germany)

b. The Nigerian Rotarian Arm (District 9120 – Nigeria)

c. The Employed Personnel

All the three arms worked together to ensure the achievement of the project goals. From the available records, it was gathered that the Rotarian arms (Nigeria and Germany) were regarded as the 'bosses' of the employed personnel while the Nigerian committees Rotarians were to be subject to the German Rotarian committees.

It was therefore imperative to find out how such a relationship played out in the outcomes of the project. Hence, the respondents were asked questions on:

(i) How they rated the management structure

(ii) Their level of satisfaction with the reporting system

(iii) Avenues for meeting

(iv) Frequency of Project reporting

(v) Frequency of Project Monitoring

(vi) Their perception of project outcomes

(vii) The linkage between project outcomes and management structure.

To find out more about the management structure, the Nigerian chairman was interviewed. Questions 14, 15, 16, 17, 18 and 19 on the Interview Schedule revealed as follows:

a. That the German Chairman:

i. Liaised between the project and its funders.

ii. Controlled the overall funds for the project and released it in tranches to the Nigerian Chairman, through the External Audit Firm.

iii. Was the overall head of the project.

iv. Was the chief planning officer of the project.

v. Headed the Rotarian committee in Germany.

b. The Nigerian Chairman:

i. Liaised between the project and the German committee

ii. Headed the Nigerian committee

iii. Was the chief executing officer of the project

iv. Controlled the funds released to the Nigerian committee

v. Was the one directly in charge of controlling the project staff.

c. The employed personnel:

i. Executed the daily project activities

ii. Monitored project activities at project delivery sites

iii. Compiled project reports

iv. Liaised between the project management and clinical service providers.

The project employed staff were interviewed also. The following tables show their responses.

Table 5.11a: Cross-tabulation of respondents status in Rotary International 3-H Projects

Post in Project	Respondent Status		Total
	Managers	LWs	
District Manager/ Research Officer	2 (22.2%)	0 (0%)	2 (8.0%)
Accountant	1 (11.1%)	0 (.0%)	
State Manager	6 (66,7%)	0 (0.0%)	6 (24.0%)
Liaison Field Worker	0(.0%)	16(100%)	16(64.0%)
Total	9(100.0)	16(100.0%)	25(100.0%)
$X^2 = 25.0$, df = 3, p = 0.00			

Source: Researcher's Survey, 2011

Table 5.11b: Chi-square tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson chi-square	25.000	3	.000
Likelihood ratio	32.671	3	.000
Linear-by-linear association	16.593	1	.000
No. of valid cases	25		
$X^2 = 25.000$, df = 3, p = 0.00			

Source: Researcher's Survey, 2011

Table 5.12a: Length of Time Working in the Project by Status of the Respondents

	Length of Time	Respondent Status		
		Managers	LFWs	Total
Length of Time working in the project	Above 7 years	2(22.2%)	0(0%)	2(8.0%
	5-7 years	7(77.8%)	10(62.5%)	17(68.0%)
	2-4 years	0(0%)	6(37.5%)	6(24.0%)
	Total	9(100.0%)	16(100.0%)	25(100.0%)
$X^2 = 7.128$, df = 2, P = 0.028				

Source: Researcher's survey, 2011

Table 5.12b: Chi-square tests

	Value	Df	Asym. Sig. (2-sided)
Pearson chi-square	7.128	2	.028
Likelihood ratio	9.636	2	.008
Linear-by-linear association	6.699	1	.010
N of valid cases	25		

Source: Researcher's Survey, 2011

a. 4 cells (66.7%) have expected count less than 5. The minimum expected count is .72.

Table 5.13a: Cross-tabulation of rating of management structure of project

Rating of Management Structure of Project	Respondent Status		Total
	Manager	LFWs	
Extremely good	0 (.0.%)	4(25.0)	5(16.0%)
Very good	9 (100.0%)	12(75.0%)	21(84.0%)
Total	9(100.0%)	16(100.0%)	25(100%)

Source: Researcher's Survey, 2011

Table 5.13b: Chi-square tests

	Value	Df	Asymp. Sig. (2-sided)	Exact. Sig. (2-sided)	Exact sig. (1-sided)
Pearson chi-square	2.679	1	.102		
Continuity correction	1.141	1	.285		
Likelihood Ratio	3.989	1	.046		
Fisher's exact test				.260	.144
Linear-by-linear association	2.571	1	.109		
No. of valid case	25				

Source: Researcher's Survey, 2011

a. Computed only for a 2 x 2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.44.

Table 4.14a: Adequacy of management structure to project achievements – Cross Tabulation

Adequacy of Management Structure to Project Achievement	Respondent Status		Total
	Managers	LFWs	
Very adequate	2 (22.2(%)	4 (25.0%)	6 (24.0%)
Adequate	7 (77.8%)	12 (75.0%)	19 (76.0%)
Total	9 (100.0%)	16 (100.0%)	25 (100.0%)

Source: Researcher's Survey, 2011

Table 5.14b: Chi-square tests

	Value
Pearson chi-square	*A*
No. of valid cases	25

a. No statistics are computed because "Was the project a success?" is c constant.

Table 5.15a: Frequency of monitoring of service delivery points – cross tabulations

Frequency	Respondents Status		Total
	Managers	LFWs	
Daily	0 (.0%)	2 (12.5%)	2 (8.0%)
Weekly	7 (77.8%)	14 (87.5%)	21 (80.0%)
Monthly	1 (11.1%)	0 (.0%)	1 (4.0%)
As necessary	1 (11.1%)	0 (.0%)	1 (4.0%)
Total	9 (100.0%)	0 (.0%)	25 (100.0%)

Source: Researcher's Survey, 2011

Table 5.15b: Chi-square tests

	Value	df	Asymp. Sig. (2sided)
Pearson chi-square	4.745	3	.191
Likelihood ratio	5.937	3	.115
Linear-by-linear association	3.786	1	.052
N of valid cases	25		

Source: Researcher's survey, 2011

a. 6 cells (75.0%) have expected count less than 5. The minimum expected count is .36.

Table 5.16a: Frequency of progress Report

Frequency	Respondents Status		Total
	Managers	LFWs	
Weekly	0 (.0%)	16 (100.0%)	16 (64.0%)
Monthly	9(100.0%)	0(0%)	9(36.0%)
Total	9(100.0%)	16(100.0%)	25(100.0%

Source: Researcher's Survey, 2011

Table 5.16b: Chi-square tests

	Value	df	Asymp. Sig (2 sided)	Exact sig. (1-sided)	Exact sig (1 sided)
Pearson chi-square	25.000	1	.000		
Continuity correction	20.848	1	.000		
Likelihood ratio	32.671	1	.000		
Fisher's exact test				.000	
Linear-by-linear association	24.000	1	.000		.000
No. of valid cases	25				

Source: Researcher's survey, 2011

a. Computed only for a 2 x 2 table

b. 1 cell (25.0%) have expected count less than 5. The minimum expected count is 3.24

In order to find out more about the reporting system, which was part of the management structure, respondents were asked a question on how satisfied they

were with the project's reporting system. The cross tabulation of their responses were as shown on table 5.17a below.

Table 5.17a: Level of Satisfaction with reporting system – cross tabulation

How satisfied with system of reporting	Respondents Status		Total
	Managers	LFWs	
Extremely satisfied	0 (.0%)	4 (24.0)	4 (16.0%)
Very satisfied	9 (100.0%)	12 (75.0%)	21 (84.0%)
Total	9 (100.0%)	16 (100.0%)	25 (100.0%

Source: Researcher's Survey, 2011

Table 5.17b: Chi-square tests

	Value	Df	Asymp. Sig (2 sided)	Exact sig. (1-sided)	Exact sig (1 sided)
Pearson chi-square	2,679	1	.102		
Continuity correction	1.141	1	.285		
Likelihood ratio	3.989	1	.046		
Fisher's exact test				.260	.144
Linear-by-linear association	2.571	1	.109		
No. of valid cases	25				

a. Computed only for a 2 x 2 table

b. 2 cells (50.0%) have expected count less than 5. the minimum expected count is 1.44.

Also when the 25 respondents were asked if there were avenues for the project employed staff to hold regular meetings with the District Committee, the 25 respondents responded in the affirmative, representing 100%. At the state level, it was monthly, while at District level, it was quarterly. In order to find out the perception of the respondents on the performance of the project, as to whether it was a success or failure, all the 25 respondents, representing 100% responded that it was a success. They were further asked if they believed that it has

contributed positively to maternal health service delivery. Table 5.18a is a cross tabulation of their responses.

Table 5.18a: Contribution of project to maternal health service delivery – cross tabulation

Level of agreement of project contribution to maternal health care delivery	Respondents Status		Total
	Managers	LFWs	
Strongly agree	6(66.7%)	6(37.5%)	12(48.0%)
Agree	3(33.3%)	10(62.5%)	13(52.0%)
Total	9(100.0%)	16(100.0%)	25(100.0%)

Source: Researcher's Survey, 2011

Table 5.18b: Chi-square tests

	Value	Df	Asymp. Sig (2 sided)	Exact sig. (1-sided)	Exact sig (1 sided)
Pearson chi-square	1.963	1	.161		
Continuity correction	.968	1	.325		
Likelihood ratio	1.990	1	.158		
Fisher's exact test				.226	.163
Linear-by-linear association	1.885	1	.170		
No. of valid cases	25				

a. Computed only for a 2 x 2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 4.32

In order to test hypothesis two therefore, the outcome of the Rotary International 3-H project was measured from the opinions of the managers and the liaison field workers. Two variables measured the management structure of the project, while one variable was used for the measurement of the outcome of the project. To determine the relationship between the management structure and the outcome of the Rotary International 3-H Project, the Chi-square procedure was adopted. The two variables used for measuring the management structure were

cross-tabulated with the outcome of the project based on the opinions of the managers and the liaison field workers.

Table 5.19 shows the perception of the management structure and the outcome of the project.

Table 5.19: Test of Association of Management Structure and Outcome of Rotary International 3-H project.

The project has contributed to service delivery of maternal health	Rating of management structure of R.I. 3-H project		Total
	Extremely Good	Very Good	
Strongly agree	4(1.9)	8(10.1)	12(12.0)
Agree	0(2.1)	13(10.9)	13(13.0)
Total	4(4.0)	21(21.0)	25(25.0)

$X^2 = 5.159$, df = 1, p = 0.023

The observed chi-square for the test is 5.159 at 1 degree of freedom. The probability level of significance observed for the test is 0.023. This indicates a strong significant association between the management structure and the Rotary International 3-H project.

A further test of this relationship between the management structure and the project's positive outcomes was further carried out as shown on Table 5.20.

Table 5.20: Management structure and the outcome of project on maternal health care delivery in Northern Nigeria.

Project has contributed to service delivery of maternal health care	Adequacy of management structure to project achievement		Total
	Very adequate	Adequate	
Strongly Agree	6(2.9)	6(9.1)	12(12.0)
Agree	0(3.1)	13(9.9)	13(13.0)
Total	6(6.0)	19(19.0)	25(25.0)

$X^2 = 8.553$ df = 1, p = 0.003

The observed chi-square value for the test is 8.553 at 1 degree freedom while the level of significance observed is 0.003. This is a further attestation to the strong relationship between the management structure and the project outcome ($P < 0.05$). This means that the null hypothesis which states that: "The Rotary International management structure did not enhance the performance outcomes of Rotary International 3-H Project" is therefore rejected. In other words, the management structure of project constitutes a major factor of its success in northern Nigeria. Hence, the alternate hypothesis which states that: "The Rotary International management structure has enhanced the performance outcomes of the Rotary International 3-H Project" is hereby accepted.

5.5 Discussion on Findings

5.5.1 Discussion on Findings from Analysis of Primary Data, Secondary Data and Test of Hypotheses

The data analysed included both primary and secondary data. Both were employed to assess the activities of Rotary International 3-H project in service delivery in the area of maternal health in Nigeria.

Findings on Test of Hypothesis Number One

The hypothesis number one was to test whether or not Rotary International project had made any marked contribution to maternal health care service delivery in northern Nigeria.

In order to do this, the measures by Rotary International towards improving service delivery in maternal health care were analysed. They included training

service providers in order to improve their skills; equipping the service delivery points with those basic equipment and materials that are needed to carry out the services, providing the commodities needed for child spacing and ensuring regular supply to the service delivery points. In fact, from the data gathered, collated and analysed, only 305 child spacing service delivery points were fully functional (able to render child spacing services with skilled manpower and necessary equipment) before Rotary's intervention. But a total of 1,785 service delivery points became fully functional after Rotary's intervention. This translates to 485% increase in the number of fully functional clinics after Rotary's intervention. Furthermore, the questionnaires administered to the clinical service clients revealed that the clients had benefited from the R.I. 3-H project. All these enabled us to reach the conclusion that the R.I. 3-H Project has actually made marked contribution to the improvement of service delivery of maternal health care in northern Nigeria.

Findings on Test of Hypothesis Number Two

The hypothesis number 2 was to test the association between the management structure of Rotary International 3-H project, and the outcomes of the project. Data obtained from both primary and secondary sources revealed that the outcomes of the project were that: more women in northern Nigeria had knowledge about child spacing through the sensitization activities of the project; more women had access to child spacing services through the capacity building

measures of the project which led to increase in the number of health facilities that offered child spacing services.

The management structure consisted of Rotarian project committees in Nigeria and Germany, as well as project staff on the other side. The interaction within this structure was observed in terms of the frequency of meetings, monitoring of service delivery points, the reporting system and the role of each group within the structure in terms of planning, implementation, monitoring and evaluation.

From the data presented and analysed, it was revealed that the most overall steering instrument were the quarterly project progress meetings in Nigeria in which all of the Nigerian District committee members, the representatives of the project states, and the German chairman and other German committee members participated. It was at such meetings that the overall direction of the project was decided upon, and the work of the state project offices was presented and discussed. Also, the work of separate expert committees (for example, Awareness Committee, Advocacy Committee, among others), were presented to direct decision making; the work of the German project management committee, which usually met in Munich, was also usually presented and discussed at that meeting. All this assisted in the implementation of the project, as well as the constant monitoring and evaluation and re-evaluation of project activities.

The reporting system consisted of two types of reporting. Reporting to the different donors and internal project reporting.

Reporting to the different donors included the 6 monthly reports to TRF (narrative and budgetary), annual reports to the Packard Foundation (narrative and budgetary), and the annual reports to the E.U. It was discovered that report formats and reporting periods to each of those donors were different, this acted as checks and balances within the organisational structure of the project.

The internal reporting included weekly reporting by the Liaison Field Workers (LFWs), monthly reports from the 6 states to the Nigerian District Office. The district office sent monthly reports which included summaries of the reports from states as well as district office activities. Also, there were quarterly reports from the states to the district office, which were also sent to Germany inclusive of the Nigerian dist rict office reports.

The Rotarian project committee members were experienced professionals in different fields, they brought their wealth of experience to bear on the project, there were medical doctors, heads of corporate organizations, public relations practitioners, media practitioners, accountants, auditors, among others.

This collectivity of Rotarian potentials contributed positively to project achievements. It also enabled the project to have access to different people in government at different tiers. The cooperation received from government, religious leaders and political leaders, all combined to enhance project implementation and project success.

5.5.2 Research Findings

The main research findings of this study include the achievements as well as the shortcomings/weaknesses:

5.5.2.1 Achievements

1. That the poor presentation of Nigeria especially northern Nigeria, on maternal mortality statistics traceable to poor service delivery, was what informed Rotary International's intervention in the service delivery of an arm of maternal health care (Child spacing) in northern Nigeria. The spacing of pregnancies and child birth by women was considered important as culturally, Nigerians seem to value large families, even in the face of extreme poverty. This tends to affect the health of pregnant women due to many biological and social factors which include unspaced pregnancies and child births. Rotary therefore embarked on a project to seek for means through which clinical service delivery could be improved.
2. That the objectives of the project were to offer such clinical services (of child spacing, family health and HIV/AIDS education) in order to contribute to improving the health of mothers. This in turn was expected to lead on the long run, to a reduction in the mortality and morbidity rates of women.
3. That the strategies adopted by the project contributed to the level of success or achievements of the project. The strategies used were carried

out at different stages of the project. The strategies were Advocacy visits to government functionaries, Religious and Opinion leaders, Traditional rulers, Men and Women groups, among others. This was done to enlist their support for the project so that the project could have the necessary backing and legitimacy. The second phase was the sensitization and awareness campaign. This was to spread information about maternal health and how to reduce maternal deaths.

The advocacy and sensitization measures of the project enabled it to obtain the confidence of the community leaders and the populace, this prepared the ground for the child spacing component when it was introduced. The intensity of these measures helped in encouraging husbands to allow their wives to utilize the child spacing services.

The next phase was the training component. The quality of the training was adjudged to be good and adequate and since many providers were trained, it enabled service delivery to be taken to health facilities at the primary level especially in the rural areas. This contrasted with the former practice where child spacing services were mainly offered at the secondary level or basically available in the state capital only.

The fourth stage was the Basic equipment component. This included the provision of basic materials and equipment, which combined with ultrasound services, combined preventive and curative

care, because as women were offered services to prevent frequent pregnancies, the pregnant ones were scanned for signs of risky pregnancies, while such risky pregnancies were attended to through emergency obstetric care services. This led to the provision of comprehensive care by taking care of pregnant women, as well as taking care of those who did not want to become pregnant.

The fifth stage was the "field phase" which is the supply of child spacing commodities, and ensuring a steady flow of the commodities, as well as ensuring a good contraceptive mix. The project reports indicated that the contraceptive use may be much higher than what is reflected in the statistics, this is because there were secret users who did not want their names documented.

4. That the programme was implemented in such a way that there was cooperation among the government, the team of Rotarians in Nigeria and Germany, as well as the project staff. This enabled all the parties to work hard towards the success of the project, due to the internal control measures introduced and manifested in the organizational structure.

Findings further revealed the following in the area of service delivery:

a. Accessibility

The child spacing services of the project were made available at both the primary and secondary levels of all the local government areas in the six states. This shows that services were made more accessible to the women. The training

of Traditional Birth Attendants who were mainly women, facilitated greater accessibility for clients. This is because the TBAs were able to visit the women users even in their homes to make some of the non-prescriptive commodities readily available to them.

The users and potential clients did not have to travel over long distances to have access to such services.

b. Functionality

Due to regular monitoring and unannounced visits of project personnel to the service delivery points, the clinical service providers endeavoured to ensure proper functioning of service delivery points. But in spite of training and retraining of service providers, it was still discovered that good record keeping at some sites was lacking or a bit challenging.

c. Affordability

At the early stages of the project, contraceptive commodities were offered free to the clients. Later when commodities were sought from commercial dealers, the commodities were offered to clients at highly subsidized rates. However, some service providers were found to indulge in sharp practices of inflating the prices and even in some cases, making certain commodities too expensive for the clients.

d. Relevance of Project

As a result of vigorous advocacy and sensitization measures embarked upon by the project, communities eventually accepted the child spacing project.

However, there was debate as to whether child spacing was actually what the communities needed, even in the face of other pressing needs. The issue was whether the project was implemented in the interest of the people or in the interest of the donors.

e. Sustainability

The sustainability of the project was facilitated through the meetings held by Rotary with officials of the Ministry of Health and the Ministry of Local Government and Chieftaincy Affairs. The two Ministries promised to sustain the clinical services of the project at all the sites. They also gave Letters of Commitment to the Project. Furthermore, a contraceptives Logistics Management System (CLMS) to ensure regular flow of contraceptives to the clinics was launched by the Federal Government. Rotary also started implementing another project which is focused on Antenatal, Delivery and Postnatal Care services.

5.5.2.2 Shortcomings/Criticisms of the Project

The R.I. 3-H project was not completely without its own challenges. Some of the challenges indicated or mentioned included:

i. Rotary International is a broad-based organisation with the ability to think big and want to take up big challenges, that explained the initial plan of R.I. to want to cover the entire northern states of Nigeria. But had to scale the project down to cover 6 states. Even then, all the local governments of the 6 states were covered. That amounted to 166 local government areas, unlike other organizations

which sometimes came in and selected just two or three LGAs per state. This must have affected the Liaison Field Workers who indicated that they had to work extra hard to cover the service delivery points in the LGAs allocated to them.

ii. Staff were allocated to project states and LGAs almost on equal basis, not taking into consideration the unique physical terrain and size of each state, apart from Kano State with 44 local government areas.

iii. The project staff had multiple Rotarian bosses to report to.

iv. Fund recovery from sales of contraceptives by service providers was low and slow, because some of the clinical service providers failed sometimes to document the money from contraceptives sale.

v. Because of the cultural and religious inclinations of the population, some of the users of the clinical services were secret users who rejected any form of documentation. This led to under reporting of project achievements.

vi. Some people in the rural areas thought that Rotary was a secret organization, hence the initial resistance to the project. But with intensive awareness campaign and advocacy, the challenge was overcome.

v. Other challenges included those of unstable supply of electricity, which led to the use of generators at a high cost; communication

between Nigeria and Germany which was usually daily by telephone, fax and e-mail, was quite challenging because the early part of the project was a period when the GSM mobile telephone service was not as prevalent as it is presently.

5.5.3 Collaboration with Other NGOs

That the records and monthly reports of the project revealed that while the project was solely initiated, planned, and implemented by Rotary, because the project was co-funded by the Packard Foundation, U.S.A., the foundation used to bring together all the grantees in Nigeria at least quarterly. This led to exchange of ideas by the grantees, hence the project staff from the different grantee organizations learned from one another. Some training programmes were also sometimes co-organised or jointly supervised.

5.5.4 Lessons Learnt

That there were various lessons learnt in the course of the project, which included the following:

i. Project planners and implementers must be responsive to the cultural sensitivities of their host communities. The initial plan of R.I. 3-H project was to name the project a “Family Planning”: project. But in the course of advocacy visits, it was discovered that the name “Family Planning”: was offensive to the people. Hence it was changed to “Child spacing”.

ii. That the challenge of maternal health care delivery should not be left solely to the government in a less developed country like Nigeria, since Millennium Development Goals were to be achieved by the year 2015. The government seems to be moving at a slow pace, hence the need for non-governmental organizations to join in.

iii. That the level of success of a project can be enhanced when the host communities take part in the planning of the project, as done by Rotary.

iv. That because Rotary has been involved for years, in the polio eradication campaign, by providing support in the areas of logistics and organization, this longstanding involvement in health issues by Rotary, has had a mutually reinforcing effect on the 3-H project.

CHAPTER SIX

6.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter concludes the research report. It consisted mainly of the summary of the findings, conclusion and recommendations. The conclusion and recommendations drawn in the study are solely based on the general experience of the researchers in the course of the study.

They are more applicable to Rotary's maternal health programme in northern Nigeria, specifically the Rotary International 3-H project.

6.2 Summary

In the introductory chapter, the focus was to find out why Rotary as an organization decided to intervene in the health sector of Nigeria in the area of maternal health. Our findings revealed that their intervention was informed by the fact that there are Millennium Development goals which were to be achieved by the year 2015, one of which is to reduce maternal mortality by 75% by the year 2015; and one of the strategies is the provision of and access to maternal and neonatal health care including family planning services (Federal Ministry of Health, n.d.:22). Another strategy is also to foster intersectoral collaboration on involvement of international agencies, NGOs and relevant government associations (ibid:23). Hence, the involvement of Rotary. Findings also revealed that strengthening of primary health care to provide family planning services is another strategy. Rotary therefore embarked on including all the local government

areas in the project area, as this will facilitate capacity building at the primary health care level.

Rotary international got involved in the health care delivery system and developed its own strategies of improving the health of women through improved service delivery system. The thrust of this study was therefore to find out if the intervention by rotary through its 3-H Project had been beneficial or not. Hence, two hypotheses were designed to guide the study as follows:

a. That Rotary International 3-H Project has not made any marked contribution to improve maternal health care service delivery in Northern Nigeria.

b. That the Rotary International management structure did not enhance the performance outcomes of the Rotary International 3-H Project.

Some terms which considered relevant to our study were outlined and defined, among them were such terms as: Advocacy, Maternal Health, Maternal Mortality, Development, Non-Governmental Organization, among others.

Chapter Two consisted of a review of related literature. It included a wide range of definitions given to NGOs as private organizations which pursue a variety of activities that enhance the general welfare of the communities they serve (Asamoah, 2003). They are regarded as partners in development (De Beer and Swanepoel, 2007:38-39). Materials in textbooks, journals, magazines, newspapers and the internet were included in the literature reviewed. A theoretical framework is also included in chapter two. The programme impact theory was adopted. It is

a theory developed by Rossi, Lipsey and Freeman (2004). The theory emphasises the identification of the target population, the service arena, which includes the programme's service utilization plan and organizational plan, which lead to the proximal outcomes, and eventually the distal outcomes.

Chapter three presented the research methodology. Here, the research design is presented, the project evaluation design was adopted for the study. The sources of the data used in the study included primary and secondary sources. Questionnaires, interview schedule, project reports and records were the means through which data were obtained in the study.

The data gathered were presented using tables. The data were analysed using percentages and averages. Statistical packages for Social Sciences Software were used in the analysis of data which involved coding and cross-tabulation of data. The chi-square and t-test were applied in the test of hypothesis. The decision rule was to reject the null hypothesis if the calculated value is greater than the critical value at 5% level of significance, and to accept the null hypothesis if the calculated value is less than the critical value at 5% level of significance.

In Chapter four, attempts were made to explain what Rotary is and its activities. There was a description of the historical background of the Rotary International 3-H Project, how it started with a pilot project in two local government areas in Kaduna State in 1995, the achievement of the pilot project, and how it was scaled up to cover northern Nigeria. But because of paucity of

funds, it was implemented as an R.I. 3-H Project covering 6 states of northern Nigeria.

Chapter five presented the data and the analysis of the data collected. The questionnaires designed were administered to different groups of people. A total of 600 to beneficiaries of the project who were clients of the clinical services, 60 health personnel who were beneficiaries of the training programme of the project, 96 MCH Coordinators and 6 State Reproductive Health Coordinators.

Interview schedules were designed to be used to interview the 2 country chairmen, but only one could be interviewed, as one of them could not be interviewed.

The data and analysis revealed that Rotary International, through its maternal health programme has been able to make marked contribution to maternal health care service delivery in Northern Nigeria. It also revealed that the management structure of the Project also contributed to its outcomes.

6.3 Conclusion

Globally, maternal health has been of great concern because of the problem of high maternal mortality. A global movement to tackle the high mortality rate especially in the less developed countries launched the Safe Motherhood Initiative in 1987 at Nairobi, Kenya. The aim was to find ways of reducing maternal mortality ratio globally by 50% by year 2000. The Nigeria's version of the Safe Motherhood Initiative was launched in 1990. By 1994, at the International Conference for Population and Development, part of the decisions taken was to

reinforce the need to reduce maternal mortality. Again, by year 2000 when the Millennium Development Goals were launched, the issue of maternal health was again one of the goals, with the aim of reducing maternal mortality by 75% by the year 2015.

It was reported that inspite of all the awareness created around the issue of maternal health, maternal mortality was still high in Nigeria, as Nigeria was the country with the second highest maternal mortality ratio in the world, after India. This prompted Rotary International to intervene and explore ways of making a contribution in that direction. Rotary International therefore embarked on the 3-H Project with emphasis on child spacing, using the strategies of Advocacy, sensitization and awareness campaign, training, equipment donation, and contraceptive supply.

Findings revealed that the management structure of the project contributed to the outcomes of the project, which in this case were positive. The structure was such that the team of Nigerian Rotarians and German Rotarians, formed parallel project committees for the planning, implementation, and monitoring and evaluation of the project, they did this in conjunction with the project's employed staff.

It was also revealed that the project has made marked contribution to the maternal health care delivery system in northern Nigeria by 485%. This was found to have been made possible by the strategies employed by the project. Those strategies contributed to making more public health facilities, to be able to provide

child spacing services; thus increasing access to child spacing and other maternal health services. This shows that when such services are available, it increases access to them; the awareness and sensitization, as well as advocacy increased utilization and when utilization increases maternal health will improve, and it will on the long run lead to reduction in maternal mortality. This explains the proximal and distal effects of the programme as contained in the programme impact theory of evaluation.

6.4 Recommendations

Based on the study, the following recommendations were made:

1. Rotary committed itself to the regular collection of data on service provision and service utilization, if practiced by other agencies at all levels such could add up in providing demographic data, which could be used for economic and social development planning.
2. The impact of population on development depends not only on the absolute size but also on its quality. Hence the need for good maternal healthcare services to be provided so that the health of the human capital can be enhanced.
3. The effort of Rotary through advocacy and sensitization of the male population has helped to promote male involvement and positive gender culture in issues of child spacing. Such a strategy, if adopted by the government, can contribute towards one of the expected outcomes of the

National Gender Policy (2006) that there should be male involvement in child spacing.

4. The tracking of service delivery indicators through periodic monitoring and evaluation is a positive attribute of the R.I. 3-H Project, which if replicated by the three tiers of government will promote improved maternal health care services at all levels and facilitate proper record keeping at the service delivery points.

5. Regular supervision by different teams:

   Rotarian Volunteer Team, Project staff and Local Government MCH Coordinators, all combined to promote better working relationships. Such could, if adopted, help to foster public/private partnerships in the development process.

6. The inclusion of community members- women, men and community leaders- at all stages of project implementation was key to the success of the project and this could lead to sustainability of projects. If projects are flexible and open to modification according to changing needs and circumstances of their beneficiaries, it will facilitate community ownership and promote sustainability.

7. While many development projects targeted at women have been or are being carried out, few of them are evaluated and documented for public reference, but the assessment of R.I. 3-H Project has demonstrated the need for documentation of projects implemented by NGOs.

8. In order to achieve the goal of reducing maternal mortality by 75% by the year 2015, clinical service delivery system must be improved by improving capacity building through training, provision of necessary equipment and all other necessary things.

9. Training and retraining of service providers must be ensured in order to facilitate skills development. It will also help service providers to be conversant with global best practices.

10. The strategies adopted by Rotary are quite commendable. It is necessary to involve community leaders at every level in all stages of a project cycle. This will contribute to the project's acceptability and success.

11. Non-Governmental Organizations must be seen by government as partners in development, especially credible ones. Governments are encouraged to accommodate them and they should be allowed to play a partnership role.

12. Non-Governmental Organizations should not be paternalistic when embarking on a project. The involvement of the people and their participation in deciding what their felt needs are, is necessary for the success of the project. There were many areas of maternal health in which intervention could have been made without necessarily posing a challenge to the people's cultural or religious beliefs. Child spacing

was not an easy field to go into in northern Nigeria, but with vigorous advocacy and sensitization, it was possible, this could be emulated.

13. Non-governmental organizations should be encouraged to either disseminate their project outcomes and processes, or to make information about their projects open, so that other people, especially in the academia can conduct some evaluation studies on their projects.

14. Since the R.I. 3-H project was carried out in 6 states, it would be good for it to be replicated in the other states for comparative purposes.

15. The challenges of the project included allocating the same number of project staff to all the project states, except Kano State. Future projects of this nature should reconsider the issue of staff allocation and do so according to the size and peculiarities of the state. For example, even though Adamawa and Plateau States have 21 and 17 local government areas respectively, their physical terrains are quite challenging, therefore, the monitoring staff had to put in more time and energy when visiting the project sites. More staff should have been deployed to the 2 states, irrespective of the fact that they have fewer local government areas than states like Kaduna and Katsina.

16. Another challenge mentioned by the project staff is that they had too many "Rotarian Bosses" to report to. It seemed that every member of the project committee at the state and district level was a "boss" to the project staff, and could issue commands to the project staff. This should

be reviewed in subsequent projects, because when there are too many people issuing commands to the staff, it is not easy for the staff to cope, and it will create confusion.

17. There should be a forum for all NGOs working in the field of maternal reproductive health to meet, so that the policies of the government could be better explained to them. It will help them to understand such policies better, and the government will be able to coordinate and monitor their activities better. It will also help to reduce fragmentation of efforts and unnecessary rivalry.

18. All activities of NGOs should be better coordinated and their achievements documented in a national data bank. This will help to provide the data needed for national planning and for developmental purposes.

19. Efforts have been made by Rotary to sustain its achievements. The government must endeavour not to fail in its commitment, to ensure sustainability of maternal health care services. This will facilitate better health conditions of women and children as well as the entire families. The improved health of women will lead to reduction of maternal mortality and enhance the development of the country.

6.5 Areas for Further Research

This study has been conducted from the perspective of programme evaluation. It does not in any way cover all the perspectives from which this

programme could be studied. Hence, the following areas have been recommended for further research.

i. A study on health care financing can be conducted using this project as a case study.

ii. In chapter two of this study, the role of NGOs were highlighted. It was however, discussed that because many NGOs depend on foreign aids, this tends to compromise the sovereignty of recipient countries. The relationship between Nigeria and the funding nations of Rotary 3-H Project could be explored further in another research.

iii. This study has focused mainly on the women as the target population. But it is a known fact that projects have unintended consequences. This area of unintended consequences can constitute another area for further research.

iv. As a Department of Public Administration, it would be interesting to conduct a research on the Role of Culture in the Implementation of a Project. The culture of the people was an initial obstacle to the R.I. 3-H Project.

v. The area of personnel management of the project can also be studied, such as how staff are recruited, developed and either retained or disengaged.

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APPENDIX I: REQUEST FOR INTERVIEW

Department of Public Administration,
Faculty of Administration,
Ahmadu Bello University,
Zaria,
Nigeria.
10th January, 2011.

Dear Sir/Madam,

REQUEST FOR INTERVIEW

We write to request your permission to be interviewed, in order to seek information on your views on the Rotary International 3-H Project (Child spacing, Maternal Health and HIV/AIDs Education).

This request is informed by the fact that you served as one of the principal partners in the implementation of the said project. The information to be gathered will form part of the data needed to enable us carry out an assessment of the project. This is to form the basis for a doctoral dissertation in the above indicated institution.

Please note that all information supplied will be treated confidentially, and will be used for academic purposes only. An interview schedule has been hereby attached for your perusal ahead of the time.

Kindly indicate when it would be convenient for you to be interviewed.

Thank you in advance.

Yours faithfully,

(Signed)

Yemisi I. Ogunlela (Mrs.)

APPENDIX II: INTERVIEW SCHEDULE FOR DISTRICTS CHAIRMEN NATURE OF ROTARY INTERNATIONAL INTERVENTION

1. Why did Rotary choose to intervene in maternal healthcare delivery in northern Nigeria?

2. What did Rotary set out to achieve through its 3-H Project (Child Spacing, Family Health and HIV/AIDs education)?

3. Can you please comment on the strategies used by Rotary in the Project?

4. How many states did the Project cover?

5. Why did the Project not cover all the northern states?

6. What informed the choice of the selected states?

7. What was the duration of the project?

ROLE OF GOVERNMENT

8. Is the provision of healthcare, maternal healthcare inclusive, not supposed to be the responsibility of the government? Why then did Rotary get involved?

9. How would you describe the relationship between Rotary and the three tiers of government in this Project?

10. What role did the respective government play?
11. How would you rate the cooperation (if any) received from the government?

MANAGEMENT STRUCTURE OF THE PROJECT

12. How was the project funded?

13. What controlled the funds?

14. Can you please comment on the management structure of the project?

15. Would you say that the management structure contributed to the success or failure of the project?

16. Would you consider the project as being successful?

17. Why would you consider it a success or a failure?

LOCAL/INTERNATIONAL ROTARIAN RELATIONSHIP

18. How would you rate the level of cooperation betweenthe German and Nigerian Rotarians on this project?

19. What role did the local Rotarians play?

20. What role did the Germany Rotarians play?

21. Was the working relationship between the German Rotarians and their Nigerian counterparts good or poor?

ASSESSMENT OF THE PROJECT

22. What were the various challenges encountered in the project?

23. What would you say were the lessons learnt?

24. Overall, in your own opinion, would you say that the project was a success or a failure?

APPENDIX III

REQUEST FOR QUESTIONNAIRE ADMINISTRATION

Department of Public Administration,
Faculty of Administration,
Ahmadu Bello University,
Zaria,
Nigeria.

10th January, 2011.

Dear Sir/Madam,

REQUEST FOR QUESTIONNAIRE ADMINISTRATION

This Researcher is undertaking a study on the activities of Rotary International in the area of maternal health in some parts of Northern Nigeria.

We therefore solicit your cooperation to kindly complete the attached questionnaire in order to know your views on the project.

All information volunteered by you will be treated with utmost confidentiality.

Thank you.

Yours faithfully,

(Signed)

Yemisi I. Ogunlela (Mrs.)

APPENDIX IV: INTERVIEW SCHEDULE FOR PROJECT STAFF

1. Post in Rotary 3-H Project

a. District manager

b. Research Officer

c. Accountant

d. State manager

e. Liaison Field Worker

2. For how long did you work for the project?

a. Above seven years?

b. 5-7 years

c. 2-4 years

d. 1 year and below

3. Please give a description of the management structure of the 3-H project

……

……

4. How would you rate the management st ructure of the R.I.l 3-H project?

a. Extremely good 5

b. Very good 4

c. Good 3

d. Fairly good 2

e. Not good 1

5. In your own estimation, was the project a success or a failure?

a. Yes

b. No

6a. If it was a failure, what do you think were the reasons

……

……

6b. If it was a success, do you agree that the management structure had any effects on the outcome?

a. Strongly agree 5

b. Agree 4

c. Fairly agree 3

d. Do not agree 2

e. Do not know 1

6c. Were the effects negative or positive?

a. Positive

b. Negative

6d. How adequate was the management st ructure to the achievement of the project:

a. Very adequate 5

b. Adequate 4

c. Fairly adequate 3

d. Not adequate 2

e. Very adequate 1

6e. Kindly give reasons

……

……

……

……

7. Could you please describe the reporting system adopted in the project?

……

……

……

……

8. How often did you have to monitor activities at the service delivery points?

a. Daily

b. Weekly

c. Monthly

d. Quarterly

e. As necessary

9. How often were you expected to submit project progress report

a. Daily

b. Weekly

c. Monthly

d. Quarterly

e. As necessary

10. How satisfied were you with the system of reporting?

a. Extremely satisfied 5

b. Very satisfied 4

c. Fairly satisfied 3

d. Not satisfied 2

e. Do not know 1

11. Did you experience any challenges with the sys tem of reporting?

a. Yes

b. No

12. If Yes, what were the challenges?……

……

……

13. Overall, do you agree that the project has contributed to service delivery in the area of maternal health?

a. Strongly agree 5

b. Agree 4

c. Fairly agree 3

d. Do not agree 2

e. Do not know 1

14a. Were there avenues for all the staff and district committees to hold meetings for project evaluation?

a. Yes

b. No

14b. If Yes, how often were the meetings held?

a. Strongly agree 5

b. Agree 4

c. Fairly agree 3

d. Do not agree 2

e. Do not know 1

APPENDIX V: QUESTIONNAIRE FOR STATE RH COORDINATORS

QUESTIONNAIRE – (STATE RH COORDINATORS)

Please tick as appropriate by putting an "X" in the correct option of your choice or opinion.

PART A- BIO DATA

1. Sex:
   a. Male ☐
   b. Female ☐
2. Your state:
   a. Adamawa ☐
   b. Jigawa ☐
   c. Kaduna ☐
   d. Kano ☐
   e. Katsina ☐
   f. Plateau ☐
3. Your years of experience as a State Reproductive Health Coordinator
   a. 12 years and above ☐
   b. 7-11 years ☐
   c. 6-10 years ☐
   d. 1-5 years ☐
   e. Less than 1 year ☐

KNOWLEDGE ABOUT ROTARY INTERNATIONAL 3-H PROJECT

4. Do you have any knowledge about Rotary International 3-H project?
   a. Yes ☐
   b. No ☐
5. Were you involved in the project?
   a. Yes ☐
   b. No ☐
6. Did your state participate in the activities of the project?
   a. Yes ☐
   b. No ☐
7. In which of these areas was your state included in the project?
   a. Training of health personnel ☐
   b. Provision of Medical equipment ☐
   c. Supply of contraceptive commodities ☐
   d. Provision of other items ☐

TRAINING OF PERSONNEL

8. Which category of health personnel did Rotary train?
   a. Doctors ☐
   b. Nurses/Midwives ☐
   c. CHEWs ☐
   d. TBAs ☐
9. Can you indicate the numbers trained in each category?
   a. Doctors _____

b. Nurses/Midwives _____

c. CHEWs _____

d. TBAs _____

10. How would you rate the quality of the training provided by Rotary 3-H project

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

11. Did the training enhance the performance of the health personnel?

a. Yes ☐

b. No ☐

SUPPLY OF CONTRACEPTIVE COMMODITIES

12. Did you receive any contraceptive commodities from the project?

a. Yes ☐

b. No ☐

13a. What was your source prior to the Rotary International 3-H project?

a. Government ☐

b. NGOs other than Rotary ☐

13b. How would you rate the supply from that source?

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

14. How would you rate the supply from Rotary International 3-H project?

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

SUPPLY OF EQUIPMENT

15. Did you receive any form of equipment from the project?

a. Yes ☐

b. No ☐

16. Which of the following did you receive from the project?

a. Basic equipment (Syphygmomanometer, Adult weighing scale, stethoscope) ☐

b. Drugs cupboards (cabinets) ☐

c. Examination couches ☐

d. Tally sheets/ patient cards ☐

e. Baby weighing scales ☐

f. Ultrasound Machine ☐

g. I.U.C.D Insertion Ki ☐

17. Was it necessary for the project to have donated those equipment?

a. Very necessary ☐

b. Quite necessary ☐

c. Necessary ☐

d. Not necessary ☐

18. Before the project, how was the supply of equipment?

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

19. What was the source of supply of those equipment before Rotary International 3-H Project?

a. Government ☐

b. NGOs ☐

20. How would you explain the necessity of those equipment to the clinical service delivery?

a. Very necessary ☐

b. Necessary ☐

c. Moderately necessary ☐

d. Not necessary ☐

e. Very unnecessary ☐

21. How would you rate the efforts of R.I 3-H Project to clinical service delivery in your state?

a. Very supportive ☐

b. Supportive ☐

c. Moderately supportive ☐

d. Not supportive ☐

e. Not very supportive ☐

APPENDIX VI: QUESTIONNAIRE FOR LOCAL GOVERNMENT MCH/RH COORDINATORS

QUESTIONNAIRE – LOCAL GOVERNMENT (MCH / RH COORDINATORS)

Please tick as appropriate by putting an "X" in the correct option of your choice or opinion.

PART A- BIO DATA

1. Sex:
   a. Male ☐
   b. Female ☐
2. Your state:
   a. Adamawa ☐
   b. Jigawa ☐
   c. Kaduna ☐
   d. 'Kano ☐
   e. Katsina ☐
   f. Plateau ☐
3. Local Government Area _____
4. Your years of experience as a Local Government MCH/RH Coordinator

a. 12 years and above ☐
b. 7-11 years ☐
c. 6-10 years ☐
d. 1-5 years ☐
e. Less than 1 year ☐

KNOWLEDGE ABOUT ROTARY INTERNATIONAL 3-H PROJECT

5. Do you have any knowledge about Rotary International 3-H project?
   a. Yes ☐
   b. No ☐
6. Were you involved in the project?
   a. Yes ☐
   b. No ☐
7. Did your local government participate in the activities of the project?
   a. Yes ☐
   b. No ☐
8. In which of these areas was your local government included in the project?
   a. Training of health personnel ☐
   b. Provision of Medical equipment ☐
   c. Supply of contraceptive commodities ☐
   d. Provision of other items ☐

TRAINING OF PERSONNEL

9. Which category of health personnel did Rotary train?
   a. Doctors ☐
   b. Nurses/Midwives ☐
   c. CHEWs ☐
   d. TBAs ☐
10. Can you indicate the numbers trained in each category?
    a. Doctors _____

b. Nurses/Midwives _____

c. CHEWs _____

d. TBAs _____

11. How would you rate the quality of the training provided by Rotary 3-H project

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

12. Did the training enhance the performance of the health personnel?

a. Yes ☐

b. No ☐

SUPPLY OF CONTRACEPTIVE COMMODITIES

13. Did you receive any contraceptive commodities from the project?

a. Yes ☐

b. No ☐

14a. What was your source prior to the Rotary International 3-H project?

a. Government ☐

b. NGOs other than Rotary ☐

14b. How would you rate the supply from that source?

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

15. How would you rate the supply from Rotary International 3-H project?

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

SUPPLY OF EQUIPMENT

16. Did you receive any form of equipment from the project?

a. Yes ☐

b. No ☐

17. Which of the following did you receive from the project?

a. Basic equipment (Syphygmomanometer, Adult weighing scale, stethoscope) ☐

b. Drugs cupboards (cabinets) ☐

c. Examination couches ☐

d. Tally sheets/ patient cards ☐

e. Baby weighing scales ☐

f. Ultrasound Machine ☐

g. I.U.C.D Insertion Kit ☐

18. Was it necessary for the project to have donated those equipment?

a. Very necessary ☐

a. Quite necessary ☐

b. Necessary ☐

c. Very unnecessary ☐

19. Before the project how was the supply of equipment?

a. Very Adequate ☐

b. Adequate ☐

c. Moderately Adequate ☐

d. Inadequate ☐

e. Grossly Inadequate ☐

20. What was the source of supply of those equipment before Rotary International 3-H Project?

a. Government ☐

b. NGOs ☐

21. How would you explain the necessity of those equipment to the clinical service delivery?

a. Very necessary ☐

b. Necessary ☐

c. Moderately necessary ☐

d. Not necessary

e. Very unnecessary ☐

22. How would you rate the efforts of R.I 3-H Project to clinical service delivery in your local government?

a. Very supportive ☐

b. Supportive ☐

c. Moderately supportive ☐

d. Not supportive ☐

e. Not very supportive ☐

APPENDIX VII : REQUEST FOR QUESTIONNAIRE ADMINISTRATION

Department of Public Administration,
Faculty of Administration,
Ahmadu Bello University,
Zaria,
Nigeria.

10th January, 2011.

Dear Sir/Madam,

REQUEST FOR QUESTIONNAIRE ADMINISTRATION

This Researcher is undertaking a study on the activities of Rotary International in the area of maternal health in some parts of Northern Nigeria.

We therefore solicit your cooperation to kindly complete the attached questionnaire in order to know your views on the project.

All information volunteered by you will be treated with utmost confidentiality.

Thank you.

Yours faithfully,

(Signed)

Yemisi I. Ogunlela (Mrs.)

APPENDIX VIII: QUESTIONNAIRE FOR TRAINING BENEFICIARIES

QUESTIONNAIRE – BENEFICIARY (TRAINING)

Please tick as appropriate by putting an "X" in the correct option of your choice or opinion.

PART A- BIO DATA

1. Sex:
   a. Male ☐
   b. Female ☐
2. State:
   a. Adamawa ☐
   b. Jigawa ☐
   c. Kaduna ☐
   d. Kano ☐
   e. Katsina ☐
   f. Plateau ☐
3. Local Government Area _____
4. Profession
   a. Medical Doctor ☐
   b. Nurse/Midwife ☐
   c. CHEW/CHO ☐

PARTICIPATION IN ROTARY INTERNATIONAL 3-H PROJECT

5. Did you participate in any of the R.I. 3-H project training workshops?
   a. Yes ☐
   b. No ☐
6. In which of these training workshops were you a participant?
   a. Ultrasonography ☐
   b. Mother and child care ☐
   c. Contraception ☐
   d. HIV/AIDs Educatic ☐
   e. Interpersonal Communication and Behaviour ☐
   f. CLMS ☐
   g. Project Management ☐
7. How many of the training workshops did you participate in?
   a. 5 and Above ☐
   b. 4 ☐
   c. 3 ☐
   d. 2 ☐
   e. 1 ☐
8. Would you say that the training has enhanced your work performance?
   a. Yes ☐
   b. No ☐

   If yes, proceed.
9. Overall, how satisfied were you with the training content?

a. Extremely 5 ☐

b. Very 4 ☐

c. Fairly 3 ☐

d. Not very 2 ☐

e. Not at all 1 ☐

10. Would you agree that the training has enhanced your work performance?

a. Strongly agree 5 ☐

b. Agree 4 ☐

c. Fairly agree 3 ☐

d. Do not agree 2 ☐

e. Do not know 1 ☐

11. In which areas has the training enhanced your work performance?

a. Scanning of clients ☐

b. Early referral of pregnant women ☐

c. Counselling in child spacing ☐

d. Inter-personal communication ☐

e. Care of pregnant women ☐

f. Contraceptive knowledge ☐

g. I.U.C.D. Insertion ☐

APPENDIX IX: QUESTIONNAIRE BENEFICIARY (CLIENT)

QUESTIONNAIRE BENEFICIARY (CLIENT)

1 Sex:

a. Male [ ]

b. Female [ ]

2. State

a. Adamawa [ ]

b. Jigawa [ ]

c. Kaduna [ ]

d. Kano [ ]

e. Katsina [ ]

f. Plateau [ ]

3. Local Government Area ----------

4. How old are you?

a. 50 years and above [ ]

b. 40 - 49 years [ ]

c. 30 - 39 years [ ]

d. 20 - 29 years [ ]

e. less than 20 years [ ]

5. Marital status

a. Married [ ]

b. Separated [ ]

c. Divorced [ ]

d. Widowed [ ]

e. Never Married [ ]

6. If married, how long have you been married?

a. 15 years and above [ ]

b. 10 - 14 years [ ]

c. 5 - 9 years [ ]

d. 1 - 4 years [ ]

e. less than 1year [ ]

7. How many pregnancies have you had? ----------

8. How old were you when you first got pregnant? ----------

9. How many children have you ever given birth to? ----------

10. How many of the children you gave birth to are alive? ----------

11. How many of the children you gave birth to are dead? ----------

12 a. How many of the children you gave birth to are males ----------

b. How many of the males are alive? ----------

c. How many of the males are dead? ----------

13. a. How many of the children you gave birth to are females?----------

b. How many of the females are alive? ----------

c. How many of the female are dead? ----------

14. What is the gap in years between one birth and the next (of your children)? ----------

15..a Where did you deliver your first child?

a. At Home [ ]

b. Government Clinic [ ]

c. Government Hospital [ ]

d. Private Clinic [ ]

e. On the way to Hospital/clinic [ ]

15.b. If at home, by who?

a. Self [ ]

b. TBA [ ]

c. Mother/mother-in-law [ ]

d. Grand mother [ ]

e. Other Relatives [ ]

f. Trained Midwife [ ]

g. CHEW [ ]

15.c. If it was home delivery, what was the duration of the labour?

a. Less than 1 day [ ]

b. 1 day – 2 days [ ]

c. 3 -4 days [ ]

d. Over 4 days [ ]

Please, specify the exact duration ----------

15.d. Was labour assisted by any of those in 15(b) above?

a. Yes [ ]

b. No [ ]

Specify ----------

15.e. If labour was assisted, what was the outcome of the delivery?

a. Baby Alive [ ]

b. Baby Dead [ ]

15.f. How did you know about the Hospital/clinic where you delivered your baby?

a. Friends [ ]

b. Neighbours [ ]

c. Husband [ ]

d. Other relations [ ]

e. TBA [ ]

15.g. If delivery was in Hospital/clinic, who took delivery of the baby?

a. Doctor [ ]

b. Nurse/Midwife [ ]

c. CHEW [ ]

d. Others [ ]

Specify ----------

15.h. What was the duration of the labour?

a. Less than 1 day [ ]

b. 1 – 2 days [ ]

c. 3 - 4 days [ ]

d. Over 4 days [ ]

15.i. Did you deliver spontaneously by yourself?

a. Yes [ ]

b. No [ ]

15.j. If no, was it assisted?

a. Yes [ ]

b. No [ ]

15.k. If it was assisted, what type?

a. Instrumental delivery [ ]

b. Caesarean section delivery [ ]

15.l. What was the outcome of the delivery?

a. Baby Alive [ ]

b. Baby dead [ ]

15.m. Sex of Baby

a. Male [ ]

b. Female [ ]

16. Are you spacing your children?

a. Yes [ ]

b. No [ ]

16.a. Did you give gap in between the births of your children?

a. Yes [ ]

b. No [ ]

16.b. If yes, how many years?

a. Above 4 years [ ]

b. 3 years [ ]

c. 2 years [ ]

d. 1 year [ ]

e. Less than 1 year [ ]

17. Was the gap deliberate or an “act of God”?

a. Deliberate [ ]

b. Act of God (natural) [ ]

18 If it was deliberate, which type of contraceptive method are you using?

a. Traditional [ ]

b. Bilateral Tubal ligation (BTL) [ ]

c. IUCD [ ]

d. Oral Pills [ ]

e. Injectables [ ]

f. Condoms [ ]

19. Who introduced you to child spacing?

a. Friends [ ]

b. Husband [ ]

c. TBA [ ]

d. Relation [ ]

e. Others, specify ----------

20. When did you first use a method of contraception?

a. Above 9 years [ ]

b. 6 – 8 years [ ]

c. 4 – 5 years [ ]

d. 2 – 3 years [ ]

e. Less than 1 year [ ]

21. Did your husband know that you were using contraception?

a. Yes [ ]

b. No [ ]

22. If yes, did he approve?

a. Yes [ ]

b. No [ ]

23. Where did you get the supply of contraceptives from?

a. Government Hospital/Clinic [ ]

b. Private Hospital/clinic [ ]

c. TBA at Home [ ]

d. Patent medicine store (chemist) [ ]

24. Did you ever have any difficulties in obtaining supplies?

a. Yes [ ]

b. No [ ]

25. Does your husband approve of child spacing?

a. Yes [ ]

b. No [ ]

26. Are you currently using contraception?

a. Yes [ ]

b. No [ ]

27. If No. why? ----------

28. If yes, which type?

a. Traditional [ ]

b. BTL/vasectomy [ ]

c. IUCD [ ]

d. Oral Pills [ ]

e. Injectables [ ]

f. Condoms [ ]

29. From where do you get your supplies?

a. Government Hospital/Clinic [ ]

b. Private Hospital/clinic [ ]

c. TBA at Home [ ]

d. Patent medicine store (chemist) [ ]

30. Have you ever heard anything about Rotary International 3–H Project?

a. Yes [ ]

b. No [ ]

31. Which of the following have you ever seen at a clinic or hospital, inscribed with Rotary International 3–H Project?

a. Examination couch [ ]

b. Weighing scales [ ]

c. Sphygmomanometer [ ]

d. Patients' hand cards [ ]

e. Patients' record cards [ ]

f. Storage cupboard [ ]

g. IUCD insertion kit [ ]

h. Ultrasound machine [ ]

32. Have you ever been informed about the activities of Rotary at the government hospital/clinic which you have ever attended?

a. Yes [ ]

b. No [ ]

33. Can you please specify what you were told about Rotary? ----------

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Thank you, madam.