

PD-ABC-438

LSN-83459

**Local Governance and USAID  
Health Projects in Nigeria**

*Submitted to:*

*Submitted by:*

Dr. Dele Olowu,  
Obafemi Awolowo University, ILE-IFE

Dr. James Wunsch, Team Leader  
Creighton University and ARD, Inc.

**October 30, 1992**

## TABLE OF CONTENTS

<b>ACRONYMS</b>	i
<b>PREFACE</b>	ii
<b>I. Executive Summary</b>	1
<b>II. Introduction and Overview</b>	3
A. Purpose of the Report	3
B. Method of Research and Analysis	3
C. Local Government Decentralization and Public Health Care in Nigeria	4
<b>III. Improved Governance and AID Policy</b>	7
<b>IV. Local Governance in Nigeria and Its Impact on USAID's Health Program</b>	9
<b>V. Administrative and Organizational Effectiveness of Local Government Authorities in Nigeria</b>	10
A. Overview	10
B. Summary of Administrative and Organization Problems	10
C. Analysis of Administrative and Organizational Problems	13
D. Administrative Problems: An Overview	16
<b>VI. Financial Sustainability at the LGA Levels</b>	17
<b>VII. Beneficiary Participation</b>	21
<b>VIII. Intergovernmental Relations in the Health Sector</b>	25
<b>IX. Suggested Project Activities</b>	28
A. Participant Applied Training for LGA and PHC Personnel	28
B. Operational Research	30
C. USAID Proposed Activities	32
<b>ANNEXES:</b>	
Annex A: Tables of Local Government Functions, Federal Transfers to Local Governments (1976-1991), and IFE Central Local Government: Major Recurrent Revenue Sources (1989-1992)	
Annex B: List of Persons Consulted	
Annex C: References	

## ACRONYMS

ARD	Associates in Rural Development, Inc.
CCCD	
FHS	
FMOH	Federal Ministry of Health
LGA	Local Government Authority
LGSC	Local Government Service Commission
M&E	Monitoring and Evaluation
MIS	Management Information System
NISER	Nigeria Institute of Social and Economic Research
NPHCDA	National Primary Health Care Development Agency
ORT	Oral Rehydration Therapy
PHC	Preventive Health Care
PHCDA	Public Health Care Development Agency
PPB	Planning, Programming, and Budgeting
SG	State Government
SHC	Secondary Health Care
SOP	Standard Operational Procedure
TBA	Traditional Birth Attendant
USAID	U.S. Agency for International Development
VHW	Village Health Worker

## I. EXECUTIVE SUMMARY

Nigeria has experienced dramatic and parallel revolutions in its local governance and health systems in the last four years. From Local Government Authorities (LGAs) which had few responsibilities, fewer resources, and increasingly less authority, and a curative, urban-centered health system, Nigeria has moved to a public health approach that now works primarily through LGAs which are vastly expanded in responsibilities, authority, and resources. Major revenue (from 2 percent in 1976 to 20 percent in 1992) and personnel shifts (most public health personnel are now employed by LGAs) have followed these changes. LGAs are now the primary mechanism through which health resources are delivered to local residents, and the primary actor in organizing and managing those resources.

LGA performance in three critical areas of administrative capacity, financial sustainability, and beneficiary participation has shown a mixed record, both generally and specifically to public health programs. While LGAs show significant accomplishments in accepting and managing these responsibilities, there are several shortfalls which limit their efficiency in use of resources, and effectiveness in reaching program goals. These include weaknesses in planning, programming, and budgeting; monitoring and supervising personnel; and developing information systems to support management functions. These shortfalls have limited the ability of public health supervisory personnel to allocate resources to such stubborn operational problems as finding an effective balance among personnel, supply, and capital budgets; deploying staff effectively; expanding health facilities in a manner which best meets local needs; bargaining effectively with political leadership; and supervising effectively the performance of primary service delivery personnel. Accountability has also been weak among LGAs, both to superior organizations (states and federal level) and to health consumers. Thus poor internal management systems are supplemented by neither a "vigilant" public nor by general supervising organizations.

Financial sustainability also faces problems at the LGA. Reliability and adequacy of revenue sources, both federal and local; effective allocation of fiscal resources within the LGA to meet local program needs; and effective systems to develop reliable and realistic budgets, and to follow and control spending are all problems. In these latter two regards, general management problems already discussed have serious adverse problems for financial sustainability.

Beneficiary participation has had mixed performance in the LGAs and in public health. While structures for participation are in place and active in mobilizing community cooperation, support and education, their effectiveness as "input" organizations is far more questionable. They do not appear to be effective participants either in the formulation of local programs and activities, or in monitoring program performances.

Considered from the broad framework of democratic governance, with its emphasis on the need for complementarity among such factors as accountability, transparency, legitimacy, pluralism, and organizational effectiveness, LGAs receive only mixed marks.

Accountability is extremely weak, both to consumers and to superior organizations. Good morale and effective local leadership (when they occur) provide some lateral accountability, but there is little more. Informal accountability to well-respected local leaders, particularly traditional figures, exists at some level at the LGAs, but varies greatly across Nigeria's vast size.

Transparency is wanting, not perhaps as much from deliberate evasion as from the ineffectiveness and opaqueness of key administrative routines in planning, budgeting, and management. Legitimacy seems to be a fairly neutral matter. On the one hand, local people do not seem to regard public health care matters with a sense of "ownership." On the other hand, there is enough obvious local cooperation that it is apparent it is not seen as "illegitimate" either. Nevertheless, greater legitimacy for the LGA as a whole might encourage greater local revenues. Policy pluralism seems to be a latent issue. While there is ample public pluralism and people are active in the participative structure, it is not clear that LGAs as a whole or public health personnel in particular are paying much attention to it.

Finally, organizational and managerial effectiveness is a serious weak point at the LGAs, and one which must be remedied before much improved governance can be expected.

Two complementary project interventions are recommended to address these weaknesses in LGA governance and LGA support for public health programs. These include a program of applied participant training which would use trainee input to develop new budgeting and managerial routines, and a core resource to provide follow-up technical assistance to alumni in their field posts. Target populations would include LGA Secretariat Members, Public Health Coordinators, and LGA political leadership. Measures to encourage a receptive environment for improved management are also suggested. Significant improvements in organizational effectiveness and transparency should emerge from these activities.

The second recommendation is for a program of applied, operations research focused on several areas identified in the report as critical to LGA performance in the health sector, but also incompletely understood. Research will be designed in a quasi-experimental way to allow testing of hypotheses in the field regarding these matters. This knowledge might help lead to further activities to facilitate other aspects of democratic governance as well as better management in the public health sector.

Nigeria stands on the brink of a major step into democratic governance. USAID is in a position to facilitate this progress.

## **II. INTRODUCTION AND OVERVIEW**

### **A. Purpose of the Report**

The USAID Affairs Office for Nigeria drew up two Project Identification Documents in 1991-1992 to sustain and expand USAID's support of the Preventive Health Care (PHC) program of Nigeria. These project proposals (CCCD and FHS-2) require significant activity at and by local governments in Nigeria (Local Government Authorities--LGAs).

The purpose of this report is to:

- review, analyze, and make recommendations to USAID on the potential of local government to effectively discharge its responsibilities in the PHC program in general, and regarding the proposed USAID project initiatives in particular;
- analyze in particular the capacity of local governance institutions to administer and manage competently their responsibilities in the health sector; to sustain health programs financially; and to facilitate effective beneficiary participation in these programs; and
- propose specific activities which would address issues raised in these areas in the context of the democratic governance concerns of USAID and the policies of the Government of Nigeria.

### **B. Method of Research and Analysis**

Three weeks of research were carried out in support of the above scope of work. The Team Leader spent the first week in Lagos familiarizing himself with the USAID Program, through reviews of extensive documents and interviews with numerous USAID personnel. The latter included both USAID direct hire and contractor personnel. Selected interviews with Nigerian officials of the Federal Ministry of Health (FMOH) were also conducted during this first week, as well as with knowledgeable persons from other development agencies and the Nigerian private sector.

During the second week, the Team Leader was joined by two Nigerian participants, both of Obafemi Awolowo University. Three site visits in selected LGAs and additional interviews in Lagos were conducted during the second week. During the third week, the team prepared this draft report and concluded a few interviews which could not be scheduled earlier.

Due to time limitations and the extensive and high-quality documentation already gathered regarding local government and the public health program of Nigeria, this report has drawn extensively on the field research of others. Nevertheless, the three LGA site visits conducted during the second week contributed much to the team's understanding of the situation, and enriched as well as confirmed much of what was reported by other teams. A complete listing of works consulted can be found in Annex C.

### **C. Local Government Decentralization and Public Health Care in Nigeria**

Due to its size (population of 85.5 million) and ethnic diversity, Nigeria, in spite of long years of military rule, has remained Africa's only example of a federally governed state. However, the federal structure at independence was one that was highly centralized at the level of the three large regions. Since the mid-1960s, when the military took power, there has been a progressive effort aimed at restructuring the federal structure and decentralizing the political system. The three regions were first broken up into 12 states; today there are 30 states. Similarly, since the mid-1970s, there has been a sustained effort at restructuring and revitalizing the system of local government. Two hundred ninety-nine (299) local government units were originally created in 1976; today there are 589. It is likely that more will be added.

The effort at political and administrative decentralization has had tremendous implications for the management and delivery of health services in Nigeria. In the past, the national health care system manifested several weaknesses associated with the centralized delivery of services: it was urban-oriented, with less than 30 percent of the population having access to modern health care by 1980; its emphasis was on curative health rather than preventive services; and there was minimal community involvement in the health care system. Health care was defined in terms of hospitals, the management of which was defined as the province of the federal and state governments. Local governments' responsibilities in the health sector declined precipitously as several of the health clinics and hospitals built by local governments were taken over by state governments. LGAs were left only with responsibilities for dispensaries and maternities.

After the failure of several attempts to change this situation, the adoption of a structural adjustment program in 1986 and the emergence of a Minister of Health who was committed to the Primary Health Care approach, led to discussion and articulation of a new health policy which was published in 1988.

The current National Health Policy adopts the community-based health approach in which primary, secondary, and tertiary health care are organized at local, provincial, and national levels with each mutually supporting the other. In 1986, 52 LGAs were selected as model LGAs whose primary health care systems were to be strengthened. Each of these were provided with an *ad hoc* grant of N0.5 million together with material and technical assistance to reorient the local health system. Each of these model LGAs were linked with colleges of

Medicine or schools of Health Technology to assist them in training their health officials.

PHC activities revolved around 10 core functions:

- public education;
- improvement in nutrition;
- \*adequate safe water and basic sanitation;
- maternal and child health care, including family planning;
- immunization;
- prevention and control of endemic and epidemic diseases;
- provision of essential drugs and supplies;
- \*elderly and handicapped care; and
- \*accident and injury care.

*\*Those asterisked have received less attention.*

The success of this approach (in terms of health care coverage, sharp reduction in preventable diseases, support by donor agencies, etc.) led to the widespread adoption of the approach by other local governments. Virtually every local government in the country is now included in the program or has shown a "willingness" to be included. In June 1990, the federal military government directed that local governments were to be fully responsible for primary health care programs. The rapid increase of nationally generated revenues going to local governments from 10 percent in 1985 to 20 percent currently was partly justified on the grounds of this shift of PHC responsibilities from the federal and state governments to the federal government.

A National Primary Health Care Development Agency (NPHCDA) is soon to be established at the federal level to assist the LGAs in the development and sustenance of their PHC Program.

One of the most important aspects of the phased movement of primary health care to LGAs is community involvement in health care. District and Village Health Committees have been established in each LGA, which provide a variety of inputs (i.e., information, suggestions for improvement) as well as outputs (i.e., mobilization of the community for the new system).

Progress has been made in terms of overall impact on health services. Seventy-seven percent of two year olds were fully immunized by 1991. Overall, population access to health services increased to 67 percent by 1990, up from 30 percent or less 10 years earlier.

In spite of these significant achievements, local governments remain weak, both in terms of their internal management capacity and their heavy dependence on higher-level governments (especially the federal government in recent years) in deciding unit size, internal governmental structure, revenues, responsibilities, and general orientation. The regularity with which the federal government has changed these various parameters at the local government level has led to an atmosphere of uncertainty and instability at that level of government.

### III. IMPROVED GOVERNANCE AND AID POLICY

In the rapid political changes of the early 1990s, AID has sought to develop a policy toward improved governance which is both intellectually sound and operationally applicable. Important strides have been made in this task, reflected in the Agency-wide policy statement of 1991 and in the Africa Bureau's publication of June 1992.

Governance, as understood by AID in these documents, is a process which includes the conventional understanding of states, but broadens that to include societal institutions outside the state which also contribute to the ordering of human relationships. In this perspective, a "governance" approach focuses on rule-governed relationships among persons, and how those rules (both written and unwritten) affect human behavior to produce outcomes, both desired and undesired. The focus of governance strategies is on assessing how various configurations of rules work in a given environment to improve the likelihood of reaching desired outcomes. The value of this approach is that it removes the often artificial boundaries between, for example, formal structures of government (i.e., the "state"), informal/traditional structures of government, generally held norms and values, and rules which regulate economic relationships (i.e., such as a market system).

"Democratic governance" strategies take the challenge of reaching desired outcomes as a starting point, and argue that rule configurations which introduce five critical qualities into governance systems are more likely to work effectively and responsively (to the public) than ones not so characterized. These five features are:

- management and organizational efficiency;
- legitimacy and responsiveness to the public;
- accountability;
- transparency of decision-making; and
- pluralism in policy choices.

The logic behind this model of effective governance is that organizations must be well-managed to achieve good governance, to avoid and correct policy errors, to avoid slipping into the control of a few who take advantage of it, or to be able to adapt to changing conditions and needs without critical qualities such as policy pluralism, transparency in decision making, and accountability. Legitimacy is particularly important when organizations call for resources, forbearance, obedience, and sacrifice from their members. Together, this model argues, these five qualities encourage truly effective structures for collective decision making and action--ones able to reach their goals and ones which, overall, work consistently with their members' interests.

A democratic governance strategy typically focuses its interventions in one (or more) of four focus areas:

- strengthening *civil society's* autonomy, capacity to organize, communicate, and act;
- strengthening the ability of *linkage institutions* to assess and convey the wants and needs of civil society, to challenge executive entities, and to develop independent policy and program options;
- strengthening the ability of *policy-making and implementing institutions* to gather, analyze, assess, and act on information, and to effectively organize and manage complex activities; and
- refining the impact of *legal and judicial frameworks* to strengthen each of the above areas, manage conflict among them, and encourage their cooperation.

Typically, democratic governance interventions will address more than one of the above areas. What is chosen should grow from a strategic analysis which assesses the relative strengths and functioning of each area, the opportunities for activity, and the existence of reliable "technologies" to address weaknesses. For example, attention may often turn to policy-making and implementing institutions, as management organization technology is thought to be relatively well-known, and such institutions are often receptive to their own "strengthening." On the other hand, access to civil society is mediated by evident cultural difference, perhaps resistance by the formal state, and a less clear technology to reach and strengthen it.

Western-style liberalism is enjoying a recent resurgence, after some 40 years of disuse in the post-colonial, socialist-oriented era. One way to enhance the impact of this renewed interest is to institutionalize democratic governance institutions and strategies. Acting while the climate is supportive may turn out to be critical.

Better governance strategies are not a cure-all. Nor, however, are they without value in a world weary of corrupt, ineffective, and failed leadership and eager to try a new model. The real task for projects seeking a democratic governance approach is to learn enough about the host country that the strategy they utilize will fit local conditions. That the model itself has transcultural applicability is suggested by much political anthropology and contemporary comparative political analysis.

Once this report has analyzed key features of Nigerian local governance, it will return to this analytical framework and suggest interventions which might strengthen democratic governance and its ability to sustain USAID's and the Government of Nigeria's public health programs.

#### **IV. LOCAL GOVERNANCE IN NIGERIA AND ITS IMPACT ON USAID'S HEALTH PROGRAM**

With the decentralization of health responsibilities to the LGAs as discussed above (Section II-C), local governance issues can be critical. Although the FMOH, the SMOH, the developing zonal offices, and the soon-to-be-established Public Health Care Development Agency (PHCDA) continue health functions and responsibilities, a key link in the delivery system is now the LGA.

The LGA is the primary vehicle through which the Nigerian health care system reaches the public, and its roles are numerous and critical. For example, most primary health care personnel are now hired, supervised, trained and retrained, paid, and led by LGA officials. (The only exception are top professional personnel whose employment is still made by the state-based Local Government Commissions, but whose salaries are paid by LGA political leaders.) The location, construction, maintenance, and equipping of the various health facilities are LGA responsibilities. LGAs also have primary responsibility for implementing the policies and guidelines established by superior units of government. The energy which goes into their implementation, the presence or absence of necessary support activities and resources, and effective monitoring and supervision of the program will rise or fall with LGA personnel.

Virtually all contact with project/program beneficiaries is through LGA personnel and dependent upon the direction and quality of LGA leadership and support. Whether or not beneficiary input is *pro forma* or even regarded as an imposition is now largely determined by the attitudes and practices of LGA leadership. They can greatly hinder or facilitate beneficiary participation by their openness to it, the managerial effort they invest in selecting and nurturing beneficiary organizations and leadership, and their managerial effectiveness in utilizing it.

Within the general context set by national (FMOH) policy-making, LGA personnel are responsible for specific needs assessment, local problem identification and monitoring, local priority setting, and local redeployment of slack resources.

Finally, if there is to be an expansion of local funding for health activities, either via in-kind contributions, user fees, or expanded local taxes, LGAs are critical in building local support for the effort.

To summarize, while the Nigerian public health system is a comprehensive effort involving federal, state, and local government units, the local unit is now a critical path through which the efforts of the superior units must flow if they are to have the desired impact. This makes the well-being and viability of local governance critical.

## **V. ADMINISTRATIVE AND ORGANIZATIONAL EFFECTIVENESS OF LOCAL GOVERNMENT AUTHORITIES IN NIGERIA**

### **A. Overview**

LGAs have come very far in a few short years. Within only 15 years, LGA budgets and functions have expanded from less than 2.0 percent of Nigerian public expenditures in 1976, to more than 20 percent in 1992. From entities with few functions, they have been assigned responsibility for nearly all primary health care delivery and primary education in Nigeria. From nominated leadership, they have moved through party-based elections and currently have elected executive and legislative councils in place. These organizations are now developing and administering budgets, managing service delivery programs, hiring personnel, managing capital goods, paying salaries, and interacting with the public and with state and federal governments.

In short, LGAs are wrestling with the tough task of allocating and administering considerable resources, and the various political and professional personnel appear to be making genuine attempts to work as a team to address local needs with those resources.

LGAs, at least in the health sector, are striving to strengthen personnel and program administration. For example, facility-level monitoring did occur, schedules for report submission were posted on walls and compliance was recorded, and a health statistical officer could be found in some LGAs, compiling data collected by field service delivery personnel. Senior health personnel recognized the importance of regular contact with service delivery personnel, and seemed to be attempting to maintain it. Also, a complex network of health advisory committees were in place and functioning at some level.

Overall, it was the team's opinion that morale among senior health personnel interviewed was good, and that LGA leadership was taking its responsibility to improve local conditions seriously and striving to serve their communities.

Nevertheless, site visits, other research and evaluation of LGA governance, and interviews with diverse persons in Lagos pointed up numerous administrative shortfalls that were limiting the effectiveness of these mostly well-intentioned efforts. These deficiencies, noted below, grow from skills, training, and routine/systemic shortfalls that are remediable, and reflect the short gestation time, brief life span, and escalating responsibilities of these entities. Nevertheless, they need to be addressed.

### **B. Summary of Administrative and Organizational Problems**

Administrative and organizational shortfalls are diverse, but can be generally organized along the following three areas:

- managerial effectiveness and follow-through;

- monitoring, evaluation, and supervision; and
- planning, programming, and budgeting performance.

***Management Effectiveness and Follow-through:***

- poor or non-maintenance of vehicles and other equipment;
- misuse of vehicles;
- poor use of beneficiary time and inputs;
- inability to attract and retain quality trained personnel to the LGA system;
- inadequate contact with primary health workers (village health workers [VHW]), traditional birth attendants [TBAs]); and
- poor information.

***Monitoring, Supervision, and Evaluation:***

- absence of knowledge and use of Standard Operational Procedures (SOPs) by health delivery personnel regarding treatment of such diseases as diarrhea, malaria, etc.;
- absence of key resources in health facilities such as Oral Rehydration Therapy (ORT) packets;
- shortfalls in supervision of primary health personnel (VHWs, TBAs) including medical kit maintenance, accuracy in data recording, retraining, cleanliness of facilities, and assessment of appropriate care;
- inadequate information to evaluate if health facility and maternity personnel training is followed by appropriate performance, both in client contact and in facility operation; and
- poor use of personnel resources in terms of both general deployment and daily management.

***Planning, Programming, and Budgeting:***

- budgets which are incomplete, arithmetically inaccurate, and poorly organized;
- repeated budgeting shortfalls during the implementing year;
- inappropriate location of medical facilities, given unserved areas;
- poor balance between personnel (i.e., salary budget) and supplies for programs (i.e., non-capital, supply budget);
- poor correlation between budget priorities and health priorities as assessed by LGA health sector professionals;
- poor correlation between approved budget and actual expenditures;
- difficulty in getting USAID project funds released in a timely and responsive way;
- lack of effective leadership, including setting clear and sustained priorities by LGA political leadership;
- wide swings in actual revenue collection;
- absence of analysis in budget/revenue estimation;
- only gross priority setting by the LGA;
- little or no relationship between budgeting and planning processes;
- lack of cross-sectoral thinking re LGA problems and programs;
- lack of cross-sectoral coordination of activities;
- arbitrary, "political" manipulation of health professionals' budget proposals; and
- weak or nonexistent capital programs.

### C. Analysis of Administrative and Organizational Problems

The above review of problems is probably no surprise to most Lagos or Nigeria-based reviewers of this report. It is likely that the following analysis of their causes will also not be particularly surprising. In general, most of the above problems grow from one (or more) of the following conditions:

- insufficient trained and/or experienced personnel at the LGAs;
- absence of knowledge and/or requirements to pursue effective planning, programming, and budgeting (PPB) systems;
- lack of effective local personnel monitoring, supervising, and evaluation (M&E) systems;
- lack of appropriate management information systems;
- insufficient support by state, zonal, and federal levels of governance regarding PPB and M&E, setting standards, following personnel training, and assessing compliance with policy directives;
- absence of incentive structures to encourage effective PPB and M&E at the LGA level or to encourage compliance with federal standards and requirements;
- insufficient resources to enable LGA supervisory personnel to get into the field;
- absence of incentive structures to attract and retain quality personnel at the LGA level;
- underdeveloped local public involvement in health policy development, appraisal, and feedback;
- shortage of effective leadership at LGA level;
- weak accountability for use of resources at LGA level; and
- poor relationships between the government levels on health matters.

These problems, though diverse, seem to turn on three general continuing and critical shortfalls at the LGA level. *First, effective mechanisms do not exist to identify problems, plan*

*strategies, set priorities, organize work plans, or develop budgets that are both appropriate (to the problems) and realistic (given available resources).* LGAs currently do no planning, and largely budget by a haphazard method where varying levels of largely non-institutionalized public input are combined with generally incremental, line item (i.e, non-programmatic) and competing budget proposals from the four sectoral offices. They are then put together with what are often wildly inaccurate local revenue estimates. This creates a budget which is soon rendered obsolete by numerous *ad hoc* changes introduced by new federal requirements, newly emerging problems, shortfalls in personnel and revenue, and, at times, an inability to move money through the pipeline. LGA budget planning for future years does not appear well linked even to previous years' experiences. For example, in one LGA, the health budget expenditures in 1990 were approximately N530.000, the estimates for 1991 were about the same, the estimates for 1992 were N910.000, but the proposed (still incomplete) budget for 1993 is over N3.4 million. However, when queried on this, no case was made that revenues to support this proposed budget would be available, nor that the LGA PHC staff had the capacity to actually manage the resources this implied. Similar patterns can be seen in budget figures regarding local revenues, with wild variations between previous estimates and actuals, and questionable projections of future local revenues.

Numerous problems such as program stagnancy, poor allocation of funds between personnel and supplies, arbitrary location of facilities, capital expenditures without comparable adjustments in personnel or supply budgets, and absence of inter-sectoral linkages and coordination all tend to be made worse by the absence of an effective planning and budgeting capacity. Recurring resource misallocations such as poor maintenance, inability to attract and hold good personnel, and inadequate travel funds can be traced to the general inability to isolate and identify problems and set priorities.

While planning, programming, and budgeting within the health sector at the LGAs is significantly better than the LGA as a whole, there is still ample room for improvement there as well, particularly outside USAID-financed activities. Planning and programming are really little more than elaborated work plans and capital investment hopes. Budgets vary widely from actual expenditures. Of course the poor status of overall LGA PPB has a serious destabilizing effect on health sector PPB.

*Second, effective and working personnel monitoring, supervising, and evaluating systems are generally not in place or operating at the LGAs, nor are any effective management information systems.* Aside from the technical, medical aspects of such a system, there was consensus among informants and reports consulted that systems of evaluating the effective performance (as opposed to training) of delivery personnel were not working. While aggregate statistics for the whole LGA and the various "basic health facilities" do exist, a system to allow for more targeted appraisal of quality of facilities and personnel performance does not.

The effectiveness of monitoring and supervisory efforts was limited by large numbers of personnel to supervise, difficulty in getting to the field, and bluntness of the data gathered.

In addition, systems which effectively used the kind of data gathered could not be identified in the field--either in site visits or from interviews with informed personnel. Epidemiological data do not generally translate into effective personnel and facility monitoring and evaluation. Managerial ability to use more sophisticated measures of personnel and facility performance (were they to exist) also appears to need upgrading, both in development and analysis of such measures and in effective managerial follow-through. Several sources suggested LGAs are still much more focused on distributing resources than assessing the impact of those resources.

Weak management information hampers the LGA ability to think and work programmatically. It also probably weakens PHC personnel persuasiveness in the budget process. Finally, it was not clear how the current incentive structure would be expected to work to encourage LGAs as a whole to take M&E and MIS seriously, and LGA personnel to pursue them even were there a capacity to do so.

*Third, and reinforcing the first two problems, is the problem of weak public involvement in LGA governance and weak supervision from above.* While LGAs are now elected bodies, having experienced one cycle of elections, elections alone do not assure effective public control. Public education as to local governmental responsibilities, the content of local program and policies, and the various responsibilities of legislative, executive, and professional personnel is a prerequisite to effective public control and a continuing challenge in democracies everywhere, even ones of long standing. Also, developing a balance among professional, executive, and legislative roles in policy-making, program, budget, and monitoring functions is a learning process--one necessarily involving transitional problems. Citizens, particularly in populous areas with poor communication and transportation infrastructure, require structures to learn of LGA policies and programs, to join with others to discuss and decide, and to transmit their wants. Such structures might be political parties, voluntary organizations, occupational associations, consensus community leaders, or formal, grassroots consulting bodies.

It takes time, however, for such learning and organization to occur and to integrate itself into a governance process. The short life span of LGAs as political entities, the instability of state and LGA numbers and boundaries, and the relative newness of the PHC strategy have meant that, although local structures express political pluralism, their ability to enforce accountability is still rather weak. All this is important because many of the operational problems discussed above would benefit from external pressure for improved performance. While some of this pressure can come from superior structures of accountability (i.e., states, zonal offices, and the federal government), the sheer magnitude of the size of Nigeria and the depth desired by the PHC program means much accountability must be asserted from below.

Accountability to superior organizations, while not a focus of this report, appeared fairly weak. The state role in PHC is evolving and unclear, the federal level is probably too distant for effective accountability, and zonal offices are only beginning to function.

In view of this weakness of accountability from above, informed citizens must demand better performance from their LGA Officials and professionals if even the best of PPB, M&E, and MIS systems are to be well utilized.

#### **D. Administrative Problems: An Overview**

In summary, a variety of organizational and managerial problems exist at the LGA which, in varying degrees, are hampering PHC-related project performance. Upon analysis, they seem to stem from three weak areas at the LGA as discussed above: planning, programming, and budgetary abilities; monitoring, supervision, and evaluation, particularly at the personnel level; and weak accountability. As noted in the introduction to this report and as emphasized in the African Bureau policy documents on improving democratic governance, several deficiencies often must be addressed in order for improved performance to occur. Specifically, accountability without improved management ability will only lead to public frustration; however, improved managerial ability without strengthened accountability is likely to lack direction and focus, and be sub-optimally utilized. Remedies are discussed in detail in Section VIII.

## VI. FINANCIAL SUSTAINABILITY AT THE LGA LEVELS

As noted above, financial sustainability is a second area of concern regarding decentralized governance in Nigeria in general, and regarding the impact of decentralization on health programs in particular. There are a number of legitimate grounds for this concern. Three important elements of such concern will be discussed in this section: revenue adequacy, expenditure efficiency, and budgetary planning and management.

The first, the *adequacy of revenues* for local governments to effectively tackle the challenges of providing public health services together with their other responsibilities, as specified in the 1989 constitution and which the present administration has encouraged them to shoulder, has become increasingly important as actual devolution to LGAs has progressed.

Besides primary health care, the Nigerian constitution (there are no state constitutions) expects local governments to be responsible for the following activities: formulation of economic planning and development for their areas, provision and maintenance of cemeteries and burial grounds, social welfare, and public conveniences (roads, drains, refuse disposal, and primary, adult, and vocational education) (see Annex A). Most of these activities are public or collective goods as well as social rather than economic services, hence they cannot be provided at full cost to all consumers. More importantly, they are very expensive services to develop and maintain. The critical issue is whether local governments have access to adequate levels of revenues to provide these services. Even though there has been a shift of more federally collected revenues to local governments as more responsibilities are being transferred to them, worries persist about the reliability of these transfers as well as the overall adequacy of the present revenue sources available to local governments in the country.

Of the three revenue sources traditionally associated with local governments (taxes or community contribution, cost recovery, and grants), the latter has been the most significant. There are three types of grants: specific or tied project grants from donor agencies, which do not enter into normal budgetary operations; statutory allocations from the Federation Account; and grants from the federal and state governments.

Grants from the federal government are usually given for specific activities such as PHC, rural roads, urban development, unemployment benefit, and rural women's projects, while state grants (10 percent of SG's internally generated revenue) are expected to be mandatory. Of these three grant sources, the most important and reliable is their revenue shares from the Federation Account. Local governments' entitlement to federally collected revenues has increased from less than 2 percent in 1976 to its current level of 20 percent, thus making it the major revenue source for LGAs generally (see Tables 2 and 3 in Annex A). However, several major concerns remain with respect to this funding pattern:

- the increasing dependence of local governments (up to 90 percent or more) on

nationally derived revenues, which are themselves subject to the swings in the international oil market;

- the correlation between higher transfers and declining internally generated revenues;
- the difficulty of making reasonable revenue forecasts at the LGA level;
- the absence of studies to determine local government revenue potential and revenue needs assessment of local government in light of their responsibilities;
- the neglect of potential revenue sources by LGA Officials, such as user fees, tenement rates, drug revolving fund type arrangements;
- absence of any direct correlation between the magnitude of LGA responsibilities and the size of grants allocated to each LGA due to the use of general controversial criteria such as population and equality in allocating grants between LGAs;
- protracted delays in receiving donor funds, since most of these are channelled through federal (and at times, state) governments; and
- absence of any compliance mechanism to ensure that statutory grants from federal and state governments are paid to LGAs.

A second concern relates to *expenditure efficiency*. This is the way in which expenditure allocations are made between recurrent and capital items and between personnel and supplies, both generally and specifically with respect to health sector programs.

Health is a major responsibility of LGAs. Many of the leaders placed it as their foremost priority. However, in terms of their budget allocation, health often comes third after education (the management of primary schools is now a responsibility of LGAs) and personnel departments. This sets practical limits to what the health department is able to do, and sometimes to its potential to attract new resources (i.e., how far they can go in matching donor funds for their respective programs, although donor funds have so far rarely called for such matching).

A second issue under expenditure efficiency relates to the spread of allocation between salaries for personnel and supplies. It is not uncommon to find a large number of idle personnel in the LGA who do not have the required inputs (vehicles, typewriters, furniture, paper, bicycles) to operate. Salaries constitute a disproportionate (over 70 percent) share of LGA recurrent expenditure. All of this underscores the need for human resource audits in LGA health departments as well as the need to reappraise the budget-making procedure.

A final issue under expenditure efficiency is the neglect of capital programs. Even though the PHC approach emphasizes operations rather than structures, some structures are still required in order to carry out PHC operations at the LGA, district, and village levels. LGA expenditure commitments seem to emphasize personnel emoluments to the detriment of capital programs. In fact, some LGAs do not have a capital program. However, this may be due to the fact that they expect funds for capital programs to come from donor programs or extra-budgetary programs of the federal or state governments. Unfortunately, federal expenditures on the health sector, outside of extra-budgetary allocations, have stagnated. This may grow into a larger problem in the Third Republic when the political leadership and direction of the Federal Ministry of Health might change hands.

A third and final issue of general concern with respect to financial sustainability is *budgetary planning and management*. The last section discussed budgetary planning in general, whereas the discussion that follows emphasizes the state of budgetary planning in the LGAs visited. LGAs have no budget plans and even though a sort of three-year rolling plan is theoretically in place, these plans are not taken seriously by the officials, nor do they constitute effective documents expressing the real aspirations and focus of their LGAs, or even outline seriously what LGAs intend to do.

LGA budgetary planning is constrained by four factors: the heavy dependence on federal transfers and donor grants which are themselves unstable and subject to factors external to the LGAs; the absence of essential and up-to-date information on the health status of LGAs; the absence of any systematic planning for the use of available resources; and the lack of skilled finance staff. As a result, one finds wild swings as earlier noted between one year's allocation and the next in the health sector as well as in other sectors. It is striking that there is no linkage between the planning and budgetary functions in LGAs. The quality of available financial information is also substandard. None of the LGAs was able to make an up-to-date financial statement (i.e., actual past expenditures) available to the team; in fact, two of the three LGAs visited could not provide their budget statements for the last three years. In the absence of actual financial accounting, auditing either by internal or external agencies becomes impossible. To compound matters, the audit departments within the local government as well as the Local Government Auditor's offices at the state level, are poorly staffed.

Of course, it is recognized that the instability of local government boundaries, tasks, structures, and personnel might have contributed to this situation. However, even where the budget was available, there is a wide divergence between the budget as planned and its implementation. One LGA visited, had an overall recurrent budget of N3.1 million and N5.8 million for 1989 and 1990, respectively, but the revised expenditures for those years were N0.8 million and N1.9 million, respectively; actual expenditures were still less. On the other hand, whereas only N150,600 was budgeted there for capital programs in the health sector in 1990, a total of N243,690 was actually expended--the largest, single divergence being PHC for which N30,600 was budgeted and N189,800 was expended.

All this points toward the need for improvements in budget planning, management, accounting, and auditing, starting with revitalizing the information base for budget-making. This will also enhance accountability and transparency at the LGA level.

The research and analysis which forms this report on democratic governance thus suggests several matters for attention:

- organization and management abilities of the LGAs will probably need to be enhanced before they are able to identify, raise, and manage more substantial local revenues;
- transparency of the budgeting and accounting processes will have to be enhanced significantly if local residents are to willingly accept paying more taxes to LGAs;
- accountability of LGA programs, both to their superior state, zonal, and federal agencies, and to local residents, will probably need to be enhanced to assure efficient resource use and to encourage ongoing citizen compliance with existing and possible future tax programs; and
- increased legitimacy of LGA programs and institutions would certainly increase local willingness to be taxed; however, the legitimacy of new institutions is substantially derivative of the above processes and takes time.

A multi-dimensional strategy (including organization and management, transparency and increased accountability) will be necessary if increased revenues are to be achieved and sustained. Without some attention to these issues, finance will continue as a serious drag on PHC, rendered worse if and when donors phase out their activities in this area.

## VII. BENEFICIARY PARTICIPATION

PHC has emphasized beneficiary participation at the LGA level since its inception. As is well documented in such reports as that of the World Health Organization (1992), a comprehensive system of village, ward, district, and LGA committees has been established. While the village-level committee is popularly selected (via varying methods), for the most part, the ascending tiers are made up of the chairs of their respective subordinate tiers. The committee system's role is to provide public input into the development and management of PHC, to help mobilize resources for PHC, and to disseminate information from and encourage cooperation with PHC programs.

Along with this formal structure for collective action, communication, and control, other mechanisms exist--either integrated with or used along side of the PHC committees. These include traditional leaders (where they exist and are recognized); other "natural" community leaders (persons respected and trusted by local residents); and various local organizations (women's and men's improvement and benevolent organizations, market associations, student organizations, and teachers' unions). In some areas, these organizations (particularly traditional and "natural" community leaders) were consciously sought out by PHC personnel to form the "grassroots" base of the PHC committee system. For example, in Ife Central, the village committees were consciously built upon the compound-elder system. In other areas, these persons and organizations appear to have played a more supplementary role to the committee system. In fact, in Ife Central, they seemed to do both (grassroots-based and additional information/action points).

In some cases, PHC personnel, whether by design or not, have integrated these advisory roles with a functional one, where a village health worker serves both as a "community" leader and as the chair of a Village Health Committee.

In assessing the effectiveness of beneficiary participation, one finds a mixed picture. The system appeared to be in place: committees existed, they were "staffed" with more or less full complements of members, they met more or less regularly, and they had carried out some tangible functions in the PHC system. However, their various roles were unevenly developed, and there were disconcerting, early signs of a waning popular interest and support for their activities.

On the positive side, several of their intended roles seem to be working well. Both PHC and the community leaders interviewed discussed information disseminating abilities in detail, and believed the committees had done well. Committees also played a key role in each community in supporting immunization campaigns, particularly in persuading people to participate, to be available at specified times, and, in one case, by building or making available temporary shelters for health workers going into the community. Committees have selected village health worker candidates from among their respective areas to be trained by the PHC program, facilitated house numbering and survey activities, found short-term workers for those activities, and encouraged residents to open their homes for health

inspections. In some areas, they helped allocate and administer funds made available under Bamako Initiative Revolving Drug Funds, including determining who were indigent in their respective communities, and making free drugs available to them. In a few cases, they have begun building facilities or obtained seed money in the hope that PHC would take over the facility they began. All these are noteworthy accomplishments.

However, there are two areas of concern which emerged from the research and analysis. First, there are a few signs of the beginning of "meeting fatigue." Several health workers reported that turnout at meetings was beginning to erode, particularly at the grassroots level. This was confirmed by the community leaders who noted that they and local residents were beginning to tire of so many meetings where there was "talk, talk, talk," but so little to show for it. They also noted that travelling for meetings of the higher tier committees was beginning to be burdensome regarding time away from work, travel costs, and simple effort.

The second area of concern is probably related to the first, and this deals with the apparent limited visible impact committees have had on the PHC system, either in generating or managing programs. They have served as conveyors of complaints in some instances, and as "lobbies" regarding the distribution of health facilities. However, the demand so out-strips the supply of capital funds, new personnel, and supply resources, that it is not really clear how this has affected LGA decision-making.

Furthermore, the committees do not seem to play any real role in setting priorities, developing programs, or monitoring programs and services. While PHC personnel talked of "input" from the committees, none could point to input which led to these sorts of impacts. While the team has no conclusive answer to why this does not occur, it can offer several hypotheses based on clues found in this research and patterns seen elsewhere:

- workers in all institutional systems find their lives and jobs easier when *they* can define their work, limit their responsibilities, and limit external disturbances;
- the scale of vision of sub-tier committees may call for particular variations difficult to disaggregate out of a larger system established at a distant point (i.e., LGA, state, or federal levels);
- many components of key programs are determined by generally accepted professional/technical standards, and may not easily allow room for much popular input; training norms tend to emphasize this for health professionals;
- the rapid growth of the PHC system has meant that most energy has been focused on getting it "in place," not on fine-tuning it;

- resource shortages may make it impossible to respond to local input, particularly when much of it calls for distribution of resources in a zero-sum situation;
- local committees may be too unfamiliar with alternatives and options to be able to offer much programmatic input; they may also be unclear as to what their proper role is to be in FHC;
- committees may be hampered in some cases by their poor fit with functioning, traditional, local governance structures, the "fourth tier" of governance in Nigeria; and
- in some areas, the multiplicity of committees may be much more than the community can support.

Which of these apply and what might be done about them will, to some extent, require further research. Specific operational research and follow-up activities could include the following:

- a comprehensive review of PHC programs and policies at the LGA level might be done to assess where and when there is "room" for committee control over aspects of PHC;
- roles of the various committees as input mechanisms might be clarified in joint sessions with key LGA PHC personnel; they might also pay heed to clarifying possible varying roles for the various committee levels;
- greater use of existing popular leadership/ organizational structures may be explored; including the use of consensus traditional leaders where they exist, existing organizations such as village development committees, modifying ward and district boundaries when appropriate to the local governance system and other local organizations;
- as PHC matures at the LGA level, more emphasis in zonal and federal guidelines might be placed on community control of programs, and on community-based monitoring systems; both PHC officials and local community leaders will need to be trained along these lines:
  - training in community relations might be given PHC leadership; and
  - training in planning, programming, and budgeting, and in monitoring and evaluation, could cover methods of generating,

using, and fiscally supporting community input.

In general, beneficiary participation has made significant progress in the PHC program at the LGA level. Communication and resource mobilization appear to work well. However, genuine local control, a key part of accountability, has not evolved. In this regard, Nigeria is hardly unique. For example, battles of local vs. central school board control in the United States continue with no apparent end in sight. There is no simple arrangement which "resolves" this issue. However, there are questions (if answered) and incentive systems (once built), which can encourage more of a balance between "top-down" and "bottom-up" control.

As is made clear in the socio-cultural analysis for this project, traditional leaders continue to play major roles in facilitating collective action by their people, including the acceptance of medical interventions. Sensitivity to the need to build their support, and awareness of the power of their encouragement (or discouragement) for PHC programs is a critical part of beneficiary participation and the development of accountability. Whenever possible, they should be integrated into PHC consultative processes, either through the committee system or via alternative, *ad hoc*, methods. Particular attention needs to be paid to broadening local governance to integrate these actors into the decision-making process.

In regard to democratic governance, the general issue of beneficiary participation is of great importance, as it is basic to the whole question of *accountability and pluralism* and has long-term implications for *legitimacy* and sustainability. As noted in Sections V and VI, these characteristics must be strengthened, or *organizational and management* efforts and work toward *transparency* are not likely to yield a high-quality, efficient and sustainable program.

## VIII. INTERGOVERNMENTAL RELATIONS IN THE HEALTH SECTOR

Even though the focus of responsibility for the management of PHC has shifted from the states to LGAs, PHC activities involve all levels of government and nongovernmental organizations as well. Aside from the fact that PHC activities must be integrated into secondary health care (SHC), federal and state agencies are required to give specific program/technical support to PHC through the LGAs. For instance, the National Health Policy Document (1988:15-23) expects the federal government to provide and review national health policy initiatives, legislation, and financing plans; assess the country's health situation and trends; promote public education on national health conditions and to define standards; issue guidelines; promote inter-institutional and international cooperation and research on health conditions and monitoring; and evaluate the implementation of national health policy at all levels. Similarly, the state governments are required to provide these same services in their areas of jurisdiction and, in addition, provide political, financial, and material resources support; promote intersectoral coordination; train health personnel; and improve health technology.

However, it is doubtful if these governmental levels possess the capability to offer such support. First, these governmental agencies are not familiar or comfortable with the PHC approach and hence continue to sustain their traditional preference for curative program activities. PHC emphasizes intersectoral activity and a high level of community involvement and participation, but governments prefer their conventional sectoral and professional-based operation in the health sector. Second, many states, do not possess skills or the appropriate institutions to facilitate PHC work at the local level. Third, it is not clear how existing incentive structures and resource flows work to encourage such support.

CCCD and FHS assistance to federal and state governments in the past has included such activities as: establishment of a viable PHC information system, assistance to participating universities (through research and training) and schools of health technology, and capacity-building at state and local levels for monitoring and evaluation. Although further exploration of the following ideas is necessary, they are offered as a starting point to review possible activities in future projects to support the capacity of superior levels of government to assist the LGAs and hold them accountable.

At the *federal level*, the newly created National Primary Health Care Development Agency could be assisted in its twofold program of LGA management improvement and health care advocacy. These are tasks which the Primary Health Care Department of the Ministry of Health has performed credibly in the past. The new Agency could specifically be encouraged to:

- pair "willing" LGAs with universities for management/health care training purposes;

- assist universities in implementing NUC recommendations on the incorporation of PHC into their curriculum for training doctors; or encourage the Ministry of specialized courses in health care management, building upon the current ongoing experiments at the universities of Benin, Maiduguri, and Ilorin (the three-month certificate in Primary Health Care Program); and
- collaborate with the Nigerian Medical Association in sustaining high-profile advocacy for PHC in the Third Republic at a time when the Federal Ministry of Health may have a Minister (political head) who may not be as interested in a PHC approach.

However, the large number of LGAs (and they may increase before the end of 1992) limit the effectiveness of direct federal/LGA relations, even with the use of the proposed zonal agencies. This makes assistance to state governments equally crucial.

At the *state level*, the capacity of the states to assist LGAs with respect to PHC could be enhanced in the following areas:

- ***Information management capacity***--SGs should be able to assist LGAs improve upon their information gathering, storage, and management capacity, first in the health sector, then in other sectors such as finance and planning; an evaluation of the impact and effectiveness of present interventions in these areas will be an essential activity to consider in designing new initiatives or sustaining the present ones.
- ***Supervision***--LGA capacity in supervising their health personnel requires enhancement; SGs can assist here.
- ***Attraction of skilled personnel***--Largely due to the instability of LGA policies, units, and finances, many skilled staff are reluctant to seek careers in LGAs. As a result, LGA personnel are managed at the state level by the Local Government Service Commission (LGSC). However, this poses problems of dual loyalty (to SGs and LGAs), or possibly of no loyalty to the LGA at all. While the problem of LGA stability will take time to settle, some progress could be made in consolidating LGA control over senior officers by devolving more managerial responsibilities from the LGSCs to the more able LGAs. Specifically, SGs could be assisted to encourage (the largest) LGAs to take on the problems of resource utilization (work appraisal, human resource auditing, deployment, training) while leaving the task of recruitment to the LGSCs.
- ***Improvement of internal governance structures at LGA level***--All LGAs currently have a uniform internal governance structure (the strong mayor form). However, it might be expected that in the Third Republic, some SGs and LGAs may want to experiment with alternative management structures.

SGs should be sufficiently sophisticated to appreciate how they can assist rather than block this process. This same logic also extends to possible modifications to the sub-LGA committee structure in the health sector.

*Development of an appropriate framework for state-local and inter-local cooperation*--There are two models that can be developed: coordination of state local relations in the governor's office through the present Directorate of Local Government; and coordination through the Ministry of Health. A third alternative is a state or local government consultative council that can provide opportunities to discuss a wide range of issues for planning and management purposes (including health and non-health sector activities). Any one of these models could be supported to improve intergovernmental collaboration.

Whichever option is favored, what will be important is to provide opportunities for information-sharing and an appreciation of each other's activities and attitudes among different organizational personnel in the health sector.

Much can be developed in the future to strengthen LGA performance by strengthening the supporting capacity and roles of the state, zonal, and federal levels of governance. Research to help develop these ideas further is suggested in Section IX.

## **IX. SUGGESTED PROJECT ACTIVITIES**

One important point that emerges from this report is that the USAID program in Nigeria's LGA health sector provides a window of opportunity to help improve governance at the LGA level. With this general opportunity, as well as specific health needs in mind, the report points strongly toward a governance strategy that emphasizes strengthening in three priority areas:

- organizational and managerial effectiveness;
- transparency in decision-making and information; and
- strengthened accountability--both to superior organizations and to local beneficiaries of the programs.

Two general project initiatives are suggested and reviewed in detail below:

- participant applied training for LGA secretariat and PHC officials in planning, programming, budgeting, and monitoring and evaluation, and in management information systems; and
- undertaking a series of operational research activities linked to quasi-experimental project activities in support of strengthened local governance.

### **A. Participant Applied Training for LGA and PHC Personnel**

Perhaps the most dramatic shortfall in the operation of local governance in Nigeria is the lack of training of LGA personnel in such key areas as planning, programming, and budgeting; monitoring, supervision, and evaluation; and management information systems. A second and parallel shortfall is the absence of routines and systems which are appropriate to the tasks, resources, and personnel abilities found in the LGAs, and which are effective in helping LGA personnel organize and manage responsibility. A third shortfall is the absence of any follow-up technical assessment and assistance efforts to improve in these areas.

Current training programs apparently fall short in both breadth and relevance. They do not cover the full scope of issues essential to LGA management, and they tend to be "cookbook" programs which do not reflect real awareness of conditions found in the LGA. Their curricula are usually irrelevant, and they have no follow-up capacity. It was reported that many participants have left training programs with the feeling that the instructor knew less than the students.

A training program that would be explicitly applied, participative, and emphasize follow-up work by faculty and students is recommended. Such a program would require

participants, both faculty and civil servants, to share in the development of training curricula, work together on actual LGA documents, and participate in field exercises. The program would emphasize real-world problem case studies generated by the students, group-team activities to work through those problems, and the development of tangible outputs (analytical studies, plans, budgets, supervision protocols, management information systems) which reflect conditions in which students actually work, and which students would field-test on their return to LGAs.

Training in these areas would last three months, and would be followed up by site visits by program faculty to assess and support students' progress in developing and utilizing planning, budgeting, supervision, and management information systems. Faculty would be serving three functions in these follow-up visits: personal support for alumni; problem-solving; and applied research to utilize in developing model routines to guide: planning, program development, budgeting, monitoring, supervision, evaluation, and effective managerial use of information.

Overall themes to be emphasized in the training program include the following:

- identification and analysis of problems;
- development of plans and programs to address problems;
- linkage between programs and budget;
- effective budgeting;
- effective personnel and program supervision;
- determination of which data are useful for evaluating personnel; and
- data gathering and application techniques in the LGA environment.

It is anticipated that three, three-month cycles will be trained each year, with the other three months of faculty time to be allocated to intensive field support, applied research, development of curricula and model systems, and vacation.

Because Nigeria is an immense and varied country, it is projected that four centers would be established to develop and implement this training. It is recommended that they be located at existing universities which have centers of local government and/or public administration, and which are willing to make a genuine commitment to supporting a high-quality, creative, and intensive training center. It is also recommended that the classes be limited to no more than 30-35 persons per cycle.

Target populations are: LGA secretariat members (particularly the LGA secretary and planners) and PHC coordinators. A shorter, one-week PHC sensitization program for LGA Chairs and Department Supervisors might also be established. With nearly 600 LGAs in Nigeria, this offers a potential population of some 2,000 persons for the three-month cycle, and some 1,200 persons for the one-week overview course.

USAID would offer support to establish such centers, including coverage of salaries and allowances for the program director, instructional personnel, and secretarial personnel. In addition, USAID would support vehicle purchase and per-diem for fieldwork, computer resources as needed, per-diem and travel expenses for trainees, materials support, institutional overhead cost in return for office and instructional space, and publication costs for course-based materials.

Discussions with the Director General of the Federal Department of Public Health indicate that such a program would be well-received, and not seen as redundant to existing training activities. In discussions with the Government of Nigeria on this idea, attention should be paid to encouraging a receptive environment for the innovations the program has in mind. These should, at a minimum, include approval to upgrade LGA planning and management routines and abilities, and possibly tightened federal and/or state planning/management requirements. A receptive environment might also include some program of challenge/incentive grants from USAID or the Government of Nigeria to LGAs which demonstrate real progress in implementing these measures. Some system of "model LGAs" in the management area might be established for the first year or two of training to encourage implementation of new procedures. Also, workshops and sensitization sessions with LGA political leadership might help "prime the pump" for improved management in the field.

## **B. Operational Research**

The project will include a program of operational research to gather additional information on conditions, problems, and options to strengthen governance at the local level. Research funded will be explicitly linked to operational problems identified in development of the Project Paper and later, during implementation of USAID's health program. Research projects will be organized to develop specific quasi-experimental follow-on activities. An initial agenda of research activities would focus on *strategic assessment of local governance in Nigeria*. This would include development of an overview of the circumstances, conditions, and potentials of local governance in Nigeria as well as an overview of organization, administration, revenue policy, participation, innovation, and other key aspects. Findings of this research will help inform and guide training and subsequent research activities, offering a baseline to work from and providing information to more clearly focus follow-on research activities as discussed below:

- ***Civic Participation:*** What factors are associated with civic participation in health affairs at the local level? This would include participation by direct

beneficiaries in health programs, by local organizations such as civic organizations, occupational associations, women's organizations, volunteer committees, traditional authorities, and others. What activities do they engage in, and with what results for health care? What socioeconomic, cultural, programmatic, policy, health education, political leadership, and other factors relate to participation?

- ***Local Government Authority Establishment:*** What is the status and functioning of key local government entities, including the LGA Council? What functions are they performing? How are they working together and at cross-purposes? How do they relate to the PHC program? To what extent is the structure officially established in place and operating? With what impact on LGA programs and services?
- ***Policy and Program Analysis of the Health Sector:*** What is the operational, field understanding of key national health policies (public health and family planning)? What is being implemented at the local level, with what problems and with what outcomes? How do local and superior levels of government communicate, solve shared problems, and develop new policies? What role is the PHCDA playing? What other state and federal policies are affecting local health policy implementation, and with what results?
- ***LGA Budgetary, Accounting, and Auditing System:*** What procedures are in place to manage spending according to the budget? What accounting and auditing systems are in place? How well do they operate? How do they affect health programs? How does this relate to federal and/or state directives? What conditions appear necessary for effective financial management?
- ***Monitoring, Supervision and Evaluation, and Management Information Systems at the LGA:*** What systems are in place? What sort of information do they gather? How well are they used by management to facilitate better performance by delivery personnel? Does performance vary across the health sector? What varying mechanisms are used to gather, interpret, and act on information regarding performance? What impact are they having on LGA health management and why?
- ***Local Revenues:*** What do LGAs do to raise own-source revenue? What is associated with successful strategies? How are strategies adjusted to regional and rural-urban variations? What leads some LGAs to raise revenue more aggressively than others? When is the public more willing to contribute revenue/taxes to LGAs and health programs in particular? What role does PHC performance, federal and state policies, civic participation, and quality of local management play in local revenue?

- ***Local Initiative:*** Which LGAs are characterized by greater and lower levels of local initiatives? What do they accomplish? How can this be related to such factors as political leadership, professional(PHC) leadership, PHC program quality, civic participation, local socioeconomic and cultural conditions, traditional authorities, and donor activities? What roles do their activities play in areas characterized by greater and lesser initiative? Is there any impact by federal, zonal, and state policies and roles?
- ***Federal Zonal and State Directive/Accountability Structures:*** How does the configuration of rules, regulations, resources, and functions of the superior organizations (to the LGAs) affect LGAs in key areas as local revenue raising, monitoring and evaluation, management information systems, financial management, local participation, local initiatives, and general PHC performance? How much impact do these superior structures have? How do they create a structure of incentives and disincentives which affect local governance and health programs? How do they play a role in managing conflict among LGAs and among the various levels of government?
- ***Public Accountability:*** How do PHC personnel utilize and not utilize directives from superior organizations? What information flows upward which superior organizations can use to appraise and hold accountable LGA performance? What impact have superior organizations had on LGA performance? If there is variance among LGAs, why? To what extent does the local public affect program choice and management? Via what structures? When do local publics have more control over PHC programs?

### C. USAID Proposed Activities

In support of this research, it is recommended that USAID assist in funding the direct cost of these activities. There are two organizational models this activity could follow. One is the development of a consortium-center for applied research in local governance and health policy. The other is an open-bidding system led by an executive committee selected from USAID project and Nigerian leadership which would award research contracts on a competitive basis to pursue these topics.

The consortium model would require several institutions, both public (universities, research institutes such as the Nigeria Institute of Social and Economic Research--NISER) and private (consulting firms and organizations), to join together to make a comprehensive proposal to execute these activities.

The advantages of a consortium include easier management, lateral communication among researchers involved in different projects, development of critical mass of expertise and experience, and possible development of a "center for excellence" in operational research on governance.

Its weaknesses include possibilities of in-breeding among researchers, difficulty in accessing top persons outside the consortium structure, absence of wide spill-over effects to other institutions in Nigeria, and possible erosion of the center once donor activity is withdrawn. In addition, linkages to the training centers would have to be consciously developed and monitored to achieve full operational benefit from the research.

The open-bidding model has pros and cons largely the converse of the consortium model. In particular, coordination and leadership of research is likely to be more difficult. On the other hand, spill-overs to multiple institutions, including possibly the training centers, are more likely to occur, leading to a broader personnel base with experience in these areas than the consortium model might. Bidding would also allow more flexibility in program development as new issues and opportunities arise which might not be relative advantages for an established consortium.

Whatever the model chosen, pursuing the research issues identified above will facilitate a greater understanding of local governance and its impact on health programs.

### *Concluding Note*

It is a critical time in the evolution of Nigeria's democracy. Many democratic theorists have argued that successful democracies can only be built on the wide civic base that working local democratic governments offer. USAID is in a unique position to strengthen implementation of its important public health program, while simultaneously strengthening Nigerian democracy and governance as a whole.

## Annex A: Tables

Table 1

### Functions of a Local Government (1989 Constitution)

**1. *Exclusive***

The main functions of a Local Government shall be as follows:

- (a) formulation of economic planning and development schemes for the Local Government Area;
- (b) collection of rates and insurance of radio and television licenses;
- (c) establishment and maintenance of cemeteries, burial grounds, and homes for the destitute of infirm;
- (d) licensing of bicycles, trucks (other than mechanically propelled trucks), canoes, wheel barrows and carts;
- (e) establishment, maintenance and regulation of slaughter houses, slaughter slabs, markets, motor parks and public conveniences;
- (f) construction and maintenance of roads, streets, street lighting, drains, parks, gardens, open spaces, or such public facilities as may be prescribed from time to time by the Military Governor or House of Assembly of a State;
- (g) naming of roads and streets and numbering of houses;
- (h) provision and maintenance of public convenience, sewage and refuse disposal;
- (i) registration of all births, deaths and marriages;
- (j) assessment of privately owned houses or tenements for the purpose of levying such rates as may be prescribed by the Military Governor or House of Assembly of a State;
- (k) control and regulation of:
  - (i) out-door advertising and hoardings;
  - (ii) movement and keeping of pets of all descriptions;

- (iii) shops and kiosks;
- (iv) restaurants, bakeries and other places for sale of food to the public;
- (v) laundries; and
- (vi) licensing, regulation and control of the sale of liquor.

## 2. *Participatory*

The functions of a Local Government shall include participation of such Local Government in the Government of a State as respect to the following matters, namely:

- (a) the provision and maintenance of primary, adult and vocational education;
- (b) the development of agriculture and natural resources, other than the exploitation of minerals;
- (c) the provision and maintenance of health services; and
- (d) such other functions as may be conferred upon a Local Government by the Military Governor of the House of Assembly of a State.

## Annex A: Tables

Table 2

### FEDERAL TRANSFERS TO LOCAL GOVERNMENTS 1976 - 1991

Fiscal Year	Amounts in Million	% of Federation Revenue
1976	100.0	1.7
1977	250.0	4.2
1978	150.0	2.2
1979	300.0	2.5
1980	278.0	2.3
1981	1085.0	9.0
1982	1018.7	8.0
1983	996.8	9.1
1984	1061.5	9.5
1985	1327.5	8.5
1986	1166.9	9.5
1987	2117.8	8.4
1988	2727	10.07
1989	3399	9.97
1990	7680	16.04
1991	10765	19.1

*Central Bank of Nigeria (1977 - 1991); Olowu (1990)*

56

Annex A: Tables

Table 3

IFE CENTRAL LOCAL GOVERNMENT: MAJOR RECURRENT  
REVENUE SOURCES: 1989 - 1992

	1989	1990 N'000	1991	1992 (estimate)
Taxes/Community Contribution	3.6	53.9	53.9	185.3
(%)	(0.3)	(0.9)	(0.3)	(0.6)
Cost Recovery (Fees charges & Commercial Operators)	111.8	552.4	556.	2,090.3
(%)	(8.4)	(9.3)	(3.6)	(6.7)
Transfers	1,214.3	5,316.0	14,837	28,850.0
(%)	(91.3)	(89.8)	(96.1)	(92.7)
Total	1,329.7	5,922.3	15,446.9	31,125.5

Sources: Budget Estimates of Ife Central LGA for relevant years

## **Annex B**

### **LIST OF PERSONS CONSULTED**

Prince G.A. Adeagbo, Community Leader, Ilode Health District, Ife Central LGA, Member of PHC Management Committee

Miss. D.T. Adebami, Head of Department, Public Health Coordinator, Ife Central LGA

Alhaji Lateef Adekunle, Vice Chairman, Egbeda LGA

Mrs. P.A. Adenubi, Chief Nursing Officer, Ojo LGA

Mr. A.A. Adesegun, Assistant Chief Environmental Officer, Ojo LGA

Dr. Hezekiah Adesin., USAID/CCCD

Mr. E.A. Adesoji, Head of Minor Ailments Treatment, Ife - Central LGA

Mr. R.O. Ajao, Assistant PHC Coordinator, Egbeda LGA

Dr. Bola Akande, Obafemi Awolowo University - Ife

Mrs. Ayoola Alao, Chief Health Sister (Head of Department), Egbeda LGA

Dr. Susan Aradon, SBA Consultant

Dr. Brice Atkinson, FHS Project

Mr. G.A. Awofidebe, PHC Coordinator, Ife Central LGA

Mrs. C.S. Ayoola, Health Supervisor, Ife Central LGA

Dr. Anne Bamsaiye, Assistant to Federal Minister of Health and Human Services, World Health Organization

Mrs. Iyabo Baoku, Chief Pharmacy Technician, Egbeda LGA

Mr. S.O. Bukola, PHC Coordinator, Egbeda LGA

Mr. Eugene Chiavaroli, USAID

Dr. Ronald Cohen, University of Florida

Dr. John Crowley, USAID/Washington

Dr. Hazel Denton, World Bank

Mr. Mike Egboh, USAID/FHS

Mr. Lanre Fadahunsi, Information Officer, Ife Central, LGA

Mr. Wole Fadele, LGA Secretary, Egbeda LGA

Dr. Doyin Fagbule, USAID/CCCD

Mr. M.O. Famoriyo, Vice Chairman, Ife Central LGA

Dr. Stella Goings, John-Hopkins University and the "Sustainability" Study Leader

Mr. James Herrington, USAID/CCCD

Dr. Goran Hyden, University of Florida

Mr. L.O. Ijiyera, Assistant PHC Coordinator, Ife Central LGA

Mr. J.A. Illeladewa, Secretary, Ife Central LGA

Dr. K.A. Kalu, USAID/CCCD

Dr. Deirdre Lapin, Health and Social Development, International Inc.

Mr. O.A. Lawal, Assistant PHC Coordinator, Ife Central LGA

Miss M.L. Lawal, Clinical Supervisor (EPI Unit), Egbeda LGA

Mr. John Lundgren, USAID

Mr. John MacWilliam, USAID

Mr. B.G. Odewale, Deputy Director of Finance, Ife Central LGA

Mr. Shina Ogunkoya, Supervisor for Health, Ojo LGA

Dr. P. Okungbowa, Deputy Director, Public Health Care Department, FMOH

Mrs. J.T. Olasoji, Assistant Public Health Coordinator, Ife Central LGA

Mr. G. Olukolu, Secretary, Ojo LGA

Mr. J.A. Omidiora, Community Leader, Ilode Health District, Ife Central LGA

Mrs. K. Onabola, Pharmacist and Acting LGA Public Health Coordinator, Ojo LGA

Mr. M.A. Opekiledede, Director of Personnel, Ife Central LGA

Mr. S.A. Opesanwo, Director of Finance and Supplies, Federal Ministry of Health

Mr. J.O. Otayomi, Treasurer, Ojo LGA

Dr. Oyewole Owolabi, HERDS-Medicare

Alhaji S.G. Oyedeji, EPI Manager, Egbeda LGA

Mr. John Rigby, Africa Democratic Governance Project, Associates in Rural Development, Inc.

Mr. Y.A. Salawu, Assistant PHC Coordinator, Ife Central LGA

Mrs. J.O. Shonola, Chief Nursing Officer, Ojo LGA

Dr. A.O. Sorungbe, Director Public Health Care Department, FMOH

Dr. Richard Spiegel, USAID/CCCD

Mr. A.F. Tairu, EPI Storekeeper, Egbeda LGA

Mr. Rudolph Thomas, USAID

## Annex C

### DOCUMENTS CONSULTED

- Ainsworth R.A., et al. (1991) *An Examination of the Management of Primary Health Care In Selected Local Government Areas In Nigeria*, Lagos, USAID.
- Ayo D, K. Hubbel, D. Olowu, E. Ostrom, T. West (1991) *The Experience In Nigeria With Decentralization Approaches of Local Delivery of Primary Education and Primary Health Services*. Burlington, ARD Decentralization: Finance and Management Project.
- CCCD (1992) *Assessment of the Potential for Programme Sustainability*, Draft Paper, Lagos.
- CCCD Project (1992) *The Primary Health Care Operational Plan and Workplan for Oyo/Osun States, Nigeria 1992/1993*. Lagos.
- CCCD Project (1991) *1991 Implementation Plan Anambra State*.
- CCCD/USAID *Annual Report 1990 and Workplan for 1991*.
- CCCD/USAID *Facility-Based Assessment: Ojo LGA, Lagos State*, Dr. Doyin Fagbule, USAID.
- CCCD/USAID (1992) *Memorandum to Commissioner of Health, Ibadan on Program and Accounting Requirements Governing the Use of USAID/CCCD Funds in Oyo State Ministry of Health*.
- CCCD/USAID (1992) *Nigeria-Family Health Services II - Population Project: Project Identification Document*, Lagos.
- CCCD/USAID *1991 Implementation Plan Anambra State*.
- Central Bank of Nigeria *Annual Reports 1977 - 1991*, Lagos.
- Robert Charlick (1991) *USAID Governance Initiative*, Washington D.C.
- Federal Ministry of Health (1992) *Instructional Guide for the Development of a Local Monitoring System at the Primary Health Care Health Facility Level*, Lagos.
- Federal Ministry of Health (1988) *The National Health Policy and Strategy to Achieve Health for All Nigerians*, Lagos.
- Federal Office of Statistics (1992) *Nigeria's Demographic and Health Survey 1990 Summary*, Lagos.

- Federal Republic of Nigeria (1989) *The Constitution of the Federal Republic of Nigeria (Promulgation) Decree 1989, Decree No. 12*, Lagos.
- Federal Republic of Nigeria (1976) *Guidelines for Local Government Reform*, Kaduna Government Printer.
- Gillespie, J.J., et al. (1992) *Institutional and Management Assessment of AAO/Nigeria - Pompolio Management Structure*, Lagos.
- HERDS Medicare Ltd. (1992) *Implementation of the Primary Health Care Policy at Local Government Area Level In Nigeria*, Lagos.
- HERDS Medicare Ltd (1990) *Primary Health Care System Appraisal - Local Government Areas In Nigeria*, Lagos.
- Ife Central Local Government. *Approved Estimate for 1989 - 1992*.
- Newswatch (Lagos) *Local Government: Crisis of Reform June 15, 1992*.
- Ojo Local Government (1990) *Primary Health Care Project Implementation Document Ojo, Lagos State*.
- Olowu, Dele, S.B. Ayo & B. Akande (1991) *Local Institutions and National Development In Nigeria Ile-Ife*, Obafemi Awolowo University Press.
- Olowu, Dele (1990) *The Nigerian Conception of Local Development*, Ibadan, Nigerian Institute of Social and Economic Research. Federal Ministry of Health (1990)
- USAID, (1992) *African Child Survival Initiative: Combatting Childhood Communicable Diseases Annual Report 1991 - 1992*. Lagos.
- USAID (1992) *Nigeria: Country Program Strategic Plans (CPSP), 1993 - 2000*, USAID Affairs Office, Lagos, Nigeria, August, 1992.
- World Bank *Federal Republic of Nigeria: Health Care Costs, Financing and Utilization Vol.1 Sub-sector Report*. Washington D.C, Western Africa Department Report No. 8382 - UNI.
- World Health Organization (1992) *Local Government Focussed Acceleration of Primary Health Care: The Nigerian Experience*, Report of a WHO Review Geneva.