



DECENTRALIZATION: FINANCE & MANAGEMENT PROJECT

**THE EXPERIENCE IN NIGERIA
WITH DECENTRALIZED APPROACHES TO
LOCAL DELIVERY OF PRIMARY EDUCATION
AND PRIMARY HEALTH SERVICES**

Managed by
Associates in Rural Development, Inc.

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Syracuse University • Metropolitan Studies Program/Maxwell School of Citizenship & Public Affairs
Indiana University • Workshop in Political Theory & Policy Analysis

Sponsored by
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AND PRIMARY HEALTH SERVICES**

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LIST OF ACRONYMS

ASSEDA	Anambra State Specialized Education Authority
BHSS	Basic Health Services Scheme
CCCD	Combatting Contagious Childhood Diseases
CDA	Community Development Associations
CHANpharm	Christian Health Association of Nigeria Pharmaceuticals
COCIN	Church of Christ in Nigeria
DFRRI	Directorate of Food, Roads, and Rural Infrastructure
DPA	Distributable Pool Account
DRF	Drug Revolving Fund
ECWA	Evangelical Church of West Africa
EDP	Essential Drugs Program
EPI	Expanded Program of Immunization
FA	Federation Account
FCT	Federal Capital Territory (Abuja)
FMG	Federal Military Government
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GNP	Gross National Product
GSF	Gross Stabilization Fund
HSC	Hima Social Club
IDA	International Development Agency
IMF	International Monetary Fund
LGA	Local Government Authority
LGEA	Local Government Education Authority
MAMSER	Mass Mobilization for Social Enlightenment
NGO	Non-Governmental Organization
NPEC	National Primary Education Commission
NRP	National Republican Party
NUD	Nawarudine
NUT	National Union of Teachers
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PSMB	Primary School Management Board
PTA	Parents-Teachers Association
PVO	Private Voluntary Organization
SAP	Structural Adjustment Program
SARDA	Sokota Agricultural and Rural Development Authority
SDP	Social Democratic Party
SLGJA	State-Local Government Joint Accounts
SOE	State-Owned Enterprise
TBA	Traditional Birth Attendant
UNDP/ILO	United Nations Development Program/International Labor Organization
UPE	Universal Primary Education
VHW	Village Health Worker
WHO	World Health Organization



Preface

This document was prepared by Dr. Dele Ayo, Dr. Kenneth Hubbell, Dr. Dele Olowu, Dr. Elinor Ostrom, and Dr. Tina West based upon their field research in Nigeria during June of 1991. The work was sponsored by the Decentralization: Finance and Management (DFM) Project, and funded by the Africa Bureau of the U.S. Agency for International Development (USAID). DFM (contract No. DHR-5446-Z-00-7033) is sponsored by the Office of Economic and Institutional Development, Bureau of Research and Development, USAID.

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The DFM Project is designed to assist developing country governments and USAID field missions to address problems associated with decentralization of services. The project's primary focus is the analysis of institutions that perform key funding, management, and maintenance functions in order to suggest ways in which these institutions can improve performance and establish policies which encourage sustainability.

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I. THE SETTING

Nigeria's regionalism and Nigeria's oil wealth, plus its sheer size, make its recent history complex. Having endured the civil war in the 1960s over the secession of Biafra, the Igbo region in the East, the political leadership has moved back and forth between civilian and military rule. The promised transition to civilian rule does not yet represent a reduction of uncertainty; many Nigerians believe the civilian/military cycle will continue. Policy changes, regional issues, and the distribution of the government's oil revenues dominate the national political scene, with serious implications for local delivery of services.

At no time since independence has there been a sense of durability in the policies adopted related to the authority of local governments, the delivery of primary education or of primary health, or of the way that services would be financed. Just when expectations are beginning to settle down concerning how a new policy will operate, a major change is announced from the center. The decree announced in January 1991 that annulled the National Primary Education Commission (NPEC) and transferred funding and control of primary education to local governments is an example of one of the many sudden and unexpected shifts in policy direction that have occurred during the past three decades. A raft of new local governments were created in 1981, then disbanded in 1984, and reconstituted in 1991. How local government officials are selected has shifted from appointment to election to appointment several times during the era since independence. Every shift in national regime has brought with it major constitutional and policy shifts that have frequently represented complete 180 degree turns from the policies pursued by the preceding regime.

The extreme degree of regional politics that has characterized Nigeria both during and after colonial rule also has many consequences. One is the lack of realistic data. Census activity has been politically charged to the point that, nation-wide, the enumeration process during census-taking since 1963 (since 1953, some argue) has been tampered with sufficiently by regional political interests that no reliable census data has been available for planning purposes for years. Primary health and primary education decisions have been made on the basis of the 1963 census data, updated at a variety of rates. Thus, siting decisions, revenue allocations, and policy impact analysis are all quite

problematic.¹ At all levels, revenue-sharing formulas weigh fictitious population projections heavily. A good census, therefore, will undoubtedly produce surprises and thus big winners and big losers. The political heat generated by the uncertainty of redistribution between government entities (from districts or wards up to states) that will be the consequence of a census intimidated governments from again attempting a census until 1991. The census conducted in November 1991 as part of the timetable for a return to civilian rule did indeed produce surprises, big winners, and big losers. Estimates of Nigeria's population had ranged from 110 to 130 million. Everyone was shocked with the new estimate of 88.5 million. Also surprising to many was the conclusion that just over half of the population lived in the North. However, this census has also aroused considerable suspicion concerning its accuracy (*The Economist*, March 28, 1992).

In spite of the uncertainty as to the exact population size, there is no question that Nigeria has the largest population of any country in sub-Saharan Africa; about one-fifth of all Africans are Nigerian. Slightly over 5,000,000 babies are born each year in Nigeria (Gibb et al., 1991: 10). Close to one-half of the population is less than 15 years old and one-fourth of the of the population is women of reproductive age (15-49). The average fertility per woman is six children leading to the estimated population growth rate of 3.3% (ibid). With a land area of 924,000 square kilometers it is a large country (the fourteenth largest in Africa) and most of the land is productive: 34% cropland, 23% pasture, and 16% forest (World Bank, 1989b: 279). Two-thirds of the population lives in rural areas in over 95,000 rural villages. Although the country is rich in natural resources, the people are poor, with a Gross National Product (GNP) per capita in 1990 of only \$290 (World Bank, 1992: 399). At least through 1980, rural people were poorer than urban dwellers, and farmers had lower

¹Laurence D. Stifel (1990), Director General of the International Institute of Tropical Agriculture, stressed the difficulties presented by a lack of accurate data in attempting to develop reasonable development policies in a recent address where he stated:

Early in the 1960's, an expatriate economist wrote a book about his experience of advising the Nigerian Government. He entitled it, *Planning Without Facts*.

Unfortunately, reliable statistical data are still lacking on the most basic parameters of Nigerian agricultural development, such as the growth rates of food production and population. Planning for agricultural development involves learning from past experience, introducing new policies or programs and making self-correcting adjustments in response to emerging circumstances. In the absence of reliable data, decisions are made on the basis of impression, anecdotes, or personal disposition. That inevitably undermines the consensus on critical issues which is important for government credibility.

income levels than those in other occupations. In recent years the urban-rural terms of trade has shifted in favor of farmers (World Bank, 1992: 401).²

As in Ghana, the Nigerian military has set a pattern of intervention in politics when military factions perceive the current government to have become ineffective or corrupt. Coups against military administrations in Nigeria have been as frequent as coups against civilian ones. There have been seven governments since independence in 1960. Five of these have been military administrations. Under both the civilian governments, elections (in 1964 and 1983) resulted in the return of incumbent civilian administrations after violent and fraudulent election procedures. Both elections were followed shortly by military coups to restore order and end corruption. Both original military regimes were ousted in "bloodless" coups by military leaders who pledged to return the country to civilian rule. The first of these, Murtala Muhammad, was assassinated in 1976 shortly after pledging a return to civilian rule. His successor, General Obasanjo, fulfilled the pledge. General Babangida, the current leader, is in the process of carrying out his pledged timetable for restoring civilian rule. In all of these governments, Northerners dominated. There are a number of hypotheses for Northern domination, including: (1) their predominance in the military; (2) the ability of rich Northerners to build party structures with the ability to carry out election campaigns nationwide, an ability other parties have not been able to match; (3) the susceptibility of the South to divide-and-rule politics, and (4) the stronger stake that Northerners have in maintaining access to state resources since they have fewer commercial opportunities.

Most economic activity is in the South. Nigeria's enormous petroleum and natural gas fields lie offshore, manufacturing is concentrated in coastal cities, and the richest agricultural areas are also in the South. Petroleum production represented over 25% of Gross Domestic Product (GDP) in 1991; agriculture 30%; manufacturing 9%, and services 30% (World Bank, 1992: 399). Obviously, the exploitation of Nigeria's oil wealth (particularly after OPEC raised prices in 1973) has distorted the development process: (1) it has led to the phenomenon of "Dutch disease," the hyperdevelopment of one sector while the rest lag behind, leading to GDP growth without integrated development; (2) it allowed an extreme boom mentality to arise in the 1970s, which led to very inefficient use of national economic resources and eventually to an enormous debt burden (which, unlike most of Africa, heavily involves private creditors); and (3) it has made government spending extremely vulnerable to

²There is considerable debate over intra sectorial and regional impacts of macro-economic policies adopted under the Structural Adjustment Program as discussed later in our report.

fluctuations in the international oil price. Because oil royalties represent such a large proportion of government revenues at all three levels of government, oil has affected the process of government in less obvious ways: (1) how to distribute the oil revenues is a running political preoccupation without equivalent energy devoted to how to invest the funds wisely, (2) neither federal, state, nor local governments have effectively tapped other revenue sources, and (3) consequently, state and local governments have operated somewhat more as irresponsible dependents than as accountable and autonomous units of government.

Nigeria was a British colony and, like Ghana, one in which Western missionaries started in the 19th century to provide educational facilities, primarily in the coastal areas. As in Ghana, the British bowed early in the 1950s to the inevitability of independence. After protracted constitutional negotiations to balance regional interests, Nigeria gained its independence in October 1960 with a Westminster-style government structure.

A sense that the Westminster model did not suit the political realities of regionalism in Nigeria led to the adoption in the Second Republic of an American-style presidential, federal government. Prior to this change, the Government sponsored a nationwide reform of the local governmental system in 1976 through the Local Governments Edicts of 1976, which created a uniform structure of local government to replace the variety of local government structures left by British "indirect rule." The elaborate new constitution failed to address the underlying and continuing issue of an overly centralized structure of power. This has plagued Nigeria's efforts at political stability, economic growth, and made it difficult to address key issues such as the national census, the allocation of petroleum revenues between federal and state authorities, and land tenure policy decisions (Olowu, 1990b).

Although the Second Republic lost its legitimacy before being taken over by the military, the notion of a federal structure is still considered desirable.³ Babangida's regime has stressed the distinctions between Federal, State and Local Government Authority (LGA) responsibilities and has taken measures to increase both the proportion of national revenues allocated to the LGAs (in January 1991) and their responsibility to provide and produce services such as primary education, primary health care and the maintenance of infrastructure (primary health care in 1988, infrastructure in 1990; education in January 1991). The timetable for return to civilian rule called for the election of local government officials in 1987, 1989, and 1991 and for the new local councils to take up their new

³See the special issue of *Publius* devoted to Nigerian Federalism (Adamolekun, 1991, and Olowu, 1991b).

responsibilities in January 1991. The actual elections held in the fall of 1990 involved the creation by the military government of two totally new political parties and the banning of other parties.⁴ Further, a "new breed" of politicians was to be encouraged by limiting participation in elections to those who had not previously held elected office.⁵ A controversial, open election format was selected for the first local elections.

Many unresolved issues relate to the duties of local governments. In education the questions of who controls the hiring and firing of teachers, who controls the amount that teachers are paid, and who can change the curriculum are far from resolved. In health care, decentralization has gone further. The states were ordered in 1988 to begin to transfer primary health care facilities and personnel to the LGAs. However, the same questions about decision-making apply. One of the purposes of our research was to observe how these issues are being addressed. To understand how SAP (Structural Adjustment Programs) and other recent changes in governmental structure and finance have impacted on the delivery of local services in rural areas, four rural villages were selected in which to conduct field research. Given the regional differences in a large country such as Nigeria, it is important to include western, eastern, mid-country, and northern states. We selected villages to study in Oyo State in the west, in Anambra State in the east, Plateau State in the mid-north, and Sokoto State in the far north.⁶ We spent time in the state capital of each of these states obtaining an overview of education and health delivery structures and practices in the state and state-level resource mobilization information. We sought advice concerning the selection of specific LGAs and villages for study. The villages selected for study were small, relatively isolated, rural villages that do receive government-provided education and health services, but are at the bottom rung of the delivery system. Studying primary education and health care delivery in these villages provides a better picture of the current situation facing the majority of rural residents than a study of services in more accessible town locations.

⁴The totally new parties were even given their names--the National Republican Party (NRP) and the Social Democratic Party (SDP) by the military governments and funds were provided by the national government.

⁵This announced policy has been changed in practice. Many of the current Presidential aspirants were politicians during the Second Republic [for example, Alhaji Lateef Jakande (first executive civilian governor of Lagos State) and Dr. Olusola Saraki (Senate Leader in the Second Republic)].

⁶These were the names of the states at the time of our field work during the summer of 1991.



II. HISTORY OF STRUCTURAL ADJUSTMENT PROGRAMS (SAP)

Nigerian leaders are caught between the need to meet some of their external creditors' demands (so that the creditors will continue to reschedule the huge Nigerian public debt) and strong popular opposition to International Monetary Fund (IMF) programs. The government's solution has been to negotiate programs with the IMF, meet the specified IMF targets, but not draw down any money from the IMF specifically related to the structural adjustment policies. The Gulf War's effect on oil prices should have helped out the Nigerian economy in 1990, which was otherwise headed for lower growth than in 1988 and 1989.

Nigeria's economic boom collapsed with the decline in real oil prices in the early 1980s. Neither Shagari's civilian government nor Buhari's military regime took effective measures to adjust to the changed circumstances; both relied on administrative measures, particularly for allocating foreign exchange, which led to shortages and, inevitably, to the creation of parallel markets. When Babangida came to power in 1985, his first broadcast indicated that he had decided on structural adjustment policies and on implementation of the stabilization policies the IMF had urged on both Shagari and Buhari (Biersteker, 1990). Bowing to the strength of popular opposition to a formal IMF program, he still began a process of devaluation and liberalization of other prices that has led, with some backsliding, to an official naira rate that is close to the parallel market rate, and an end to most other administered prices (Ayo, 1990; World Bank, 1990b). As in Ghana, the growth of the parallel market before devaluation accustomed people to higher than the official prices, and dampened popular protest. The Babangida regime also emphasized control of government expenditure at the state and federal levels. Although the SAP formally ended in June 1988, the government continues to pursue both stabilization and structural adjustment objectives.

Decentralization Initiative

As did Ghana's military regime in 1983, the Babangida regime linked economic policy change with political reform in the direction of a more decentralized and participatory structure under eventual civilian rule. At the end of his first Budget Speech in December, 1985, Babangida announced that the process of transition to a return to civilian rule would begin immediately. The announcement diverted public attention from the orthodox stabilization measures contained in the budget, and Babangida did indeed move swiftly to set up the Political Bureau to gather public testimony on the requirements for an orderly transition and a new republic (Biersteker, 1990). Again

as in Ghana, ordinary people and government institutions have been subjected to multiple changes as a result of the linked objectives of structural adjustment and decentralization.

In Nigeria, the need for specific changes or the nature of actual changes does not always seem to be consistent with either structural adjustment or decentralization objectives. The tariff structure, for example, despite several revisions, favors imports of finished consumer goods over those manufactured locally with some imported inputs (Phillips and Ndekwa, 1987). With primary education, the regime first set up a new, powerful hierarchy of management boards, then at the end of 1990 abruptly transferred responsibility for primary education to the LGAs. The boards were effectively dissolved, but the specific decision loci for various aspects of primary education delivery were left unclear, which resulted in confusion and some recentralization when the LGAs got into difficulties.

Policies for the financial, state-owned enterprise (SOE), and private sectors have been increasingly market-oriented, and by December 1990, 20 out of the 110 SOEs (excluding the nonwater assets of River Basin Development Authorities) at the national level had been fully privatized. A larger number are being commercialized and required to operate without subsidies. The overall result of the first four years of adherence (with one major lapse in the first half of 1988) to the new policies has been positive real growth in the past three years. As in Ghana, the rate of growth is only somewhat higher than the rate of population increase. Thus, living standards have not improved dramatically, although incomes in some rural areas are thought to have improved faster than urban incomes. Incomes of those dependent on imported goods have undergone dramatic shocks.

Income levels in Nigeria fell in the 1980s; in 1988 the World Bank changed Nigeria's status from middle-income to IDA-eligible, i.e., poor. This change in designation has allowed Nigeria to borrow from the Bank on concessionary terms, and has paved the way for increases in Western aid through the Consultative Group for Nigeria, organized by the Bank in 1988. The World Bank plans to lend approximately \$1 billion per year for the near future.

The uncertainties that face Nigeria in the next year or two include the planned return to civilian rule, the continued Christian/Muslim internal strife, and the volatility of world oil prices. Nigeria's leaders must continue to maintain stabilization policies and good relations with external creditors, while addressing basic problems of infrastructure, civil service reform, and social services improvement.

After our fieldwork, talking to people at all levels, and reading the most recent publications by Nigerian academics, a few points stand out.

The government has lost control of the debate over the success of SAP. With so little good data available and with so many conflicting points of view based on poor data, most people are going primarily on their own perception of whether or not they are better off. Very few Nigerians that we encountered perceived themselves to be better off; although few people said that things were still getting worse. What often seems to be missing is the understanding of the links between SAP, the international oil price, and the government policies that affect inflation. If things get worse, it's because of SAP, not because of a lower oil price; if the inflation rate increases, it's SAP, not the government's fiscal and monetary policies. If the civil service needs to be down-sized, it's SAP, not the end of the boom.

SAP seems to be regarded, not as a process of economic change characterized by consistently using prices and policies to change the incentive structure to more productive and more diversified economic activities, but as a substitute for the lost oil income. In other words, SAP was sold on the grounds that a limited period of belt tightening would produce prosperity without major dislocations. Many citizens bought the sales pitch and have expected instant prosperity to occur without having to suffer real economic costs. Obviously one cannot adjust to the extreme economic problems facing Nigeria without inflicting substantial costs on many individuals who were not responsible for the profligate ways that brought on the crisis.

Three fundamental problems confront a policy of structural adjustment in an economy like this: (1) the many imperfections of the market and its capacity to respond quickly and accurately to a new environment, (2) the perception made by citizens that SAP is imposed, and (3) the weak policy implementation and review that has been involved. We return to these issues in Section 8.



III. POLICY AND PROCEDURES FRAMEWORK: SERVICE DELIVERY AND LOCAL GOVERNMENT AUTHORITY

At the time of our fieldwork, Nigeria had a three-tiered structure of 21 state governments and 453 local government units, excluding the mayoralty of Abuja, the nation's new capital which has a peculiar local government system. The second tier of government has increased steadily from only three regions at independence to four (1963), twelve (1967), nineteen (1976), twenty-one (1987), and thirty states in 1991. The system of local government is the outcome of a major national reform of state-based local governments by the Federal Military Government in 1976. Only 301 local governments were created in 1976. During the Second Republic (1979-83) State governments created many additional local governments. These efforts to create additional local governments were nullified when the military returned to power in 1984 and it was not until quite recently (May 15, 1989 to be exact) that additional local governments were created by restructuring the old ones. Each local government was divided into a maximum of 20 wards and seven 'Development Areas'. During the summer of 1991, the number of local government units was suddenly and unilaterally increased to 589 when the number of states was increased to 30.¹

No definite responsibilities or governmental powers are accorded any institution below local governments—at least in government decrees. In practice, however, a large number of community organizations are to be found below the single-tier local government system. The Directorate of Food, Roads, and Rural Infrastructure (DFRRI) estimated these as 114,000 in 1990, but they may be many more. In each of the villages that we visited, we located several very active community organizations that raised substantial resources to cope with community problems.

In spite of the presence of many state and local governments, the Nigerian federal system is a highly centralized one. The federal government takes the initiative in creating additional states or local governments, usually in response to local/regional pressures. The pre-eminent position of the federal government is also unmistakable in the field of revenue collection and sharing, as well as in providing leadership in the delivery of major services such as education and health services.

Local governments have received sustained and substantial attention since 1976. The 1976 reorganization not only created the units but outlined their powers, program responsibilities, financing and political structure. These have changed in degrees rather than substance in the last fourteen years.

¹This change came *despite* the clause in the 1989 Constitution setting the number of local governments at 453 (see Gboyega, 1991).

Thus, one result of the 1976 reorganization is that all local governments throughout the nation have a common structure, powers and financing mode. That local governmental structure, powers, and finance are established at a national, rather than at a state, level again illustrates the centralized federal system within which they operate. The political structure has recently been changed from a weak executive system in which elected councilors appointed a member to act as the chairman of the council. The chairman is now elected by the whole electorate; he and the Secretary, a civil servant, appoint the members of the executive cabinet, and a clear separation is made between the cabinet and the council.

Local government responsibilities are grouped under two broad categories—those that are mandatory and which must be delivered by every local government and those for which they share responsibility concurrently with State or Federal or other quasi-government organizations. It is significant to note for the purposes of our study that the local governments are accorded the responsibility, under the new constitution, of formulating 'economic planning and development schemes' for their respective jurisdictions. This is one of the important innovations in the new constitution which will become fully operational from October 1992.

In addition, local governments share a joint responsibility with State governments for primary health care and primary education. Much more has been done within the last few years (since 1988) to fully transfer these services to local governments. One of the actions of the reform of the local government system in 1976 was to set up the local government as the third tier of government in the Nigerian federal system. Within the last fifteen years, local governments have become tangible entities in revenue sharing, development planning, governmental structure and the overall political system.

Today, a range of services are provided by the various agencies within the Nigerian public sector. Not all of these services are "public goods," and some public goods are provided by private or voluntary agencies. In addition, multilateral and bilateral donor agencies have also been very active in the fields of agriculture, health, education, economic management, and especially, population control.

IV. FISCAL AUTHORITY

The concept of local government as the third tier of the system has been in place since 1976, but local governments have been confronted with a significant number of federally imposed fiscal and administrative changes in recent years. The scope and frequency of these changes have introduced a high degree of administrative uncertainty within the local government sector that has disrupted or impaired local government performance. The unsettling aspects of these changes are illustrated by the federal government's decision in 1981/82 to double the number of LGAs, and the recently mandated shift in primary education and primary health care services to the LGAs.

The 1981/82 politically motivated increase in LGAs was particularly hard on the LGAs. First, the sudden expansion occurred just five short years after their establishment. Local governments, in essence, were still struggling with the three-tier government concept and their functions when the defined boundaries were abruptly altered. Second, irrespective of the accountability problems created with this sudden shift, the expanded demand for professionally trained local government civil servants placed an undue burden on an already thin civil service system. Put simply, there was not a sufficient number of professionally trained treasurers, planners and other administrative heads to staff these new LGAs properly. The folly of the decision was soon recognized, and in 1984 the newly created units were collapsed into the pre-1981/82 structure. The recent increase to 589 units again threatens stability and the capacity of local units to perform.

Administrative uncertainty pervades all aspects of local government organization and finance. The LGAs recognize that their boundaries may be redrawn at any time, with little or no local consultation. Such an administrative change occurred in Sokoto State in 1989 when the number of LGAs were expanded from 19 to 37. In the summer of 1991, both state and LGA boundaries were redrawn throughout the country. With respect to Federally mandated policies, there have been three important changes, two of which are the subject of this study. As discussed at length elsewhere, primary education and primary health care are to become local governments' responsibilities. Considerable confusion exists at the local level as to just how these functions will be financed and whether the additional revenues will be sufficient to cover existing salaries, let alone the cost of supplies and other operating expenses. Perhaps of equal importance to the LGAs is the new federal minimum wage policy and its extension to local government employees, including primary school teachers and health care workers. The new wage rate is more than 250% of the old rate. Every LGA

covered in this study claimed it would be impossible for them to implement such a wage policy, despite the recent increase in the Federal Account revenues.

In addition to these Federal mandates, the LGAs also must comply with a number of State-imposed directives. Their budgets, for example, must be prepared according to guidelines issued by the state governors. Limits are placed on the LGAs in terms of their personnel costs (30% of expenditure) and overhead costs (25%); they are required to set aside 10% of their revenues in a contingency fund, and no less than 20% of their total revenues must be transferred to a local Capital Development Fund.

Clearly, local government decision-making has been constrained by these policy actions. Yet, despite these externally imposed limitations, the local government sector's share of total government outlays has steadily increased since 1976. As depicted in Table 4.1, local government expenditures increased more than three-fold, rising from 2% of total outlays in 1976 to between 7% and 7.5% in 1988/89. Furthermore, the latter two years do not reflect the recent (1990) change in the intergovernmental transfer system. Thus, the 1988/89 figure may understate the 1991 percentage.

The principal explanation for this apparent anomaly is the significant rise in transfer payments from the Federation Account. Not all of the funds officially recorded as LGA expenditures, however, were budgeted and spent from their accounts. Some of the funds, for example, failed to reach the LGAs because state governments unilaterally deducted at source forced contributions for various projects and services. Local government finances and the historical development of the pivotal Federation Account allocation system are analyzed below.

Fiscal Federalism

The current structure of governmental finance can be traced to the Local Government Reforms initiated in 1976. In addition to the broad structural changes of that year which created a new unified local government system, the National government significantly altered its intergovernmental transfer system. The most important change in this regard was the dissolution of the Distributable Pool Account (DPA) and the establishment of the Federation Account.¹ The Federation Account is the basis for sharing national revenues among the three tiers of government--Federal, State and LGAs.

¹The DPA was formed in 1948 as a method of sharing nationally generated revenues between the Federal Government and the States. In the pooling arrangement, one-half of the revenues of the states and Federal government were allocated to a common pool account for redistribution to them through an intergovernmental formula.

Table 4.1

State and Local Government Expenditures as a
Percentage of Total Sector Expenditures
1976 to 1990

Year	Federal	State	Local
1976	57.3%	40.7%	2.0%
1977	63.8%	32.9%	3.3%
1978	64.2%	32.1%	3.7%
1979	57.5%	38.9%	3.6%
1980	62.0%	35.0%	2.2%
1981	47.2%	48.0%	4.7%
1982	51.5%	44.3%	4.2%
1983	49.1%	46.7%	4.2%
1984	59.0%	35.7%	5.3%
1985	64.8%	29.8%	5.4%
1986	71.1%	23.8%	5.1%
1987	66.1%	26.3%	7.5%
1988	66.5%	25.8%	7.6%
1989	70.8%	22.4%	6.8%
1990	n.a.	n.a.	n.a.

^a The figures for the years 1988 and 1989 are predicted on an assumed Federal Allocation to total LGA expenditure ratio of .86.

Source: Federal Republic of Nigeria, Central Bank of Nigeria, 1976 to 1991.

The bulk of all revenues in Nigeria flows into this shared pool from the following sources: import and export duties, excise taxes, mining rents and royalties, petroleum profits taxes, capital gains taxes, company income taxes, personal income taxes, sales or purchase taxes, and stamp duties. Under this structure, state governments are assigned jurisdiction over the following revenue sources: sales or purchase taxes (except on commodities so designated by the Federal Government), football pools and other betting taxes, entertainment taxes, estate duties, gift taxes, land taxes (other than agricultural land), land registration fees, capital gains tax, stamp duties, and personal income taxes. Similarly, LGAs have jurisdiction over the following revenue sources: property taxes, market and trading fees and licenses, motor park dues, canoe park dues, entertainment taxes, motor vehicle taxes, driver license fees, land registration fees, and license fees on television and radio stations.

Clearly, the lion's share of revenues flowed to the Federation Account. State and local governments required funding beyond their own revenue sources. The Federal government made the allocation decisions. In the initial year, 1976/77, the Federal government allocated N 100 million for the local governments' share of this Account, 25% based on equal shares and the remaining 75% according to population.

Over the period from 1976 to 1980 the local governments' share of the Federation Account grew in absolute terms from N 100 million to nearly N 300 million in 1980. However, from Table 4.2 we note that in relative terms their allocation averaged a mere 2.5% of the Federation total. States during this same period averaged approximately 27.8%, according to the available data. Since oil receipts make up 75% or more of all federally-collected revenues, the Federation Account's revenue pool is primarily determined by conditions in the international oil market. Thus, most of the observed year-to-year fluctuations in the allocations to local government reflect this fact. The observed sharp increase in 1981, however, was the product of both an improvement in the country's oil export revenues and an increase in local government's share of the Account to 10%. For the period from 1981 to 1986, which includes the years prior to SAP, allocations from the Account were essentially flat, averaging N 1,110 million per year. But cast in real terms, the average annual transfer was just N 312 million during this period, or only slightly more than the LGAs received in 1980. A fortuitous turn of events in the world crude oil market in 1987 resulted in a 74% increase in the Federation Account revenue pool from 1986 to 1987. Paralleling this increase, LGA transfers jumped from N 1,166.9 million in 1986 to N 2,117.8 million in 1987, or by 81%. Significant increases were also recorded in 1988 and 1989, with LGAs' transfers rising by 28.8% and 25%, respectively.

Table 4.2

**Statutory Allocations from the Federation
Account to the State and Local Governments
1976 to 1989**

Year	Total (Mil N)	State (Mil N)	State Percent	Local Govts	LGA Percent
1976/77	N 6765.9			N 100.0	1.48%
1977/78	8042.4			250.0	3.11%
1978/79	6815.2	1637.1	24.02%	150.0	2.20%
1979/80	11809.1	2541.8	22.52%	344.3	2.92%
1980	11859.8	4128.6	34.81%	278.0	2.34%
1981	14745.7	3825.6	25.94%	1085.0	7.36%
1982	10617.7	3245.7	30.57%	1018.7	9.59%
1983	10947.4	3239.8	29.59%	996.8	9.11%
1984	11738.5	2865.1	24.41%	1061.5	9.04%
1985	15041.8	3344.2	22.23%	1327.5	8.83%
1986	14189.9			1166.9	8.22%
1987	24692.2	6323.6	25.61%	2117.8	8.58%
1988	26770.3	8332.7	31.13%	2727.1	10.19%
1989	34675.8	11080.6	31.96%	3409.4	9.83%

^a The Federation Account is total federally collected revenues minus the federal government's independent revenues, i.e., personnel income taxes on the armed forces, the special capital territory tax, etc. In 1987, these funds amounted to 1.6% of total federally collected revenues.

^b State data not available separately prior to 1980.

Source: Federal Republic of Nigeria, Central Bank of Nigeria, 1976 to 1991.

In 1989, of the total federally-collected revenues, N 49,262 million was paid into the Federation Account. A policy decision was made by the Federal government that not all of the revenue transferred to the Federation Account would be distributed to the three tiers of government. A Gross Stabilization Fund (GSF) was established whereby oil receipts in excess of \$16.00 per barrel would be sterilized in this account. At the end of 1989, N 14,586.2 million, representing 29.6% of the Federation Account, was credited to the GSF, while as noted in Table 4.2, N 34,675.8 was distributed among the three tiers. Although data are not available, the policy was continued in 1990 and 1991 as well. Unpublished data obtained from the Office of President show that approximately 44% was withheld in 1990. It was unclear from our interviews with federal officials how the GSF is to be managed, and how it is to be used as a monetary or fiscal policy tool.

The Fiscal Sharing Arrangement

In response to growing political pressures and the expanded number of LGAs, a major revision was made in the inter-governmental transfer system in 1981. In Table 4.3, which highlights the four basic revisions in the transfer system, we see that the 1981 change altered the formula in two important ways. First, the percent reserved for the National government was reduced from 57% to 55%. Second, the "Special Fund" category was revised to address some observed inequities among the states stemming from the nation's largely mineral-based economy. The total percent earmarked for this "Special Fund" was raised to 4.5% and was to be distributed among the eligible states as follows:

- | | |
|---|------|
| • Derivation (Mineral Producing Areas) | 2% |
| • Ecological Problems (Mineral Producing Areas) | 1.5% |
| • Ecological Problems (General) | 1% |

In addition to these allocative changes, the 1981 Act also provided for the creation of a State-Local Government Joint Accounts (SLGJA) mechanism to distribute the LGA transfers. Under this system the monies were first directed to the states for distribution to the LGAs. These state-level Joint Account Committees, comprised of representatives from each LGA and the state, disbursed the funds in accordance with a jointly determined allocation formula. Further, under this Act, states were mandated to share 10% of their total revenues (Federal transfer payments plus own-source revenues) with the LGAs. Because state governments under this revenue definition were sharing a part of their own allotment from the Federation Account with the LGAs, the latter mandate was amended in 1985 to 10% of the state's own-source revenues.

Table 4.3

Allocation of Funds From The Federation Account

	1977-80	1981	1984	1990
Federal Government	57.0%	55.0%	55.0%	50.0%
State Governments	30.0%	30.5%	32.5%	30.0%
Local Governments	10.0%	10.0%	10.0%	15.0%
Special Fund	3.0%	4.5%	2.5%	5.0%
Total	100.0%	100.0%	100.0%	100.0%

Source: Federal Republic of Nigeria, 1989c

In 1984, the basic revenue sharing formula was again modified. The principal focus of this allocation *Decree* was to clarify the computation of the aforementioned Special Fund percent. The Decree stipulated that before allocating the funds among the tiers of government, 2% of the revenues derived from minerals extracted from mineral-producing areas should be paid directly to those states based on the value of their output. The net effect of this modification was to increase the percent received by the state governments by 2%, from 30.5% to 32.5%.

While the allocation formula, per se, remained unchanged from 1984 to 1989, the federal-state-local allocation mechanism was overhauled. More specifically, it was discovered that the pass-through mechanism of the SLGJA system was being perverted. State governments took the position that local governments were administratively and constitutionally responsible to the states. Thus, the states felt justified in unilaterally deducting the cost of some projects from the federal allocation to the LGAs. In many cases the deductions were questionable and amounted to a confiscation of the LGA's revenues. To correct such abuses, starting in 1988 local governments began to receive their payments directly from the regional Federal Pay Office. All of the local governments surveyed in this study indicated that the transfer of monies had greatly improved under the new system of payment.

Transfers are made on a timely basis and the federal officer is careful not to debit an LGA's account without their consent or proper documentation of the transaction.

As depicted in Table 4.3, the most recent restructuring of the intergovernment transfer occurred in 1990.² Following the *National Revenue Mobilization Allocation and Fiscal Commission Report's* (Federal Republic of Nigeria, 1989c) recommendations, the current government moved to bolster the transfer revenues flowing to the Local Government sector by increasing their share in the Federation Account from 10% to 15%. The 5% increase essentially came from reducing the Federal Government's percentage to 50% from 55%. The participation of the state government sector in the Federation Account is also affected by the revision; it declined from 32.5% to 30%. The offset to this reduction is an increase in the percentage going to the Special Fund from 2.5% to 5%.

The previously cited four-factor breakdown is expanded to five in the modified Special Fund. The individual components and their relative weights are as follows:

- Federal Capital Territory 1.0%
- Stabilization .5%
- Derivation (1% of Mineral Revenues) 1.0%
- Development of Oil & Mineral areas 1.5%
- General Ecology/environment 1.0%

Because the Constitution failed to include the Federal Capital Territory (FCT) as one of the States of the Federation, the new area did not receive an allocation from the Federation Account. To correct this oversight, it was decided to include the FCT as an item in the Special Fund and allocate 1% of the funds belonging to all tiers of government for the development of the territory. The other new category within the Special Fund is the .5% that is set aside for the establishment of a Stabilization Fund. Monies flowing into this account are to be used as a buffer against possible future economic disturbances. In essence, the Fund's purpose is to stabilize the budgetary operations of the various tiers of government, including the national government.

Horizontal Sharing of the Federation Account

Like the basic intergovernmental transfer allocation, the formula for distributing the statutory funds among the states has changed over time. During the period from 1976 to 1981, a simple two-factor formula was employed; 20% was distributed based on equality and 80% on population. In the

²In 1991, the Local Government Share of Federal Revenues was increased to 20%. Our discussion in the text is based on the 15% distribution in effect at the time of fieldwork.

1982 Decree, this simple, but yet very practical scheme was dropped in favor of a complex weighing arrangement. More specifically, an attempt was made to introduce the traditional concepts of performance and backwardness through the addition of "social development" and "internal revenue effort" as distribution weights. Although an attractive public policy innovation, it is not at all clear whether such refinements are possible given the lack of reliable statistical data. The selected sharing measures and their relative weights are detailed in Table 4.4.

Table 4.4

Sharing Measures and Relative Weights

Factors	1976	1982	1990
Population	80%	40%	40%
Equality	20%	40%	30%
Land mass	-	-	10%
Social development	-	15%	10%
Internal revenue effort	-	5%	10%
Total	100%	100%	100%

The first three factors, population, equality and land mass are readily understood; the last two items, however, require further discussion. As originally conceived, the Social Development factor was to be a multi-dimensional measure with access to potable water, the level of primary health services, and enrollment in primary education as the components. However, because no reliable data existed on water access and primary health services, primary school enrollment became a proxy variable by default. For similar reasons Internal Revenue Effort was measured in an indirect and convoluted way. Again for lack of an appropriate data base, funds were distributed on the basis of the ratio of total internal revenues to total recurrent expenditures. This is a poor indicator of revenue effort for two reasons. First, under the present system of local governmental finances, a state's current expenditures are not functionally related to its revenue base; they are, like the LGAs, heavily impacted by the federal government's budgetary policies. Second, in a similar way, the internal revenue component contains a number of revenue sources that are largely externally determined.

Hence, the resulting pattern of expenditures in reality bear little relationship to the real revenue effort of the states.

The foregoing formulation remained the prevailing method for distributing funds among the state governments from 1982-1989. As noted in Table 4.4, based on recommendations of the National Commission, the horizontal or interstate sharing formula was changed in 1990. The revised formula tends to de-emphasize population and school enrollment as weighing factors while stressing the importance of land area and internal revenue effort. More specifically, the new measures are: equality 40%, population 30%, primary school enrollment 10%, land area 10% and internal revenue effort 10%.

In addition to doubling the revenue effort percentage in the formula, the basis of calculation also was changed. The revised index uses as a proxy for revenue effort the incremental growth of internal revenues. The amount allocated is simply based on each state's percent of the total *incremental* growth in internal revenues of the states. A significant drawback to this particular index is that a disproportionate amount of the funds goes to the more developed states due to their economic size. Put differently, the proxy variable does not relate internally generated revenues to the individual states' revenue capacity. This constitutes a serious weakness in the current method, a weakness of which the commission is aware. Once again, this points to the difficulty of implementing an accepted concept for revenue sharing when the necessary data are either unavailable or unreliable.

Local Government Sharing

Turning to the Local Government sector, the Revenue Decree of 1982 specified that the local governments should follow the same basic horizontal sharing formula as that employed by the states. That is to say, local governments within a state were to receive an allocation from the Federation Account deposited to the State-Local Government Joint Account (SLGJA) of their state using the same factors and weights as the states. In practice this was not the case, as many states elected to develop their own allocation schemes. To illustrate, in the State of Oyo a formula which is heavily weighted by population has been the accepted standard for disbursement among the 42 LGAs for many years. In their formulation, population is awarded a weight of 80% and primary education enrollment and equality are each given a weight of 10%. In contrast, in the State of Plateau the LGAs elected to award 45% of the funds based on equality, 40% on population, 10% on primary school enrollment, and 5% on land mass.

The LGAs in the State of Anambra, on the other hand, settled on a position between Oyo and Plateau. According to their formulation, population is accorded a weight of 50%, equality 33%,

primary enrollment 10%, internal revenue effort 3%, reserve fund 2% and traditional rulers 2%. The illustrated variations in the allocation methods among LGAs have also been documented by others as well. In a survey of the then 19 states in 1982, I.B. Bello-Imam (1990: 95) reported finding only two states following the formula employed in sharing federal allocations to states. It should be pointed out, however, that state assemblies have the discretion under the 1979 and 1989 Constitutions to set their own allocations, and apparently they freely exercised that option.

Local Government Fiscal Relations

The clearest finding to emerge from the local government fiscal analysis is that LGAs are fiscally incapable of absorbing the primary responsibility for the major public services recently thrust upon them. The most visible example of this shift is the passing down to local governments of the functional responsibility for primary education. Under the new arrangement, LGAs are to pay the salaries of teaching and non-teaching staff in the primary schools. Supposedly, this previously nationally financed but state-administered function is to be financed out of the LGAs increased share from the Federation Account. In the Federal government's mind, an increase in the LGA's share from 10% to 15% is sufficient to cover this transfer of responsibility.

If the six LGAs of our study are representative examples, the selected financing mechanism is deficient in at least two respects. First, as noted in the previous section on local government sharing, the allocation formula used for distributing monies among the LGAs employs a multiple weighing scheme. Thus, for a particular LGA the amount which it receives from the incremental 5% share will vary, depending upon how the formula is applied within their state. More importantly, regardless of the amount, there is absolutely no relationship between this figure and the cost of providing primary educational services at the LGA level. Second, there is strong evidence that the incremental funds are insufficient to meet the responsibility. From the visited LGAs it is visually apparent that the vast majority of the primary schools buildings are in desperate need of repairs. Most of the LGAs are currently struggling just to cover their teachers' salaries, and virtually no funds are available for maintenance or repairs. Compounding the problem is the added requirement that the LGAs comply with the new federal minimum wage law. The LGAs interviewed estimated that compliance, or raising all local government employees, including the teachers, to the new rate, would increase their overall expenditures by 50% or more.

Put somewhat differently, the federal government's selected intergovernmental transfer mechanism is inappropriate for this function. The method of determining the total pool of funds to be distributed to LGAs for primary education is not meaningfully related to the total cost of providing

this critical service. Furthermore, the allocation method does not directly recognize the differences in the cost-of-provision of this service among LGAs within a state, nor among LGAs nationally. Finally, there is no recognition of current inequities in the provision of this service nationally.

To further worsen the financial plight of the LGAs, they are now required to fund primary health care services. Some assistance is being received from the Federal government and from international organizations such as UNICEF, but the added financial burden is heavy, and the LGAs must look to own-source revenues to fill the gap. As with primary education, there is no recognition of the existing inequities in this service and differences in the cost of provision in different areas.

Local Government Finance and Administration

A separate and equally important policy issue is the ability of the LGAs to administer properly these newly assigned functions. Does the professional expertise exist in the areas of planning, accounting, and budgeting to provide effectively these critical services?

Budget Planning

In the six LGAs visited, financial budgeting for all intents and purposes is not practiced. While annual budget forecasts are prepared and submitted to the state governments for their approval, the budget estimates are neither realistically constructed nor apparently taken seriously. They are simply regarded as a necessary step to obtain the Federation Account allocation. In many cases, the estimated budget for the year and the actual budget differed by 50% or more. We also found no instance where the forecast or estimated budget was used as a planning tool or monitored during the course of the fiscal year.

A more troublesome finding is that local government treasurers do not compile their budgetary information in a timely manner. Six months after the close of the 1990 fiscal year the LGAs visited found it difficult to furnish year-end data. After some effort, preliminary data were obtained on 1990 revenues but no detailed information existed on local expenditures. Here again, the system emphasizes budget forecasting, not fiscal management.

The poor state of fiscal planning may be traced to several factors. First, as noted below, the lion's share of a local government's revenues consists of transfer payments. With close to 95% of their revenues now coming from this source, there is little incentive for LGAs to seriously budget the remaining 5%. Second, the chief financial officers at the local government level, the treasurers, are frequently reassigned by the Department of Finance. This practice fosters instability and discourages longer-term innovations by these officers. Another contributing factor is the lack of skilled personnel in the supportive staff positions. We encountered on several occasions well-informed department

heads who were severely hampered in this regard. Given these factors, it is very doubtful that LGAs at this time have the capacity to plan effectively, budget, operate, and monitor complex projects or programs. Therefore, local fiscal management capacity will limit the ability of the LGAs to absorb new responsibilities.

Local Government Revenues

The heavy dependency of LGAs on transfer payments is clearly shown in Table 4.5. Transfers, as a percent of total revenues, have steadily increased since 1985, rising from 71.2% to 92.7% in 1990. From our extremely limited sample, it appears that rural LGAs have a greater dependency than do the urban jurisdictions. The rural LGAs averaged 85% in 1985 rising each year to 94.2% in 1990. The rural average for the entire six-year period was 89.8%.

Table 4.5
Transfer Payments As A Percent of Total Revenues
1985 to 1990

LGA	1985	1986	1987	1988	1989	1990
Atakunmosa	81.3%	68.6%	85.6%	89.6%	90.6%	93.6%
Barakin Ladi	72.9%	87.9%	92.6%	91.6%	93.1%	95.4%
Bodinga	91.7%	98.1%	96.2%	94.3%	93.3%	93.3%
Ibadan	44.3%	44.6%	66.2%	69.2%	80.0%	n.a.
Jos	42.3%	63.6%	77.7%	68.2%	78.8%	87.0%
Oji-River	94.8%	91.6%	93.4%	78.3%	93.9%	94.4%
Average	71.2%	75.7%	85.3%	81.9%	88.3%	92.7%
Rural Ave.	85.2%	86.6%	92.0%	88.5%	92.7%	94.2%

The LGA's of Atakunmosa, Barakin Ladi, Bodinga & Oji-River are considered rural communities. Ibadan and Jos are listed as urban areas.

Source: Data compiled during visits to LGAs

Own-source revenues contribute little to the overall resource base of the local governments, and from our survey, are not taken seriously. Before discussing the basis of this latter assessment, a brief overview of the sources of LGA internal revenues is in order. Referring to Tables 4.6 and 4.7 we

Table 4.6

Total Internal Revenues of Four Rural Local Government Authorities by Source
1980 to 1990

(N 1000s)

Item	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Internal Revenues	345.4	416.5	557.7	518.5	1064	1624.7	1041.5	1031.6	1638.07	1539.9	1609.3
Taxes	203	111.5	93.1	168.2	415.6	432.5	462.5	433.6	822.8	761.3	650.6
Tenement Rate	3.8	17	8.8	26.8	229.2	328.6	11.9	6.7	20.5	44.2	26.1
Licenses/Fees	71.2	228.3	339.6	243.6	187.4	192.8	423.9	441	355.1	351.9	255
Earn of LGA Ent	2	2.2	87.8	47	59	152.2	55.3	40	101.5	108.3	130.4
Rent LGA Propert	16.7	12.6	4.4	9.4	148.8	360.1	4.8	5.9	56.9	56.5	138.4
Interest & Divid.	0	14.3	0	0	11.1	127.3	65	18	101.47	143.3	333
Misc.	48.7	30.6	24	-23.5	12.9	31.2	18.1	86.4	179.8	74.4	75.8

Percentage Contribution of Internal Revenues by Source
1980 to 1990

Item	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Internal Revenues	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Taxes	58.77%	26.77%	16.69%	32.44%	39.06%	26.62%	44.41%	42.03%	50.23%	49.44%	40.43%
Tenement Rate	1.10%	7.08%	1.58%	5.17%	21.54%	20.23%	1.14%	.65%	1.25%	2.87%	1.62%
Licenses/Fees	20.61%	54.81%	60.89%	46.98%	17.61%	11.87%	40.70%	42.75%	21.68%	22.85%	15.85%
Earn. of LGA Ent	.58%	.53%	15.74%	9.06%	5.55%	9.37%	5.31%	3.88%	6.20%	7.03%	8.10%
Rent LGA Propert	4.83%	3.03%	.79%	1.81%	13.98%	22.16%	.46%	.57%	3.47%	3.67%	8.60%
Interest & Divid.	0.00%	3.43%	0.00%	0.00%	1.04%	7.84%	6.24%	1.74%	6.19%	9.31%	20.69%
Misc.	14.10%	7.35%	4.30%	4.53%	1.21%	1.92%	1.74%	8.38%	10.98%	4.83%	4.71%

Source: Compiled from Tables 4.8 through 4.11, Internal Revenues for Atakunmosa, Barakin Ladi, Bodinga, and Oji-River.

Table 4.7

Total Internal Revenues by Source for Six Surveyed Local Government Authorities
1980 to 1990

(N 1000s)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Internal Revenues	6114.3	7706.1	6219.6	8305.3	9200.2	12767.6	12578.3	4243.9	9410.57	8433.8	5018.9
Taxes	544.4	439	274.1	299.7	777.9	726.1	2127.1	902.3	1918.9	1808	1448.9
Tenement Rate	541	610.4	683.5	751.5	1090.7	1129.1	11.9	6.7	1355.2	1522	226.4
Licenses/Fees	3339.8	4852	3183.9	5032.9	4291.9	6628.2	9422.5	1403.3	2895.2	2728.5	1394.9
Earn of LGA Ent	1021.7	1192.7	1322.8	1393.7	1661	1656.2	55.3	40	957.1	1003.5	1118.5
Rent LGA Proper	16.7	308.8	331.8	305.6	688	360.1	4.8	5.9	970.5	274.2	141.7
Interest & Divid	385.9	15.7	2	4	17.1	1048.5	65	18	286.57	185.8	607.7
Misc.	264.8	287.5	421.5	517.9	673.6	1219.4	891.7	1867.7	1027.1	911.8	80.8

Percentage Contribution of Internal Revenues by Source

1980 to 1990

Item	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Internal Revenues	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Taxes	8.90%	5.70%	4.41%	3.61%	8.46%	5.69%	16.91%	21.26%	20.39%	21.44%	28.87%
Tenement Rate	8.85%	7.92%	10.99%	9.05%	11.86%	8.84%	0.09%	0.16%	14.40%	18.05%	4.51%
Licenses/Fees	54.62%	62.96%	51.19%	60.60%	46.65%	51.91%	74.91%	33.07%	30.77%	32.35%	27.79%
Earn of LGA Ent	16.71%	15.48%	21.27%	16.78%	18.05%	12.97%	0.44%	0.94%	10.17%	11.90%	22.29%
Rent LGA Proper	0.27%	4.01%	5.33%	3.68%	7.48%	2.82%	0.04%	0.14%	10.31%	3.25%	2.82%
Interest & Divid	6.31%	0.20%	0.03%	0.05%	0.19%	8.21%	0.52%	0.42%	3.05%	2.20%	12.11%
Misc.	4.33%	3.73%	6.78%	6.24%	7.32%	9.55%	7.09%	44.01%	10.91%	10.81%	1.61%

Source: Compiled from Tables 4.8 through 4.13, Internal Revenues for Atakunmosa, Barakin Ladi, Bodinga, and Oji-River.

see from the summary data compiled on the six LGAs that the rural LGAs derive more of their internal revenues from taxes than do their more urban counterparts. Tax receipts, which essentially come from a locally levied community tax, contributed 39% to the internal revenues of the four rural LGAs from 1986 to 1990, whereas the percent for the six units combined averaged not quite half that figure (22%). Revenues gained from licenses and fees are the second-most important sources of local government revenues and are derived from eighty-nine different types of charges, ranging from bicycle licenses to vault fees. Over the last five years receipts from this source accounted for approximately one-third of own-source income, but the contributory share has been steadily falling. For the six LGAs as a whole, the percent fell from a high of 75% in 1986 to 28% in 1990.

At the other end of the spectrum, it is apparent that "Tenement Rates," an important revenue source for local governments in many development countries, is insignificant as a local revenue. Again concentrating on the rural LGAs, in recent years this very simple form of property taxation has accounted for less than 2% of the total. The revenue potential for this revenue source would appear to be far in excess of the amounts now being collected by both classes of LGAs, rural and urban. This is particularly true for the more urbanized LGAs.

The low level of tenement rate collections is symptomatic of a fundamental problem confronting the LGAs--the overall poor revenue performance of the local governments. Again turning to Tables 4.6 and 4.7, and assuming the studied LGAs are representative of the sector, the data suggest that revenue yields have been highly erratic and decreasing in real terms. At the risk of over-simplifying an admittedly complex issue, local governments themselves must bear the major responsibility for this anemic performance. While admittedly forced to operate within a narrowly defined set of revenue options, the LGAs nevertheless failed to exercise fully the local discretion delegated to them.

Innumerable examples of this unwillingness to pursue statutory revenue sources were uncovered. To illustrate, in Bodinga, tenement rates have not been collected by that government since 1986, and nothing is projected from this source in 1991. When local officials in Atakunmosa were queried as to the reason for the almost three-fold increase in community tax revenues from 1986 to 1987, the response was, "an effort was made to collect the tax in 1987." When the effort was abandoned in 1988, tax receipts fell back to the 1986 level. As discussed earlier, this minimal tax effort attitude is also reinforced and encouraged by the current Federation Account distribution formula. The most recent figures on real per-capita transfer payments and internal revenue generation for the LGAs of Atakunmosa, Barakin Ladi, Bodinga, and Oji-River point to a reduction of revenue effort. In all four LGAs, local tax revenues fell in absolute terms following the substantial rise in transfer payments in

1988. Revenue effort is an allocative factor in the distribution of state funds, but currently plays no part in the allocation of funds to the local governments.

Besides exhibiting large year-to-year fluctuations, internal revenues have failed to keep pace in real per-capita terms. During the decade of eighties, the Nigerian economy experienced an average annual rate of growth of inflation of 19.5%, and the population grew by at least 2% per year. Based on these figures, a seven-fold increase in internal revenues is required just to offset the eroding effects of inflation and population. Using the data in Table 4.6, revenues are calculated to have increased 5.5 times between 1980 and 1990, or by about 80% of the required amount.

Thus, when cast in real per capita terms, the fiscal position of the four LGAs has deteriorated over the decade. Part of this decline, as touched upon above, is self-imposed, i.e., the result of poor fiscal administration. It is also possible that the LGAs are saddled with revenue sources that are income-insensitive or that lack buoyancy, increasing less than the overall rate of economic growth. This presents a long-term problem for the LGAs. The community tax, for example, is in reality a head tax and is therefore unaffected by economic activity per se. Many of the fees and charges are determined by the state or federal government, and the rates or levies are static. This issue clearly warrants further attention, especially in light of the move to place additional expenditure responsibilities at the local level.

Conclusions and Recommendations

Local governments have been whipped-sawed by a number of federally imposed fiscal and administrative changes. From this study of the effect of these changes upon four rural LGAs, the following three policy observations are offered. First, the LGAs are at present ill-equipped to absorb functional responsibility for primary education and primary health care services. The delivery systems associated with these two social programs are complex and demand administrative skills beyond those required for most local government services functions, i.e., rural road maintenance, markets, etc. Therefore, some extensive professional training and staff development is necessary if these crucial services are to be efficiently and effectively managed by the LGAs.

Second, irrespective of the aforementioned administrative problems, there is a fundamental problem with the way the education and health care functions are financed. In large part, the federally mandated services are financed from an increase in the LGAs' share of the Federation Account from 10% to 15%. The difficulty is that the basic formulas for allocating these funds are not sensitive to the cost of providing of these services. There is no recognition of current inequities, nor possible geographic differences in the cost of providing education and health care. The local mismatch

between financing and expenditure responsibilities is a pressing financial problem for many LGAs, and one which only can be addressed at the federal level.

Third, it is clear from the financial data that local tax effort is a serious problem. Local governments have come to depend upon the federal transfer payments to finance the lion's share of their expenditure responsibilities. Federal and state transfers in 1990 accounted for approximately 90% of their revenues and a noticeable decline has occurred in local government revenue effort since 1986. The limited evidence suggests that the federal government's policy of allocating funds irrespective of a community's revenue effort is discouraging rather than encouraging local government fiscal performance. If local fiscal performance is a priority of the federal government, then some modifications in the current intergovernmental system seem warranted.

V. DELIVERY OF PRIMARY EDUCATION IN RURAL AREAS

The provision of all levels of education in Nigeria was under direct mission control until 1898. Through 1942, the missionary system was the predominate form of primary education. In 1942, 97% of the students attended mission schools (Coleman, 1958: 113, cited in Enemuo, 1990: 95). The role of the colonial government was to set guidelines and award subsidies. Primary education was provided only by missionary or philanthropic organizations before the mid-1950s. They financed the schools either alone or in collaboration with the local communities or local governments.

In 1955, the Western Regional government introduced a universal primary education program; the Eastern Region government followed suit in 1957. Local governments played a major role in the finance and management of these schools. In 1957, for example, in local governments in the Western Region about 37% of the total expenditure went on education, while governments in the Eastern and Northern Regions spent 21% and 28% respectively (Olowu, 1989: 207). The Regional Government role was limited to providing financial grants to local governments, usually on a matching basis and maintaining a robust inspectorate system. The Federal Government had no responsibility for primary education whatsoever, except in the Federal Capital Territory of Lagos which it administered through the Lagos City Council. This represented a departure from indirect rule and helped to create genuinely local, self-governing institutions.

In the wake of the centralization trends and the oil boom of the late 1960s and 1970s, Regional Governments began to take over the management of primary schools from local governments. By 1970, all mission schools throughout the country had been taken over by relevant government authorities even though the schools continue to carry the name of their founding organizations to this day. Regional governments established Primary School Management Boards with local offices in the Local Government Areas.

In a dramatic move in 1976, the Federal Military Government (FMG) transferred primary education from the 'residual' list (i.e. not listed in the Constitution) to the concurrent list (i.e. shared responsibility) and launched an ambitious nation-wide program of universal primary education (UPE). There were already over six million students enrolled in primary schools during the 1975-76 school year, representing almost half of the primary school age population (see Table 5.1). The costs of providing primary education to all of the growing population of school age children would prove to be overwhelming. The structure of management adopted to meet this new challenge varied between

Table 5.1

Changes in Primary School Enrollment 1912-1990^a

	Pupils Enrolled Millions	% Change	Average Change	Gross Enrollment Rate	% Fed Recurr Expend Educ ^b
Preindependence					
1912 ^c	.022				
1929	.146				
1937	.165				
1947	.670				
1957	2.410		11.0%		
Low Growth					
1960	2.913			42% ^d	
1961	2.803	-3.8			
1963	2.896	3.3			
1964	2.849	-1.6			
1965	2.911	2.2			
1966	3.025	3.9	1.6%		
Rapid Growth					
1970	3.516			37%	
1971	3.894	10.8			
1973	4.747	10.9	10.5%		
Very Rapid Growth					
1975-76	6.2			47%	
1976-77	8.1	30.6%		59%	
1977-78	9.9	22.2%	26.4%	71%	
Rapid Growth					
1978-79	10.8	9.1%		75%	11.3%
1979-80	12.1	12.0%		83%	8.5
1980-81	13.8	14.0%	11.7%	91%	11.2
Moderate Growth					
1981-82	14.3	3.6%		92%	13.3
1982-83	14.7	2.8%	3.2%	92%	11.8

(Continued on next page)

Table 5.1 Continued

	Pupils Enrolled Millions	% Change	Average Change	Gross Enrollment Rate	% Fed Recurr Expend Educ ^b
Contraction					
1983-84	14.4	-2.0%		88%	10.5
1984-85	13.0	-9.7%		77%	9.7
1985-86	12.9	-0.8%		75%	6.3
1987	11.5	-10.9%	-5.0%	77% ^e	2.3
Rebuilding					
1988 ^f	12.7	10.4%			
1989	12.7	0.0%			
1990	13.6	7.1%	2.4%		

^a Data for enrollment 1975-1984 adopted from World Bank, 1988a and 1989c.

^b Olowu, Laleye, and Ayeni, 1990: Table 17.

^c Data on primary school enrollment from 1912 to 1976 obtained in Taiwo, 1989: 228.

^d 1960 and 1970 data from World Bank, 1988a: Table A-7.

^e World Development Report, World Bank, 1990, Washington, D.C.

^f Data for enrollment for 1984-85 to 1990 provided by Statistics Branch, Federal Ministry of Education.

the northern state governments, which continued to rely on local governments to run primary schools, and the southern states, which established management boards to run and manage primary schools.

The federal government provided full grants (both recurrent and capital) to finance UPE from 1976 to 1978, during which time school enrollment grew rapidly. The first oil shocks led the federal government to begin to demand that state governments shoulder some part of the responsibilities for UPE. In 1981, with the passage of the Revenue Allocation Act by the National Assembly, which reduced the proportion of the federal share of the Federation Account from 75% to 55%, the federal government announced that primary education was 'an exclusive responsibility' of the state and local governments. In reality, the constitution assigned the power of ensuring and maintaining minimum standards of primary education to the federal government while the task of the actual management of these schools was allocated to state and local governments.¹

The withdrawal of the federal government from financing UPE meant serious financial distress for primary education. Public expenditures for education (all levels) dropped dramatically between 1980 and 1983 from 4.7 billion to 2.7 billion (in 1983 constant dollars) (Gallagher and Ogbu, 1990). Estimated per pupil expenditures dropped from \$92 in 1970, to \$60 in 1974; \$48 in 1981; and \$55 in 1983 (all calculated in constant 1983 dollars) (World Bank, 1988a: Table A-17, p. 141). In several states during the early 1980s, in both the northern and southern parts of the country, primary school teachers' salaries remained unpaid for long periods of time (up to 7 or 8 months). This situation continued even after the military intervened again in 1984 and into the SAP era.² A number of recommendations on ways to improve the financing the UPE program were made both by the civilian and the successor military administrations between 1981 and 1985.

If the withdrawal of the federal government from UPE financing meant distress for the primary education system as a whole, SAP had the significant effect of forcing some parents to withdraw their children from school. Records of primary school enrollment showed a marked drop not only in pupil enrollment (see Table 5.1) but also in the number of schools. Two types of pressures help to explain this outcome. First, several state governments responded to the additional financial responsibility

¹ See the Federal Ministry of Education, 1981, *National Policy on Education*, section 3 for a statement of the role of the Federal Government in primary education.

² The effect of low investments in education is always difficult to measure directly. The International Association for the Evaluation of Educational Achievement in Stockholm included Nigeria and Swaziland in a large international study of mathematical aptitude during the 1981 school year. "Students in Nigeria and Swaziland answered just over half as many items correctly as students in Japan, the highest scoring country, and about 65% as many items correctly as students in the seventeen better-off countries." (World Bank, 1988a: 33)

thrust on them for primary education by the federal government by increasing school fees or raising development levies (flat rate taxes on all adults). For poor parents with several children in the primary school, the response was to withdraw some, if not all, of their children from school. In 1987, for example, the number of students enrolled in primary schools in the Oji River Local Government, fell by 50% as a result of the 50 naira per student fee that was implemented in Anambra State for one year. Secondly, in their bid to rationalize operations, state governments merged and closed down some primary schools. Teachers who were not fully qualified were retrenched, thus reducing the number of places available for pupils in the system.

Some aspects of the retrenchment in educational expenditures had been initiated prior to SAP and cannot be attributed fully to structural adjustment policies. During the late 1970s, the proportion of government expenditures allocated to education varied widely around 10%. In the period of 1980 to 1985 prior to SAP, the proportion of government expenditures allocated to education varied somewhat around 8%. In 1986, the percentage fell to 5%, and in 1987, the first year in which SAP would have been felt, the percentage fell to 2.8%. This probably reflects the fact that repayment of debt absorbed an increasingly large proportion of government spending. If one looks at spending on education in real 1980 dollars, the trend is similar. Spending ranged from \$.5 billion to \$3.5 billion in the era from 1975 to 1979--an era in which considerable investment was made in the construction of higher level educational facilities. In the period from 1980 to 1985, the average expenditures in constant dollars is closer to \$ 1 billion. During 1986, the total spending was \$848 million and in 1987 the total spending was \$680 million dollars (Gallagher and Ogbu, 1990: A.II.3 and A.II.5). A similar trend is observed if one focuses on the expenditures on education as a proportion of GDP. In the late 1970s, the proportion of GDP spent on education fell below 1.8% in only one year (1978) and exceeded 3% in 1975 and 1976. In the period from 1980 to 1985, it declined to about 1%. In 1986 and 1987 it fell to .9 and .7 respectively (ibid.: A.II.4). All three indicators thus show a similar trend. Some retrenchment had already taken place prior to SAP, but the major cutbacks in the support of primary education came immediately after SAP was initiated.

Data made available to us by the Ministry of Education (see Table 5.2) illustrates the high level of drop outs between Primary Grade 1 and Primary Grade 6. Many students have only one or two years of schooling and thus acquire few literacy and numeracy skills.

Table 5.2

Students Passing Out and
Entering Primary Schools in Nigeria

	Students Passing Out of Primary VI	Students Entering Primary I Six Years Prior	Percentage of Students Passing Out of Primary 6
1985	1,698,609	2,713,988	62.6%
1986	1,721,481	2,971,696	57.9%
1987	1,433,537	2,966,542	48.3%
1988	1,494,873	3,013,041	49.6%
1989	1,513,460	2,859,288	52.9%
1990	1,606,299	2,730,281	58.8%

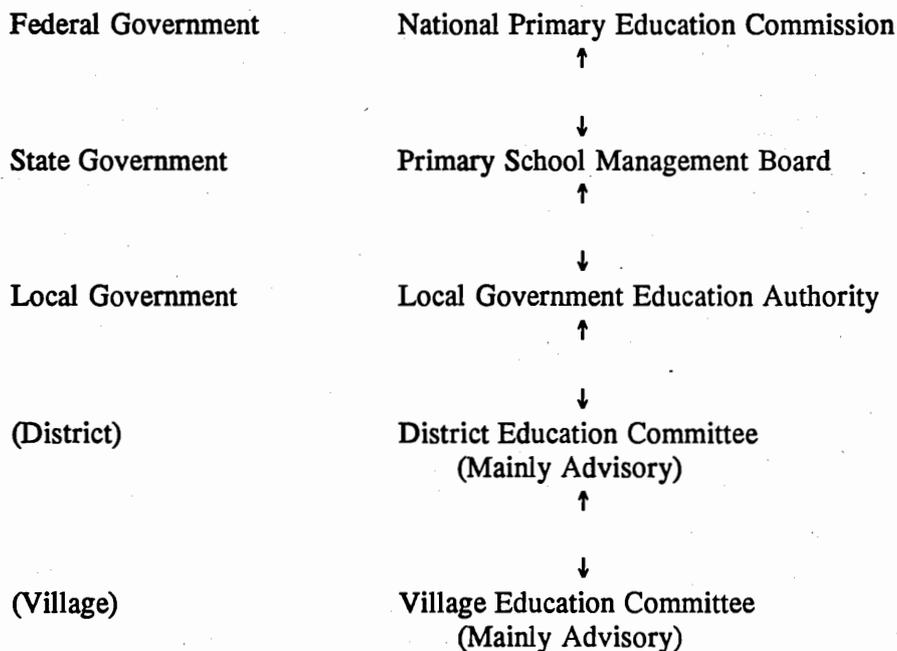
Source: Statistics Branch, Planning, Research and Statistics Department, Federal Ministry of Education, Victoria Island, Lagos, June, 1991.

Partly as a response to these problems in the system and the accusations that the administration was destroying the country's educational system, and partly in reaction to the recommendations of a series of study groups on primary education, the federal government announced a new plan for funding primary education in 1988. Primary education became an intergovernmental activity both in terms of funding and management. The federal government paid 65% of teachers' salaries while the states and local governments were responsible for the balance of 35%. The policy statement (codified into Decree No. 31 of 1988) was silent on other costs (capital and recurrent) but it was presumed that state and local governments would continue to be responsible.

According to this decree, the management of primary schools was coordinated nationally by the National Primary Education Commission (NPEC), an independent federal government agency which administered the funds contributed by all three levels of government for the financing of primary schools in the country. At the state level, a Primary School Management Board (PSMB) was responsible for managing the primary schools in each state and providing all personnel management function for all officers in the system, except that it could delegate this function to the Local Government Education Authority (LGEA) for junior level officers (06 and below). The LGEA was

based at the local government level and was to be responsible for actual day-to-day operations of the primary schools including payment of teachers' salaries, maintenance of school buildings etc. There were also to be District and Village Education Committees. The decree thus envisaged five layers of institutions from the national level down to the village as follows:

Level of Government



By all accounts this new system operated fairly well during 1989 and 1990. Its major problems included: the multiplicity of institutions and officials, the failure of some state governments to pay their own contribution to the National Primary Education Fund, and the refusal of these states to contribute any funds for primary education.

In January 1991, the federal government, in a sudden turn-around, announced the abrogation of the NPEC and stated that local governments were now to be fully responsible for the financing and management of primary education. This decision was rationalized by giving the additional 5% of the Federation Account allocation to the local governments earlier in 1990.

Decree No. 3 of 1991 which provides the legal backing for this new policy stipulates that each local government is to have a separate body, the Local Government Education Authority (LGEA), which shall be managed by a Local Government Education Committee comprising:

- a) the Chairman of the Local Government Council as chairman of the Education Committee;
- b) the Councillor for Education;

- c) one representative of the Inspectorate of Education in the State;
- d) one representative of the recognized Teachers' Union in the Local Government Area;
- e) one representative of women in the Local Government Area;
- f) two representatives of District Heads in the Local Government Area;
- g) two representatives of Religious Organizations in the Local Government Area;
- h) one representative of Parent Teachers' Association in the Local Government Area; and
- i) the Secretary to the Authority.

The decree is silent on the role of the State government but it is presumed that the Commissioner for Education will continue to exercise some supervising role over local governments in the discharge of the latter's responsibilities.

The responsibilities of the LGEA, according to the Decree, include the following:

- a) posting and deployment of teachers, including inter-local government area transfer;
- b) disbursement of funds provided to it from the Local Government sources;
- c) setting up effective and functional supervisory units;
- d) supervision of all other units set up under its jurisdiction;
- e) providing guidelines on the establishment of new schools and new capital projects;
- f) retirement and re-absorption of teachers;
- g) responsibility for the approval of schemes for the training and retraining of teaching and non-teaching staff;
- h) assessment and provision of salaries and allowances of teaching and non-teaching staff based on the scheme of service drawn up by the Local Government Area;
- i) ensuring that annual reports are rendered by Heads of Schools on teachers appointed to serve under them.

The debate about this sudden turnabout continues. The National Union of Teachers (NUT) had not been consulted about the proposed change, and its representatives were highly critical. Some states (such as Oyo State) immediately found mechanisms to insure that the payment of school teachers continued without interruptions. Other states did not take such corrective action and teachers in eight of Rivers State local governments went on strike, as did the teachers of the Enugu local government in Anambra State (*Citizen*, May 27, 1991: 24).

In Ibadan, we visited the State Education Management Board and talked with the staff, who were completely uncertain about their own future. They had just been told that the accounts from which

they were being paid had been frozen and thus did not know whether they would continue being paid or not.

The reaction of the Commissioner of Education in Anambra and the Primary Schools Management Board, with the blessing of the military governor, to the January 1990 directives was to create a new education agency, the Anambra State Specialized Education Agency (ASSEDA), to supervise primary education plus adult education, nomadic education, education for the handicapped, and technical colleges. The personnel and assets of the PSMB were transferred to the state, which transferred them intact to the new agency. The agency is financed solely by the state. The four new responsibilities are financed by appropriations in the state budget. Until January 1991 primary education in the state had been financed through Anambra state and the LGAs' decision to allocate 50% of the LGAs' share of the Federation Account to the PSMB to manage primary education and pay teachers. In 1991 teachers' salaries were paid directly to the LGAs, and payment delays were feared. The PSMB programs for primary education had been cut by about 30%, but were funded by savings that the PSMB had accumulated. In effect, the state was providing no funding for primary education from its 1991 budget. The new agency submitted a proposal to the state in July for a new revenue-sharing formula that would fund primary education under the direction of the new agency. The Director believed that during the PSMB's two years, all three levels of government, particularly the LGAs, had paid more attention to solving the problems of primary education than at any time in her career.



VI. DELIVERY OF HEALTH CARE SERVICES IN RURAL AREAS

In Nigeria, government delivery of health care services is constitutionally a concurrent responsibility, that is, Federal, state and local governments all have responsibilities for delivering health care services. The system until 1988 was essentially curative. Since 1988, the government has been reorganizing its health services to allocate proportionately more resources to preventive and primary health care, to shift the responsibility for primary health care to the LGAs, to integrate donor initiatives into the overall system of service delivery, and to increase user fees and community preventive health care efforts.

Nigerian governments have recognized the logic of re-allocating health resources towards preventive care for a long time, but have found it difficult to implement policies that direct resources away from curative care. Although the majority of deaths resulted from preventable diseases, and even though the successive National Development Plan documents, especially the Third National Development Plan (1975-1979), emphasized the need for preventive health services, actual expenditures by governments went to capital-intensive programs oriented to curative care.

In 1976, the Federal government introduced an ambitious Basic Health Services Scheme (BHSS). Intended to be a separate preventive health care system which incorporated a referral system between health care institutions from the community to the topmost hospitals, it was not fully implemented. Most of the planning for the scheme was undertaken at the federal level. State and local governments were involved only minimally in implementation, in spite of the 1976 reorganization of local government and the increased responsibilities of local government under the 1979 constitution. The BHSS scheme was finally abandoned, without having produced many positive results. The health facilities that were built were transferred first to state governments and then, under the current Primary Health Care (PHC) program, have been transferred to the LGAs since 1988.

The training facilities, the Schools of Health Technology, created under BHSS initiative, however, continued to operate. They are slowly producing a pool of community health workers with a primary health care orientation; the personnel are now mainly working in LGA facilities that provide a mix of curative and preventive care.

At the beginning of the 1980s, health service delivery in rural areas had not improved significantly, in spite of the oil wealth. The Fourth Development Plan (1981-85), drawing heavily on a 1980 ILO report on the basic needs of Nigerians, characterized the major weaknesses of the Nigerian health system as follows:

- a) The bias of the health system was still toward curative, hospital-based programs;
- b) The investment in hospital facilities and equipment was still biased towards urban centers where only about 30% of the population lived;
- c) Health personnel tended to concentrate in the urban areas (48% of total doctors were in Lagos metropolitan area) and increasingly in the private, rather than the public sector;
- d) An estimated 35% of the population had no access to any form of modern health care services.
- e) Communicable diseases continued to be the major causes of morbidity and mortality in the country (World Bank, 1990a).

The financial crises of the mid-1980s quickly brought government health care services in rural areas to a virtual halt. Without transport or drugs, state ministries of health could not supervise or provide inputs to rural health facilities. Utilization dropped in response to the lower quality of available care, and dropped still further when fees were imposed in late 1984.

In 1986, the Federal Military Government began the current effort to reorient the government health care system to put primary health care at the forefront of its delivery system. The policy discussions and pilot projects did not directly affect local-level health care, but the government and the donors began to agree on overall directions. The Health Minister, Professor Ransome-Kuti, has been a strong and consistent advocate of the primary health care approach, and should personally be credited for the unwavering policy emphasis in recent years. Health department staff at state and LGA levels are certainly aware of this emphasis, as our interviews confirmed.

The government's major statement came in 1988 with the publication of the comprehensive National Health Policy document, "Health for All by 2000 A.D." The cornerstone of the new health policy is primary health care, which is the responsibility of local government. Generally, the Federal Ministry of Health (FMOH) is responsible for setting national health policies, training medical doctors, provision and maintenance of tertiary (i.e. specialized) curative health services, and control of communicable diseases. Supervision of primary health care in both states and LGAs was assigned to four new regional PHC zones staffed by the FMOH. The State Ministries of Health provide secondary and nonspecialized curative tertiary health facilities, and training for nurses, midwives, and auxiliary personnel. They also assist and supervise local governments in managing their network of primary health facilities. Most State Health Management Boards have been dissolved and their erstwhile responsibilities for operating the primary health care system have been passed on to local governments.

In effect, preventive health care now has been coupled with curative care in the Primary Health Care program. The ten PHC activities are:

- public education on prevailing health problems
- promotion of food supply and proper nutrition
- adequate safe water and basic sanitation
- maternal and child health care, including family planning
- immunization
- prevention and control of locally endemic and epidemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs and supplies
- elderly and handicapped care
- accident and injury care (Federal Ministry of Health, 1988a)

In 1986, the FMOH chose 52 LGAs as "model LGAs" to take over PHC activities from the states. The FMOH policy has been to encourage LGAs to take up their new PHC responsibilities by giving one-time grants to the LGAs as they demonstrated their preparedness for PHC activities. The preliminary steps that an LGA must complete to become a "model LGA" and qualify for the grant are:

- after receiving state approval to apply for "model LGA" status, the LGA must appoint a PHC Coordinator.
- the LGA must perform an epidemiological survey to provide base-line data and to set health care priorities. It must also assess the adequacy of its staff and physical plant.
- the PHC Coordinator and outside consultants analyze the data collected. This is also a training exercise for the PHC Coordinator.
- again with some outside help, the PHC coordinator develops a project plan for the LGA based on the analysis of the base-line data. In many communities the activities that the FMOH policy statement designated as PHC activities were being provided primarily by NGOs, but with some overlap with government or other NGOs. The PHC implementation plans have sought to coordinate the existing services provided by NGOs.

After these preliminary steps have been taken, the LGA receives its grant. Virtually all LGAs in Nigeria have either become or are in the process of becoming "model LGAs." Those that have completed the process, but have not received the grant are called "willing LGAs." The FMOH is under pressure from donors to adjust the original N 500,000 grant for inflation. All four of the local governments that we selected for study were participating in the "model LGA" program. Part of the reason for our selection was that we hoped that more relevant data about the delivery of primary health care in rural areas would be available in these sites. In fact, the only LGA where the full series of reports was obtainable was the one "willing LGA," indicating, among other things, that the information gathered for the application process is not being used in the LGAs' management of their PHC programs.

The FMOH has also put uneven pressure on states to relinquish their PHC staff and facilities to the LGAs. In 1988, the FMOH directed the states to complete the transfer in 1990; in June 1990, the states were directed not to unduly burden the LGAs. As we saw, states have handled the transfer in different ways, but in all the LGAs operating decisions are now being made by staffs located in the LGA headquarters and reporting to the LGA chairman. Some of the staff were still being paid by the states, and those in salary grades seven and above came under the management of the Local Civil Service Commission. If the continuing supervisory responsibilities of the state and federal health ministries are taken into account, PHC staffs in LGAs, and LGA chairmen, are faced with unclear lines of command. As we saw in one LGA, the LGA staff do not have the authority to assign personnel to rural posts and expect the assignments to be implemented. Responsibility and fiscal reality are not clearly aligned; the multitude of recent changes and exceptional financing for LGAs have obscured the fact that rural LGAs have probably been given more responsibility than increases from central revenues and user fees will cover. Unlike the arrangement for paying teachers' salaries, the LGA share of the Federation Account was not debited or manipulated by the Federal Pay Officer to guarantee funding for health activities.

A series of programs targeting specific aspects of health care has provided some incremental funding. The most important grant is for "model LGAs." Other programs are the drug revolving funds (DRFs). The Federal government provided the initial capital to set these up in teaching hospitals in 1986, and then extended its grants to states and LGAs in 1988. Each LGA received N100,000 (about \$13,000). In 1990, the FMOH made grants-in-kind of cartons of mixed essential drugs to all LGAs. A USAID program supporting primary health care will provide two years of exceptional funding to LGAs. The states also continue to provide financial support for PHC staff

salaries. LGAs thus receive funds for health services from four sources: the Federation Account, the state budget, their own revenues, and external donors.

A new incentive for LGAs to provide PHC satisfactorily is the new Federal program to upgrade LGA facilities to include a first referral hospital. The FMOH, having asked the states to recommend eight of their LGAs as outstanding PHC providers, has chosen 3 to 5 in each state for upgrading. The state will receive N 25 million against the capital costs of upgrading facilities. The FMOH believes that the demonstration effect and community interest will spur LGAs into increasing their delivery of PHC services in order to qualify for upgrading (FMOH interview). On the strength of our visits to some of the original "model LGAs," this seems misguided on two counts. First, to award a curative facility for PHC performance sends a mixed message, particularly when it will add significantly to the recurrent costs of hard-pressed rural LGAs. A more appropriate reward would be vehicles, which would help both supervision and community education, and basic equipment, e.g. scales, whose shortages slow down preventative efforts. Second, the LGAs that were selected by the states to be the original 1986 "model LGAs" got their grants, but struck us as being perhaps less good at management, data collection, and planning than the "willing LGA." If some LGAs are to be rewarded in some fashion, it ought to be against some objective standard that is appropriate for the area, preferably some measure of on-the-ground PHC service delivery, or improvement in reporting systems, rather than an assessment by state and federal officials. There may be more of a "demonstration effect" if LGAs compete on equal, measurable terms than if some are simply chosen.

There have been a number of other initiatives in the health sector during this period. One major initiative of the federal government, post-SAP, is the publication of a national policy on population in 1989. Specific responsibilities are assigned to each level of government for ensuring that the population growth rate is reduced to 2% (currently 3.5%) by the year 2000. This initiative is supported by a number of external agencies and Private Voluntary Organizations (PVO). Another important initiative is the program to develop health planning capacity at all levels of government. This program is headed by the Federal Department of National Health Planning, Research and Statistics and assisted by the World Bank. Another initiative, supported by the World Bank and the World Health Organization (WHO), is the Essential Drugs Program (EDP) to ensure that essential drugs are available at all levels of the health care system.

Family planning, immunization, CCCD (Combatting Contagious Childhood Diseases) and programs for specific diseases are receiving funds from both the Federal government and donors.

Since SAP began, the FMOH has coordinated more closely with international donors and the secular NGOs.

It is important to remember that only in the north is government-provided health care the dominant mode in rural areas. USAID estimated that only 20% of utilized care was provided by government services (USAID, 1989: 13). For-profit private medical care is primarily located in urban areas (32% of Nigerians live in communities of more than 50,000) (ibid.). In rural areas of the middle belt and south, PVOs provide approximately 50% of health care. Most are church-affiliated and operate entirely independently of the government system (ibid.: 46). Traditional healers, and particularly traditional birth attendants, are an important source of health care in rural areas, and their willingness to take payment in kind is an attraction in hard times. An important informal source of health care used to be the thousands of licensed drug hawkers. Because of price-gouging and the extent of sales of expired and counterfeit drugs in the mid-1980s, licenses for drug hawkers were revoked. Other than at health facilities drugs can now only be bought at licensed drugstores, mostly located in towns. This change adds to rural inhabitants' private costs.

A health sector assessment was conducted for USAID/Nigeria in 1991 which confirms the extremely low level of health care that we observed in our field visits. In a background paper on health sector management, Richard Morrow and his colleagues at Johns Hopkins University (1991) conclude:

Without question the general quality of medical services rendered by the public sector, and quite possibly by the private sector as well, are totally inadequate...

The implication is that posts are staffed with health care workers who have nothing to provide. Hence there is little point in attending; the resulting underutilization is clearly indicated by the fact that many facilities (in Ogun State) operate at less than 600 visits per health worker per year (Morrow et al., 1991: 17).

VII. RESOURCE MOBILIZATION, HEALTH, AND EDUCATION IN FOUR LOCALITIES

A. Localities in Oyo State

1. Local Government in Oyo State¹

Oyo State was created in 1976 at the time that the former Western State was divided into Oyo, Ogun, and Ondo States. With its many large urban centers--Ibadan (the state capital), Ikire, Iwo, Ogbomoso, Ile-Ife, Osogbo, and Oyo--the state is among the most densely populated areas in Nigeria. The population in 1963 was 5,208,944 and is estimated to be over 11 million in 1990, most of whom are Yoruba-speaking people. While there is considerable linguistic homogeneity (countered in part by the presence of many dialects) in Oyo State, considerable cultural and religious heterogeneity exists among different communities within the State. The two dominant religions are Christianity and Islam. Most of the Christians are Protestants, although there are clusters of Catholics. The Atakunmosa Local Government is located near the large urban center of Ilesha. The rural village within the Atakunmosa LGA selected for study--Itagunmodi--is located about a 40-minute drive, partially along a steep dirt road, from Osu, where the headquarters of the LGA is located.

2. Atakunmosa

a. Local Government and Its Setting

The history of Atakunmosa Local Government is related to that of Ilesha, its neighboring urban center. British colonial administrators arrived in Ilesha-land during the late 1930s. The administrative machinery of the region was moved down to Oyo Alafin in the early 1940s. Under the regional governments created in 1954, Ilesha-land was one of three local administrative authorities (Onade, Obokun, and Ilesha). In 1958, the District Council system was introduced in the former Western region and three district councils were created for the territory surrounding Ilesha. The present Atakunmosa would have comprised a major portion of the Ilesha Southern District Council. With the local government reforms of 1976, the Atakunmosa local government was carved out of the Ilesha Southern District Council, and the former Ilesha Urban District Council became the Ilesha Local Government.

¹After completion of our fieldwork and the initial drafting of our report, Oyo State was further divided into two. The LGA selected for study, Atakunmosa, ended up in Osun State. Given the lack of available data, we have not attempted to change the information in this report about state and LGA boundaries and relationships. What is written here is accurate as of the time of our fieldwork in June and July 1991.

The boundaries remained the same until 1982 when Atakunmosa was fragmented into three units: Atakunmosa West with its headquarters in Osu, Atakunmosa Central with headquarters in Iwara, and Atakunmosa East with headquarters in Iperindo. With the coming of the Buhari/Idiagbon military regime in 1984, all of the local governments created by the civilian administration were dissolved and local governments reverted to their 1976 boundaries.² An area in the south-eastern part of the LGA, bordering on Ifesowapo in neighboring Ondo State, is under dispute as a result of the changes in LGA boundaries that occurred in 1989. The LGA is bounded on the North by Obokun and Osogbo local governments, in the south by Ifesowapo local government in Ondo State, in the east by Ilesha and Obokun local government and in the west by Oranmiyan and Ede local governments.

It is one of the 24 Local Government Councils established prior to the expansion of LGAs to 42 in the state in 1989. Much of the economy of the region served by Osu is centered on Ilesha. The LGA has a large terrain of 870.5 km. The estimated 1990 population is 319,425 (based on a 3.5% projection of the 1963 census). Extrapolating from the 1963 data, the LGA officials assume that the population is distributed according to the following age groups:

0 - 4 years	44,190
5 - 14 years	80,050
15 - 44 years	158,055
45 & above	36,123

Within the LGA are located 14 wards that have over 5000 inhabitants and 112 smaller towns and villages with less than 5000 population. The local government headquarters is located in Osu, midway between Ile-Ife and Ilesha.

The region served by Atakunmosa is one of moderate hills and valleys with tropical forest cover and without significant rivers to serve as the basis for a local water supply. As of 1988, only Osu and Ibodi were served with electricity, and only Ifewara had pipe borne water. Several bore holes have recently been constructed in the area with varying degrees of success. While there are a few good roads through the area, most of the feeder, dirt roads are not in good condition. The transport of goods and local service delivery is very difficult. Transportation in these areas is thus more reliable during the dry season than during the wet season. Nor are there adequate communication services to the area. In 1988 there were no phones, telexes, post offices, nor radio-call systems in the

²Interview with Prince Buraimoh Adeyeye Adewusi by Dr. Dele Ayo, June 14, 1991.

area. At the time of our fieldwork, some telephones were beginning to appear. The newly elected chairman of the Atakunmosa Local Government, for example, carries a radio phone with him so it is now possible to contact him by phone at any hour of the day or night.

The main economic activities of the area are farming, trading, and local weaving. Cocoa, kolanut, palm products and cassava, yam, plantain, banana, and vegetables are grown. Osu is noted for its preparation of akara (bean fritters). There is a gold deposit in the area which may commercially exploitable.

b. Resource Mobilization in Atakunmosa LGA

Similar to other LGAs surveyed, Atakunmosa relies heavily upon the Federation Account for its revenues. Moreover, its dependency on federal transfer payments has increased over the years as transfers have risen from 72% of their revenues in 1980 to 94% in 1990. The State of Oyo has provided a portion of these funds recently, but the allocated amount is small and has not conformed with the statutory requirements of the Federation Account.

The community tax, which is an annual tax of N 20 per able-bodied person, is the only significant local tax. This seemingly stable form of taxation has been anything but stable, exhibiting sharp year-to-year changes. From our inquires, the observed wide fluctuations are the result of an inconsistent administration of the tax. An estimate of the potential revenue from this tax source, or conversely, the degree of under-collection, is suggested by the 1986 figure. According to local officials, an earnest effort was made to collect the tax in that year, and as shown in Table 7.1 tax receipts jumped from N 71,000 the previous year to N 184,200 in 1986 (see also Table 7.2 for Ibadan).

The other local tax source, the tenement rate, is for the most part not collected. From a visual inspection of the community, there is no economic reason for the extremely poor performance. A large number of ratable buildings was observed just within a few kilometers of the town hall. Monies raised from licenses, fees and charges are Atakunmosa's most productive internal revenues. In 1990, 42% of their own-source revenues was generated in this way. Again, from the data, it seems that poor administration is robbing the LGA of appreciable monies. While it is not possible to measure the potential yield from this source, in 1989 the yield from this tax was 30% greater than in 1990.

Although it is hazardous to assert any type of cause-and-effect relationship based on just three observations, the noticeable decline in revenue effort does coincide with the rise in transfer payments. There is sufficient evidence to cause one to question the wisdom of allocating funds irrespective of a community's revenue effort.

Table 7.1

Atakunmosa
Local Government Revenues and Expenditures: 1980 to 1990
(N 1000s)

	1980	1981	1982	1983	1981	1985	1986	1987	1988	1989	1990
Transfers	388.2	398.4	565.5	699	833.6	714.3	702.3	1456.8	2586.9	3410.8	5356.1
Federal	388.2	398.4	565.5	699	833.6	714.3	702.3	1456.8	2384.2	3204.5	5302
State									202.7	206.3	54.1
Internal Revenues	154.3	103.9	71	177	158.5	164.1	321.1	245.8	298.5	354	366.6
Taxes	114.5	66.1	56.7	122	80	71	184.2	87.4	82.6	83.4	76.9
Tenement Rate	1.2	0	0	2.2	0	0	1.5	0.4	0.3	1.1	0.7
Licenses/Fees	22.5	35.1	14.3	47.2	23.8	34.8	100.6	107.2	116.6	178.5	125.4
Earn of LGA Ente	1.8	2.2	0	5.6	14.2	51.9	26.1	9.7	8.1	2.1	9.2
Rent LGA Propert	9.8	0	0	0	16.5	0	1.2	1.1	1.6	1.7	2
Interest & Divid	0	0	0	0	11.1	0	6.4	18	67	67.6	147.1
Misc.	4.5	0.5	0	0	12.9	6.4	1.1	22	22.3	19.6	5.3
Capital Invest				30							
Total Revenues	542.5	502.3	636.5	906	992.1	878.4	1023.4	1702.6	2885.4	3764.8	5722.7
Total Expenditure	544.8	474.6	655.4	914.3	1104.5	882.5	890.9	1534.8	2598.8	4479.9	5335
Recurrent	485.3	457	640.2	816.2	982	741.5	756.3	1170.4	148.8	1633.9	2387.3
Capital	59.5	17.6	15.2	98.1	122.5	141	134.6	364.4	1115.9	2846	2947.7
Surplus/Deficit	-2.3	27.7	-18.9	-8.3	-112.4	-4.1	132.5	167.8	286.6	-715.1	387.7
CPI (Rural)	2.03	2.452	2.645	3.268	4.554	4.823	5.049	5.588	5.556	10.945	12.039
Population Est	260.7	268.5	276.6	284.9	293.5	302.3	311.3	320.7	330.3	340.2	350.4

(Continued on next page)

Table 7.1 Continued

Health and Education Expenditures: Selected Years

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Health & S.W.	37.1	67.7			290.2	273	260.7	325.1	402.6	448.6	797.9
Recurrent								314.1			609.4
Capital								12			188.4
Education	185.6	3.3			0	4.9	3.6	2.7	3658.1	4137.2	4916.5
Recurrent						0			5.1	22.7	16.2
Capital									0	293	440.3
Teachers Sal.									3360	3674.2	4900.3
Tot £ Pupils								28196	24407	23997	25727
Real Per Capita Revenue and Expenditure Measures											
Real PC Transfers	0.73	0.61	0.77	0.75	0.62	0.49	0.45	0.81	1.41	0.92	1.27
Real PC Inter-Rev	0.29	0.16	0.10	0.19	0.12	0.11	0.20	0.14	0.16	0.10	0.09
Real PC Tot Rev	1.03	0.72	0.90	0.98	0.83	0.61	0.57	0.86	1.42	1.20	1.26
Real PC Tot Exp.	1.03	0.72	0.90	0.98	0.83	0.61	0.57	0.86	1.42	1.20	1.26
Real Per-Pupil Ex									26.98	15.75	15.87

Source: Unpublished data obtained from local government accounts.

Table 7.2

Ibadan
Local Government Revenues and Expenditures: 1980 to 1989
(N 1000s)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Transfers	1596.9	3747.4	2898.3	2865.1	2816	3168.4	7259.3	10831.1	11167.1	15206.1
Federal	1593.7	3747.4	2898.3	2865.1	2816	3168.4	7259.3	10831.1	10172.2	14245
State	2.2								678.5	871.5
Other	0								316.4	90.1
Internal Revenues	1771.4	1463.9	1592.3	2448	2855.6	3972.9	9017.1	5530.1	4978.4	3804.6
Taxes	296.9	274.7	120.8	53.3	273.3	173.6	992.9	212.7	191.8	191.5
Tenement Rate	137.1	43.4	74.7	74.2	110.9	0.5	0	0	1124.8	1117.5
Licenses/Fees	788.5	643.7	736.9	1588.9	1377.5	1815.4	7877.7		1739.5	1475.7
Earn of LGA Ente										
Rent LGA Property		296.2	327.4	296.2	539.2				906.3	217.7
Interest & Divid	384.8			0	0	915.2			170.6	-21.4
Misc.	164.1	206.9	332.5	436.4	554.7	1068.2	146.5	1030.8	846.4	823.6
Capital Invest RE	888.1	2.8	2.9	1.7	37	15.4	0	0	0	0
Total Revenues	4256.4	5214.1	4493.5	5314.8	5708.6	7156.7	16276.4	16361.2	16145.5	19010.7
Total Expenditure	2170	1453	1429.5	1970.8	3621.9	2410.5	4746.3	18064.5	13112.1	21733.5
Recurrent	1881.9	1331.1	1339.3	1927.3	2134.3	1558	3293.6	4044.7	8052	10345.1
Capital	288.1	121.9	90.2	43.5	1487.6	852.5	1452.7	14019.8	5060.1	11388.4
Surplus/Deficit	2085.4	3761.1	3064	3344	2086.7	4746.2	11530.1	-1703.3	3033.4	
CPI Index (Urban)	2.179	2.631	2.832	3.398	4.797	4.938	5.436	5.816	7.395	10.892
Pop Ext. (1000s)	3039.6	3174.9	3316.1	3463.7	3617.8	3778.8	3946	4122.6	4306.1	4497.7

(Continued on next page)

Table 7.2 Continued

Real Per Capita Revenue and Expenditure Measures

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Real PC Trans	241.10	448.62	308.62	243.43	162.26	169.80	338.42	451.73	350.69	310.40
Real PC Inter Rev	267.45	175.25	169.55	207.99	164.54	212.91	420.37	230.64	156.34	77.66
Real PC Tot Rev	642.64	624.21	478.48	451.57	328.94	383.54	758.79	682.37	507.02	388.06
Real PC Expend	327.63	173.95	152.22	167.45	208.70	129.18	221.27	753.41	411.77	443.64

Source: Unpublished data obtained from local government accounts.

c. Health Care in Atakunmosa LGA

District Health Statistics. Atakunmosa Local Government, like many other LGAs, is trying to qualify as one of the Federal Ministry of Health's "model LGAs." As part of the application process they carried out a pilot survey in June 1988, submitted a five-year plan in August 1988 and received a review from the FMOH in November 1988. In 1989, UNICEF produced an Oyo State situation report, which confirms many of the findings of the Atakunmosa sample survey. The Primary Health Care Department of Atakunmosa Local Government was kind enough to produce a short report with figures from 1988 to June 1991 for our project.

This wealth of publications does not translate into a wealth of reliable data; rather, it confirms that there are still significant problems with data collection and availability in Nigeria. Atakunmosa had more available reports and LGA records than any other place we visited. However, births and deaths are not systematically recorded. For children under five, weight-for-age cards have only recently been introduced (in 1988) and are only in use at a few locations. Since about half of the babies are born at home, there are no universal birthweight data and some evidence that there are more low birthweight babies among those that are born at home.

In spite of the limitations of the data, some parts of the health care picture emerge clearly. The great success of the last three years has been the immunization program. It has been well-organized, well-publicized, and well-accepted. Atakunmosa inaugurated its EPI/ORT (Expanded Program of Immunization/Oral Rehydration Therapy) in March 1987. In 1988, there were nine National Immunization Days; in 1989 and 1990 immunization days were organized by Oyo State. In Atakunmosa the number of immunized babies and mothers increased as follows:

<u>Year</u>	<u>Babies</u>	<u>Women</u>	
1988	30,490	5,601	pregnant women
1989	40,599	6,589	pregnant women
1990	58,714	12,869	pregnant women and newly delivered mothers

It was confirmed by the Atakunmosa PHC department staff and by Itagunmodi villagers that the incidence of measles, by far the most prevalent of the target diseases before EPI started, had dropped dramatically. The villagers in Itagunmodi felt that the impressive results of vaccinating for measles boosted the credibility of EPI.

The head of the Atakunmosa PHC department believes that education in the use of sugar and salt to make oral rehydration solutions (ORS) at home has reduced the number of cases of diarrhea that are brought to health facilities; we could not confirm this in the village since the dispensary does not treat diarrhea and does not have ORS sachets.

The public health care facilities at the time of our visit were comprised of:

Primary Health Care Centers	3	(Kajola, Iwara, Ifewara)
Maternity Centers	12	
Dispensaries	19	

The staffing levels for Health Facilities in Atakunmosa LGA were:

<u>Position</u>	<u>1988</u>	<u>1991</u>	<u>Needed (Per 5-year Plan)</u>
Community health officer	1	4	6
Midwives/nurses	6	8	12
Public health nurse Community	-	-	6
Health supervisor	1	1	10
Community health assistant	3	3	9
Public health superintendent	5	9	10
Public health technician	-	1	-
Pharmacy officer	6	11	12
Total	22	37	65

The totals of trained staff still fall far short of what the Five-Year Plan considered desirable. There has been no change in the number of facilities since 1988, but a number of maternities still do not have a nurse or a midwife. The situation in Itagunmodi testifies to the shortfall: the dispenser in the village is only an auxiliary aide without the qualifications to do much more than refer patients to higher level facilities, and the nearby maternity at Igun is not staffed by a trained midwife. The people of Itagunmodi, therefore, are not served at the two closest government health facilities by any trained staff.

There is no source of data to show morbidity and mortality for Itagunmodi or, with precision, for Atakunmosa or Oyo State. The Atakunmosa Pilot Survey and the UNICEF report, however, concur in the list of major health problems. The Atakunmosa reports list the ten major causes of morbidity as:

- 1) malaria
- 2) malnutrition - all reports find multiple causes: the economic situation, the trend towards shorter breastfeeding periods, the beliefs about appropriate diet for children, which results in protein deficiencies, and beliefs about the appropriate diet for pregnant women.
- 3) measles - agreement at the time of our visit that incidence has declined since reports were compiled.
- 4) anemia - again, often related to beliefs about diet as well as to frequent pregnancies
- 5) tuberculosis
- 6) diarrhea - number of serious cases may have declined, but UNICEF survey found that 36% of adults living in rural areas in Oyo State believe that children's stool is "harmless," i.e., does not spread disease (p. 107)
- 7) whooping cough - suffered by all ages
- 8) polio
- 9) pneumonia
- 10) vomiting

The ten major causes of mortality in Atakunmosa in 1988 were believed to be:

- 1) respiratory diseases
- 2) accidents
- 3) tuberculosis
- 4) sickle cell anemia
- 5) typhoid
- 6) high blood pressure
- 7) stroke
- 8) complications of pregnancy
- 9) complications of childhood diseases
- 10) malnutrition (Federal Ministry of Health, 1988b)

Administrative Subdivisions. Atakunmosa is divided into health wards. It is clear from the situation in Itagunmodi that the boundaries do not always coincide with inhabitants' patterns of utilizing health facilities. The primary health center in their health ward is more difficult for them to get to than the teaching hospital in Ilesha. Not only is the distance shorter to Ilesha, but there is reasonably frequent taxi service for N 4 round trip. The private cost of using the hospital in Ilesha is probably lower than going to the health center, and the quality of care is higher.

Special Characteristics of the District. The Oyo State Ministry of Health has been gradually transferring PHC responsibilities to the LGAs since 1988, following first the 1988 FMOH directive to complete the transfer by 1990 and then the June 1990 directive to slow down to avoid over-burdening the LGAs. The state trained LGA personnel to take over the functions and budgeting process, for

example, of the EPI unit. The state handed over the health facilities in 1990 and is continuing to transfer personnel.

Like all LGAs in Nigeria, Atakunmosa received from the FMOH N 100,000 in 1989 to set up a Drug Revolving Fund (DRF) and N 20,000 worth of drugs in 1990. The LGAs send their returns to the State MOH monitoring unit.

Expenditure on health in the LGA seems to follow the pattern we expected: before the 1988 initiative, virtually the entire budget went for personnel emoluments; in 1988 a significant amount was spent on drug purchases and the EPI/ORT program. We could not obtain a comparable breakdown for 1989 or 1990. The pattern is confirmed by evidence from Itagunmodi: for about five years before 1988 the dispensary and all other government health facilities had no drugs, but since 1988 their supply has been consistently better. The DRF is reportedly working well financially, although the dispenser in Itagunmodi has some complaints that will be discussed below. The EPI/ORT Unit receives assistance from UNICEF. UNICEF provided a van, now described as "old," and three motorcycles. These vehicles apparently constitute the entire PHC fleet.

Because Atakunmosa is a "willing LGA" that has not yet received the FMOH grant for "model LGAs," its PHC efforts to date have been self-financed or undertaken with the help of external donors. In the chairman's address to the council, he reported that the LGA had received N 69,000 from the Federal Ministry of Health in May 1991 to boost the PHC effort. This was presumably money funded by USAID's PHC Support Program. No one during our interviews at the LGA mentioned this money specifically or how it would be spent.

Construction of health facilities is being undertaken by a number of communities in the district; Itagunmodi is not unique in its community effort to upgrade its health service provision by constructing a facility. Eleven other communities in Atakunmosa are building either maternities or Primary Health Centers (Atakunmosa Local Government Primary Health Care Department, 1991: 1-2). Three are close to completion. Most of these projects must have been started before the responsibility for PHC was transferred from the state to the LGA. The implications for recurrent costs to the LGA for operating these facilities were not explicitly recognized by the PHC Coordinator, but the change in rules clearly puts the burden on the LGA.

The head of the PHC department in Atakunmosa lays most emphasis on the LGA's lack of infrastructure (roads, wells, piped water, LGA vehicles), the absence of a hospital in the LGA and the dearth of trained health personnel as the primary problems of improving PHC in a large, sparsely

populated rural LGA, which so far has found few means to finance itself. Her comments reveal something of a curative bias.

Community Links with the Health Department. The LGA has conducted workshops to familiarize local notables with the concept of PHC and with LGA responsibilities as defined by FMOH since 1988. The LGA has also instituted a PHC Management Committee with representatives from a number of LGA departments and community groups that meets monthly and is actively participating in efforts to upgrade services in the LGA. The PHC department has brought all government health workers to Osu for two-day workshops on the new PHC responsibilities. The dispenser at Itagunmodi attended one of these.

At the time of our visit the PHC Coordinator estimated that there were ten active village health committees. One hundred village health workers had been trained. They serve on a voluntary basis, although they may receive kits of medical supplies. In Itagunmodi, as in the other villages we visited, residents did not mention village health workers as part of the health service available to them. Atakunmosa participates in the Pathfinder/Columbia University Community-Based Distribution program. This program was fully transferred from the state to the LGA level in January 1991. It will involve selecting and training voluntary health workers from local communities. In March 1991 at an opening ceremony, the Local Government Council was formally briefed about the program, and the LGA received bicycles and a grinding mill.

Effects of Decentralization. As in all LGAs, the changes in local government responsibilities, the donor-funded projects, the actual transfer of PHC staff and facilities from the state to the LGA, and the communities' push for better curative services by building health facilities will have major effects on service delivery and LGA recurrent costs. From what we saw in the village, the availability of drugs and the success of the EPI program are the two effects that have been felt since 1988 by consumers of government health care services.

d. Primary Education in Atakunmosa LGA

Many of the primary schools currently in use in the rural sections of Atakunmosa Local Government were constructed long ago by the parents of prospective students. They retain such names as the Methodist School in Itagunmodi even though the Methodist Church has had no responsibility for them since 1970. By 1977, 86 primary schools had been constructed with a total of 19,932 primary school students. By 1980, enrollment had grown to over 23,561 and 110 schools.

Following the economic hardships resulting from the first full year of SAP, enrollment fell back in 1987 to 21,896 (see Table 7.3), and the number of teachers fell from over 900 to just over 700 teachers. The number of schools has remained at somewhat above 100 since the early 1980s³.

Table 7.3

Enrollment Data for Atakunmosa LGA, 1979, 1980, 1987-1991

Year	Number of Schools	Number of Teachers	Enrollment	Student/Teacher Ratio
1979	110	923	23,900	25.9
1980	110	984	23,561	23.9
1987	111	712	21,896	30.8
1988	110	791	24,407	30.8
1989	106	830	23,997	28.9
1990	106	930	25,727	27.7
1991	107	888	24,489	27.6

Source: Atakunmosa LGA unpublished records

Student-teacher ratios have varied from 27 to 31 pupils per teacher during the last five years. Given that the salary paid to teachers has not risen rapidly since SAP and that the cost of living has risen substantially, "real" expenditures for primary education have fallen in Atakunmosa. We estimated that per pupil expenditures for 1988 to be 27.0 N (in constant naira); those in 1989 to be 15.8 N and those in 1990 to be 15.9 N (see Table 7.1). This was the only LGA where reliable cost data and reliable enrollment data were both available so that we could examine the per-pupil cost of education. The dramatic drop between 1988 to 1989 and 1990 reflects how the change in the value of the naira as a result of SAP combined with low levels of local resource mobilization affected rural education. The real resources spent per-pupil were about one-half during 1989 and 1990 of what they had been in 1988.

³ Some of the reduction occurred in 1989 when the number of schools dropped from 110 to 106 due to the boundary dispute at the time that the LGA boundaries were changed.

3. Itagunmodi

a. Itagunmodi Village and Its Setting

Itagunmodi is a small rural village of approximately 200 households. It is the central village in the ward of the same name. The population of the ward is around 5,000 and there are 25 settlements in the ward. Within a five kilometer radius are 47 settlements that make use of the dispensary and attend the five churches in the village. Itagunmodi is on a dirt road, five miles from the main Osu to Ilesha road about seven miles from Ife in the other direction. The road was built by the villagers in 1933. Igun is the nearest village to Itagunmodi which is about two miles (four kilometers) further along the road to Ife. The road to Itagunmodi has several steep sections that are impassible by vehicle after a heavy rain.

The village used to have a full-time postal agency employee who delivered mail. With the economic crisis, he has taken a government job in Osu. He now gets paid on commission for the stamps he sells, takes delivery of mail, but does not make delivery rounds in the village. The village is served by about four mini-buses per day. The fare depends upon where villagers wish to go, but the fare to a central motor park in Ilesha used by several of the teachers is N 4 per day round trip. (Some of the teachers then take a second bus at N 2 round trip to complete their journey.) In addition, taxis do come to the village and many of the villagers have motor cycles. The foot traffic on the road is also quite heavy. All villagers who met with us in the town hall (approximately 30 to 35) and the ten teachers with whom we talked agreed that getting an improved road is their first priority for future infrastructure investment. The reasons given for this priority:

- Several of the women who were traders indicated that an improved road would enable them to obtain trade goods at lower transportation cost and more dependably.
- The farmers wanted an improved road because of access to markets.
- Farmers also wanted a better road because there is a demand for farm labor from the town to cultivate the crops and a road would ease the problem of laborers getting to the village.

Also, the teachers indicated that the lack of a reliable road was a big drawback in teaching in this village—even though all of the teachers at the Methodist School indicated that they would much prefer to teach in this village as contrasted to more remote villages. In the meeting the villagers indicated that the segment from their village to Ife was as important to them as the segment coming in from the Osu to Ilesha road.

After the road, there was some disagreement about the order of the next most important items. The Village Chief indicated that the next priority was for herbicides and pesticides for spraying cocoa farms, and the third was a hospital. The consensus of others seemed to put a maternity next, and that

either water or a market was the third. There is no electricity or running water in the village but an electrical system is nearly in place (poles along the road, electric wire in place, meters connected). The reason for the lack of completion is that the contractor used inferior materials in the poles and some of them collapsed. (We saw one pole down on the way in.) Thus, electricity may not be far away. There is a connection fee of N 260 and only about 30 of the 200 houses have actually paid their connection fee. However, power service now seems within reach.

There is no piped water in the village or treated water supply. Village women have to go 15 minutes by foot to a nearby stream to obtain water for their households. Two deep wells have been promised by the local government council. Two wells have been dug and neither is operational. The first well has a pump but is a dry well. The second well hit water but has no pump. There are several houses in the village with inside toilets. A few years back the local government built a public toilet that is located near the Nawarudine school; however, it is too far for most people to use, and it is used primarily by four nearby families.

b. Resource Mobilization in Itagunmodi

Local farmers have switched during the last decade from subsistence crops to cash crops such as cocoa, cassava, rice, kola nut. During our visit, we met a cocoa buyer who had taken the time and effort to visit Itagunmodi to purchase cocoa. So far, no efforts appear to have been made to tax this new source of income for service provision purposes.

There are several community associations in the village. The Village Development Association has two parts: one of these primarily involves resident indigenes of the village and the other involves non-resident/urban based indigenes. The Itagunmodi Progressive Union is composed of the sons and daughters of the village who are currently working away from the village. They hold an annual meeting on December 26 in the village. At this meeting, they discuss with resident members of the village what some of their major concerns are that could be tackled during the next year. They are asked to take up matters like rural electrification, location of health centers, etc. with government officials in Osu, Ibadan and other locations.

Some of the public buildings in the town owe their origins to illustrious members of the community. The materials for construction of the secondary school and the town hall, for example, were donated primarily by one individual or family in each case and the community then provided the labor to construct the buildings. The secondary school in Itagunmodi is named after the family who donated the materials, since the father passed away soon after the donation was made. The town hall, which is a very substantial building of approximately 35 feet wide by 50 feet long made out of

concrete blocks with a corrugated roof and poured cement floor, was constructed recently under such an arrangement. A daughter of the village who lives in Ibadan--a proprietress of a nursery school--provided the land and most of the materials. The community finished the basic construction of the town hall within one year of her gift. They have continued to work on the town hall--plastering the outside of the building, and making gratings for the windows, shutters, and inside furniture during the past several years.

The villagers meet fortnightly to discuss any matter of concern to the residents of the village. They meet and discuss items in two groups. The younger, able-bodied members of the village, who will be performing any physical labor decided upon in the village, is the group that proposes ideas for future projects to the elders who then discuss and approve it.

Other groups include the Mass Mobilization for Social Enlightenment (MAMSER) work brigade (the government-encouraged organization), the Harmony Brothers (a group of younger boys), and the Parent-Teacher Associations for the two schools. The local CDA indicated that they had mobilized resources for various purposes in the past, and currently have N 400 in their development account.

Two years ago it was a decision of the village that what they really needed was a maternity facility to serve the 47 outlying villages in addition to the main village. They decided that the levy for the maternity was at least N 20 per male and N 2 per female to buy concrete, iron sheets for the roof, and nails. The wood they obtained from the village, but they paid someone to saw it. They contributed the mud bricks and communal labor. As in many villages, the town crier beats the gong to indicate which days everyone was supposed to show up to work. The maternity is now a completed shell of a building, and they need to do the finishing. They are planning to expand the maternity to a cottage hospital.

Villagers participate also in trying to keep their road to Ilesha open. After a heavy rain that makes the road impassable, the town crier beats the gong, signaling that everyone should turn out to help get the road back into passable condition. Further, they maintain both of the primary schools. The headmaster of each school assesses the maintenance needs of the school and makes an estimate of the cost and levies a per family assessment to cover the expense. This is frequently around N 10 to N 20 per child. In addition, they also provide communal labor to do the construction or repair. In recent times, the level of maintenance of the schools may not have been as high as earlier times due to several factors, including the difficulty economic times, the alternatives available to villagers to earn cash income, and/or the leadership capabilities of headmasters.

c. Health Care in Itagunmodi

Itagunmodi Health Facility. The village has had a dispensary since 1956; the existing substantial, plastered concrete-block building was completed by the community in the mid-1960s. It was built to government specifications and consists of a large porch (approximately 20' x 15') with benches, a large inner treatment room (about the same size) with benches, a table, a high workbench/chest, a wash-stand with a small enamel basin, and a tall chair with steps (for dressing leg and foot injuries). There are two smaller rooms, one of which is the dispenser's office/examining room. The records and drug cabinet are here, and there is a low bed for an examining table. Both the villagers and the dispenser describe the services available as "first aid," for which the facility seems unnecessarily large. During each of our interviews there were three patient visits.

The facility was moderately well-maintained. It does not have running water or refrigeration. Mr. J. O. Omotoso, the dispenser, was washing his hands when we arrived, vials of medicine and syringes for injections were sitting in water in a kidney basin on his desk; the dispensary was neither truly clean nor truly filthy. Mr. Omotoso does the cleaning himself and keeps the ground immediately around the dispensary clear of vegetation. He gets school children to fetch water from the river, and the community clears the bush in the larger area around the dispensary and the new, half-built maternity, which is about 100 feet away.

In the Five-Year Plan the dispensary is due to be upgraded. The village has already applied to the LGA for equipment for the new maternity. These anticipated changes would end the current situation that places Itagunmodi in an awkwardly shaped health district, with a Primary Health Center in Iwara that is little used by the villagers. Their first preference for most health services is to go to the teaching hospital in Ilesha. This may partly reflect a preference for going straight to a tertiary facility, but is certainly partly because the facility in Iwara is more difficult to reach from Itagunmodi than the hospital in Ilesha. Itagunmodi's natural catchment area is quite large; an upgrade would benefit more than just the village population.

The dispensary obtains its drugs through the LGA revolving drug system. It supplies chloroquine tablets and injections, aspirin and paracetamol tablets, procaine injections and Vitamin B injections. It does not have Oral Rehydration Solution sachets; this may be because LGA policy is to teach mothers how to mix salt and sugar solutions at home, but there were no ORS sachets in any of the government facilities we visited. The dispenser makes a monthly return to LGA headquarters. He complains that the system is not responsive to the actual needs of the village. The dispenser cannot order drugs; he simply waits for delivery of whatever is sent out from LGA headquarters at

unpredictable intervals. The last delivery was in mid-February. The one before that was in mid-November, 1990. If he were to run out, villagers would have to go to the private pharmacies in Ilesha. Since the government outlawed pharmaceutical drug hawkers to combat the widespread sales of adulterated or expired drugs, there are no intermediate outlets for pharmaceutical drugs.

To provide dressings for wounds, he and other dispensers have set up their own impromptu revolving funds. In theory, the government is supposed to supply dressings, but in practice they have not been supplied for years. People were putting sand or leaves onto cuts and getting tetanus or infections. He buys supplies and is reimbursed by patients. His predecessor in Itagunmodi did this, and so did he in his previous posting. The staff in the village we visited in Anambra state did the same thing; the practice appears to be a long-standing, wide-spread solution to the problem of lack of supplies from higher in the government system.

Health Care Providers in Itagunmodi. Mr. Omotoso is the only health worker in the village. He has worked as a dispenser for 30 years, although his training is only as an auxiliary aide. He was posted to Itagunmodi a year ago. Apart from first aid, he keeps the village's patient record cards and writes referrals for cases he can not treat. The dispensary hours are 8:00 a.m. to 3:00 p.m. Monday to Friday, but Mr. Omotoso lives in the village and is available in emergencies.

In our interview with Mrs. C. M. Adeshina, the PHC Coordinator, we found that a woman trained to the level of pharmacy assistant had been posted to Itagunmodi and should have begun work at the time of our visit. No one in the village appeared to know that she was due to begin work there. She had not taken up her post several weeks later, and was trying to obtain a transfer. From her point of view, presumably, working in isolation would be unsatisfactory both professionally and personally. It seemed likely that the process at the LGA level of either persuading her to begin work or assigning someone else to the position might well deprive Itagunmodi of any improvement in health care service for months.

The service delivery implication of a better trained dispenser would be that more drugs could be safely distributed to the village. Mr. Omotoso has few drugs, basically the same as the list of appropriate drugs at the village level in the Five-Year Plan. Mrs. Adeshina indicated that, with a pharmacy assistant, Itagunmodi's dispensary could be stocked with a larger selection of drugs.

The posting of a pharmacy assistant would not increase preventive and public health services to the village. Pharmacy assistants are products of Nigeria's curative training branch, not the PHC branch. Working with the community to increase their understanding and use of public health concepts would not have been part of her training.

Residents and Health Care. At the meeting in the town hall both men and women listed the maternity as the priority project that followed roads, the highest priority. As described elsewhere, building the maternity was being accomplished through both communal labor and a levy on inhabitants. Water was also a priority, although the efforts to dig wells to provide clean water had so far been fruitless.

We were joined in our interviews of the dispenser by a number of villagers. When asked about the situation before and after SAP, the consensus response was that, post-SAP, charges had increased manyfold. The registration fee for a dispensary patient record card went from N 0.10 before 1988 to N 2. A child's card used to be free; now it costs N 1. Drugs and injections from the dispensary used to be free, now they must be bought for N 10. However, there was agreement that the prices at the dispensary are lower than at the chemists in Ilesha. Over the course of our time in the village, it became clear the issue involved was not so much ability to pay for cards or outrage at the level of government charges for drugs and injections as outrage at the concept of charges for what used to be the free services promised by the government.

Residents have few strategies to contain health care costs. One strategy is to give birth at home. Since the first of this year (1991), the women in the village indicated that all village babies had been born in the village with the aid of traditional birth attendants. Women go to Igun or Ilesha for post-natal care. A visit to either location would consume at least half a day. The women saw access to health care as primarily dependent on how much the users are willing to pay for it. One male villager, supported by the rest of the group, indicated that in the case of illness, health care and drug purchases were items for which the money simply had to be found, by borrowing from family if necessary. He estimated that about one-sixth of household cash incomes went to health care.

Evaluation of Health Care in Itagunmodi. Residents of Itagunmodi do not receive much health care at the moment from the government. They built the dispensary earlier and now the half-completed maternity, but do not have easy access to any government health care providers with advanced training. This is not because of lack of some effort by the LGA. The ability of the newly-assigned pharmacy assistant to refuse to take up her assigned post, negating the LGA's effort to improve services, is a systemic institutional issue, not a local one. It is not clear when, or whether, the LGA will staff the maternity and upgrade the complex to a Primary Health Center, although with Itagunmodi's population and location, such an upgrade would help a currently under-served area. The proximity of the teaching hospital in Ilesha may always draw those residents who can afford to use it. With little health care available in the village, the private cost of health care includes significant time and travel costs, which may preclude some residents from getting care they need.

The residents seem to put health care high on their priority list. However, they, like the PHC Coordinator, measured health care first in terms of curative care: they wanted to complete the maternity, upgrade it, and have it fully staffed by the LGA. The evidence that immunization had actually reduced the incidence of measles had impressed them. The structure of frequent community meetings allowed for easy acceptance and participation in the EPI program, and could presumably be equally easily used for other public health efforts. The well-educated residents appear to be both influential in village affairs and committed to obtaining better health care services.

Both men and women in the meeting with us in the town hall wanted better preventive and curative health care. The poor siting of the "public" toilet indicates that there are some difficulties reaching equitable solutions to collective problems. The recent mishaps--the pharmacy assistant's recalcitrance, the dry wells--will require persistence to redress, and, like replacing the sub-standard electricity poles, perhaps increased vigilance by villagers on behalf of their own interests.

d. Primary Education in Itagunmodi Village

The two primary schools serving Itagunmodi were initially private, religious schools that became public schools in 1970. Both schools were constructed by villagers who intended to send their children to the school. The Methodist Primary School was constructed first, perhaps as early as 1920. The Nawarudine (NUD) Primary School began offering classes in January of 1955. The enrollment, number of teachers, and pupil-teacher ratio for the two primary schools in Itagunmodi for 1988 to 1991 is shown:

	Methodist Primary School			Nawarudine Primary School		
	T's	P's	P/T Ratio	T's	P's	P/T Ratio
1988	8	210	26	4	135	34
1989	10	240	24	8	150	19
1990	9	235	25	8	145	18
1991	9	248	28	8	135	17

The number of students taking and passing the state-administered Primary School Leaving Certificate is shown on Table 7.4. Both schools are well established in this village. Teachers at both schools indicated that all eligible students attended primary school in this village and that parents did not try

Table 7.4

Itagunmodi Primary Schools
Number of Students Taking and Passing Grade 6
Examination

Year	Methodist			Nawarudine		
	Taking	Passing	%	Taking	Passing	%
1975				17	15	88
1976				12	5	42
1977				13	5	38
1978				11	11	100
1979	40	36	90	12	11	92
1980	no examinations given					
1981	no examinations given					
1982				19	19	100
1983	24	24	100			
1984	18	13	72	8	6	75
1985	24	21	88	19	15	79
1986	22	7	32			
1987	24	24	100	13	13	100
1988	18	15	83	19	na	
1989	19	19	100	17	15	88
1990	31	28	90	18	na	
Overall			85			82

Source: School records

to keep any children at home. On the other hand, few parents were able to purchase books for their children. There are at most three or four children per class who own the books that are supposed to be used in conjunction with classroom instruction. The teachers indicated that some of the required books cost between N 35 to N 45 and that the cost of materials to support a pupil would be around N 100 during a year. The list of textbooks authorized by the Ministry of Education is changed every year and thus books used by one class are not used by the next year's class. Other sources confirmed that textbook authorization has been a problem and scandal for years.

Each school is supported by a Parents-Teachers Association (PTA). The PTA at the Nawarudine School built a new classroom and a pit latrine for this school during the past year. The Headmaster at each school indicated, however, that it was harder now than it had been earlier to obtain parental support for school maintenance. At the Nawarudine School, for example, the ceiling materials in several classrooms are breaking loose. Both schools are built out of locally made mud-bricks with cement floors. There are desks and blackboards in each classroom. In some of the younger grades, two or three students share a desk, but in the advanced classes each child has his or her own desk.

The teachers reported that the lack of teaching aids and textbooks makes their task very difficult. In addition, they indicated that many of the villagers had not received an education and could not help their children at home gain further skills in literacy. Several teachers, who had taught in more urbanized settings, indicated that children living in a village without access to radios, television, newspapers, and other media learned at a slower rate than children living in settings where these amenities were present.

The teachers reported that the assignment to teach in these two schools was far more desirable than teaching in some of the more isolated schools not served by a road. On the other hand, the teachers did face considerable hardship given the lack of good transportation and amenities in the village. Four of the nine teachers at the Methodist Primary School and four of the eight teachers at Nawarudine live in the village at least during the week and travel home on the weekends. Housing used to be provided free to these teachers by the villagers. During the last decade, teachers have had to pay for their housing. Several of the teachers share one structure in order to keep the cost of housing as low as possible. They pay N 10 per month for their housing. The other teachers live in Ilesha or other nearby localities and come in each day using one of the private minibuses that regularly come to the village. Transportation time varies from thirty minutes to two hours each way per day and from N 4 to N 6 per round trip. When it rains, some teachers are not able to come to

school. Others trek in the rain. One teacher indicated that he had to trek about once a week even when it did not rain due to the unreliability of transport to the village.

In all, we were able to interview both Headmasters and seven other teachers. All of them indicated that their level of financial hardship had increased during the past decade. In earlier times, not only had housing been made available in the village without cost, but villagers regularly brought food and allowed the teachers to plant their own subsistence crops without charge. Since farmers can now sell most of their crops, they do not offer any free crops to the teachers nor are they allowed to plant their own crops. Given that there are so few teaching materials available, the teachers also have to dig into their own salaries to provide some charts for teaching and other teaching supplies.

The teachers were generally worried about the change of jurisdiction over primary schools from Oyo State to the local governments. They felt that primary education would get caught up in local politics and that they would suffer as a result. Even under state control, they indicated that the time they have had to spend in a grade before a promotion has been long (five to six years); that opportunities to move to better schools are quite limited; that they have no input to school curriculum or school organization and finance; and that they feel helpless to control much about their assignments to particular schools.

The career path of the Headmaster of Nawarudine provides some insight to lack of control that primary school teachers have over their assignments.

- 1979: Graduated from Teachers College Ijebu Jesa in 1979.
- 1979-1981: Posted to Ileoluji in Ifesowapo LGA
- 1981-1983: Posted to a Primary School in Osu.
- 1983-1985: Posted to the Methodist School in Itagunmodi
- 1985-1986: Posted as Headmaster to R. C. M. Koyo, in Osu
- 1986-1987: Posted to Lapeje Anglican School, Atakunmosa LGA
- 1987-1888: Posted to St. Johns School, Atakunmosa LGA
- 1988-1989: Posted to the Methodist School in Itagunmodi
- Jan. 1990: Became Headmaster at Nawarudine

The only transfer he requested was in 1981 when he asked to move into his home zone so that he would be closer to his family living in Ibodi. This level of career mobility does not allow for a

serious effort by a long-term and dedicated educator to develop any of the schools to which he was assigned.

All in all, the education facilities and processes we observed in Itagunmodi were among the best of the four villages we visited. The schools were in better condition and the teachers had a higher level of morale even though their condition had obviously worsened dramatically during the past few years.

B. Localities in Plateau State

1. Local Government in Plateau State

Plateau State, in the center of Nigeria's middle belt, was created in 1976 when Benue Plateau State was divided in two. The land area is 54,232 square kilometers. Jos, the state capital and a major mining and industrial city, is located at the extreme end of a northern salient. The Jos plateau, Nigeria's only extensive elevated tableland lies in the northern part of the state and enjoys a near-temperate climate; the southern part of the state is tropical.

Plateau State's population (estimated to be 3,947,746 as of 1990) is made up of many small ethnic groups, and immigrants who came when the tin mines were in full production. Christians made up about half the population; Muslims and traditional practicants about one-fourth each in 1980 [National Population Bureau, n.d.(c): 5]. In 1980, only about 5% of the population lived in urban areas (ibid.: 2). The education levels of the people living in Plateau State are significantly lower than the average for the country. Primary education was not made widely available until the 1970s (ibid.: 6). Fifteen percent of the men and 8% of the women sampled in 1980 were estimated to have had primary education; an additional 8% of men, and only 3% of women, had more than a primary school education.¹ In 1980, an estimated 53% of boys and 47% of girls were enrolled in primary school (ibid.: 7). James Urwick's preliminary work in 1991 suggests that many children still do not attend primary school (interview, June, 1991). Of those who do formally attend primary school, many do not attend during the rainy season when the need for additional agricultural workers is high. A poignant and visible sign of the inattention given to primary schools in the state was the number of school blocks without roofs that we observed in our drive across the state. Our visit and further research confirmed that this widespread phenomenon was of long standing.

¹ Nationally in 1980, 24% of men and 17% of women were estimated to have had a primary education, and 28% of men and 17% of women were estimated to have had more than primary education (National Population Bureau, n.d.(c): 8).

2. Barakin Ladi

a. Local Government and Its Setting

Barakin Ladi LGA was established in 1976, when the defunct Jos Division was split up. It lies 54 kilometers south-east of Jos, the Plateau State capital. Below the LGA level are eight districts, which in turn are sub-divided into village groups, villages and wards. The land area is 1,957 square kilometers, and the 1963 population was 134,935² (Jos/Durham, 1989: 19). Projecting population figures from the 1963 census (256,416 in 1990 using 2.5% growth rate) is the primary strategy used to estimate population. This may be particularly inappropriate for Barakin Ladi because, as the center of tin-mining in Plateau State, the population has fluctuated wildly depending on the level of mining activity, which has been declining since the mid-1960s (Jos/Durham, 1989: 345).³

The indigenous population belongs to a number of Nigeria's minority populations, primarily the Berom, the Ganesh, the Ron (Chala), and the Aten (Ganawuri). There is also a significant seasonal population of Fulani nomads. Immigrants or "strangers" who came to work in the large-scale tin mines and have remained to farm (often on land legally leased to the mining companies) (ibid.: 310) or to engage in small-scale tin-mining form a large proportion of the population in settlements at the decaying sites of shut-down tin mines (ibid.: 326). The social services and infrastructure that the large tin mines used to provide to their workers have now become the responsibility of the LGA or are not now being provided, e.g. electricity. The joint University of Jos/University of Durham project on environmental resources development has been studying the problems of the tin-mining region since 1977. Wereng, the village we visited, is one of two villages that they have studied intensively since 1990.

Barakin Ladi LGA is in the beautiful, tableland section of Plateau State that local tourism developers hope will become the "Switzerland of Nigeria." However, between tin-mining and deforestation,⁴ the massive erosion gullies and tin-mine spoil heaps are as salient as the spectacular

²This area has been the site of an innovative University of Jos/University of Durham long-term cooperative action-research program. We have relied on an excellent series of publications produced by this project. We will cite these in the text as "(Jos/Durham, date: page number)."

³However, the number may not be too far off, fortuitously, as a population study in 1983-85 as part of the Jos/Durham work indicated a population of 243,361 in 1985 (Ihemgbulem, 1989: 314).

⁴Caused by bush-burning and overgrazing, as well as woodcutting.

and unusual ridges and geological formations.⁵ The Jos/Durham report indicates that about 25% of Barakin Ladi's land area was rendered unusable for agriculture by tin-mining (ibid.: 314). It is a land-deficit area, farmed intensively but with decreasing soil fertility. The increasing amount of fertilizer required has usually not been available through the government-controlled allocation system, as we witnessed in Wereng this year. Fertilizer is currently the primary constraint to increased production.

The climate, the most temperate in Nigeria, allows double-cropping where water is available in the dry season. Since the water table is high in the area, obtaining water from dry-season water sources is often feasible. Increasingly, high value-added vegetables (tomatoes, onions, potatoes, etc.) grown during the dry season are sold in specialized vegetable markets and exported to cities in the South. Retrenched tin-miners have been foremost in the new truck farming efforts (Jos/Durham, 1989: 346). Orchard fruits are being developed as a new high value-added crop. Tin-mining continues on a small scale with hand-dug shafts; there is a widespread network of tin buyers. The airport for Jos, some light and agro-processing industry, and the country's earliest hydro-electric power station are located in Barakin Ladi, but have no direct economic impact on the village we visited.

Barakin Ladi LGA headquarters is located in Barakin Ladi town. The town has several Class I schools, a hospital, and several clinics. Electricity and modern communications facilities are available in Barakin Ladi town. The roads in the LGA appeared to be adequate for light vehicles, although not all are suitable for trucks. Two national trunk roads run through the LGA. DFERRI has done some work in recent years to improve the extensive network of laterite roads built to serve the tin mines. Within the LGA the laterite roads on which we travelled were well-engineered and passable even in rainy weather. Many of the bridges are narrow wooden structures; some were dicey, but we did not encounter the tree-trunk bridges described in the Jos/Durham report. Motorcycles and bicycles seem to be the most common vehicles.

b. Resource Mobilization in Barakin Ladi LGA

Federation Account transfers, which are the revenue mainstay of every LGA, increased by an astonishing 125% in 1990. In fact, as noted in Table 7.5, the jump was so large that N 4,219,300 of the N 17,978,900, or 23% ended up as a cash surplus in that year. This anomaly illustrates two important issues with respect local government finances in Barakin Ladi and in other LGAs as well.

⁵inselbergs and tors (Jos/Durham, 1989: 342)

Table 7.5

Barakin Ladi
Local Government Revenues and Expenditures: 1980 to 1990
(N 1000s)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Transfers		3244.5	1882.5	2355.6	4145.2	3078.5	3112.8	5075.6	6645.6	7988.2	17978.9
Federal					0				11469.2		
State		3244.5									
Internal Revenues		64.5	127.7	52.6	514.9	1052.6	427.7	407.7	610.1	590.6	663.9
Taxes		8.4	0.3	0	127.8	175.3	246.5	280.1	402.9	400.7	413.7
Tenement Rate		0		12.1	202.3	289.9	10.4	6.3	5.8	8.7	5.1
Licenses/Fees		30.9	39.6	0	74.2	81.6	62.4	70.4	61.7	97.4	82.5
Earn of LGA Ent.			87.8	40.5	1.6	46.7	29.2	30.3	29.5	40.6	65.6
Rent LGA Property		10.9			109	331.8	3.6	4.8	1.7	2.5	5.3
Interest & Divid		14.3				127.3	58.6		0	1	35.4
Misc.							17	15.8	108.5	39.7	56.3
Capital Invest Rev		57.3	288.9	102.5	176.3	92.4			0		200
Total Revenues		3366.3	2299.1	2510.7	4836.4	4223.5	3540.5	5483.3	7255.7	8578.8	18842.8
Total Expenditures		3090.5	1872.8	2501.4	4509.1	3723.9	3723.9	5615.4	7782.8	8459.3	14623.5
Recurrent		2652.1	1635.3	2495.1	4090.3	3637.1	3637.1	4475.4	5702.1	6541.9	10184.1
Capital		438.4	237.5	6.3	418.8	86.8	86.8	1140	2080.7	1917.4	4439.4
Surplus/Deficit		275.8	426.3	9.3	327.3	499.6	-183.4	-132.1	-527.1	119.5	4219.3
CPI (Rural)	2.03	2.452	2.645	3.268	4.554	4.823	5.049	5.588	5.556	10.945	12.039
Population Est	205320	210453	215714	221107	226635	232301	232301	238108	250162	256416	262826

(Continued on next page)

Table 7.5 Continued

Health and Educational Expenditures: Selected Years

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Health & Soc Welfare					2839.7					252.2	234.2
Recurrent					2839.7	0	0	0	0	252.2	234.2
Capital											
Education					303.1	2490.5	2490.5	2923.1	3620.6	2058.4	0
Recurrent					303.1	2490.5	2490.5	2923.1	3620.6	1633.7	
Capital										424.7	
Tot £ Pupils										30926	31048
Real Per Capita Revenues and Expenditure Measures											
Real PC Transfers		6.29	3.30	3.26	4.02	2.75	2.65	3.81	4.78	2.85	5.68
Real PC Inter-Rev		0.12	0.22	0.07	0.50	0.94	0.36	0.31	0.44	0.21	0.21
Real PC Tot Rev		6.52	4.03	3.47	4.69	3.77	3.02	4.12	5.22	3.06	5.96
Real PC Tot Exp		5.99	3.28	3.46	4.37	3.32	3.17	4.22	5.60	3.01	4.62
Real Per-Pupil Exp.										6.08	0

Source: Unpublished data obtained from local government accounts.

First, local revenue mobilization almost becomes a side issue when transfers represent 90% or more of a LGA's total revenues. Second, a change of this magnitude, if not planned for well in advance of the actual transfer, swamps any effort the local government is making to budget and plan. The LGA is simply reduced to ad hoc expenditures and revenue decision-making, with the predictable problems and inefficiencies such a policy fosters.

Given this general setting, let us examine the roughly 8% of total revenues raised by Barakin Ladi. Unlike the other three LGAs of this study, the community tax is Barakin Ladi's chief own-source revenue. In the last three years, the tax has produced 62% to 67% of their internal revenues. Parenthetically, it is interesting to note that the N 413,000 generated in 1990 is five times the revenues produced by Atakunmosa, and Barakin Ladi has an even smaller population--the basis of the tax.

Licenses, fees, and charges are the community's second most important revenues, accounting for 12% to 15% of the total. Receipts from this source fell from N 97,400 in 1989 to N 82,500 in 1990, and have shown no real growth in the last five years. The real decline may be attributable to ineffective management, or to rate structures that are economically unresponsive, or some combination of the two. Our brief visit suggests that both factors were at work over the period.

The development of local enterprises is one of the declared policy goals of Barakin Ladi. An upward trend in income from LGA enterprises points to some success in this area. Although not large, the income increased from N 29,500 in 1988 to N 65,600 in 1990. One possible caveat with respect to the operation of these enterprises: it was not clear from our review of the accounts whether the reported earnings figures were net or gross.

Barakin Ladi at one time raised a considerable share of its revenues from tenement rates. The total amount raised peaked in 1985 at N 289,900; it dropped to N 10,400 in 1986, and is now down to half the 1986 figure. The unusual history of this source leaves a number of questions answered, but suggests that tenement rates may have some real potential in the future. (See Table 7.6 for data related to Jos.)

c. Health Care in Barakin Ladi LGA

Barakin Ladi LGA is close enough to Jos to be affected by public health programs other than those administered by the LGA PHC department. The university has two programs that involve the LGA: a UNICEF grant to the Community Health Department, and the university's choice of Barakin Ladi as the LGA where medical students go to do their practical training in a rural area. However, the medical students are based in the state-owned general hospital in Barakin Ladi town, not in the

Table 7.6

Jos
Local Government Revenues and Expenditures: 1980 to 1990
(N 1000s)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Transfers	5559.6	4886.4	9685.8	9086.7	5742.1	5699.4	4404.2	6860.1	8127.2	11469.2	22896.7
Federal	4500.5	4582.7	5850.7	4826.1	2980.2	4803.2	4404.2	6860.1	8127.2	11469.2	22896.7
State	988.4	128	2480.9	2980.6	787.9	296.2	0	0	0	0	0
Other	70.7	175.7	1254.2	1280	1974	600					
Internal Rev	3997.5	5824.7	4069.6	5337.8	5280.6	7170	2519.7	1968.8	2793.1	3089.3	3409.6
Taxes	44.5	52.8	60.2	78.2	89	120	671.7	256	904.3	855.2	798.3
Tene. Rate	400.1	550	600	650.5	750.6	800	0	0	209.9	360.3	200.3
License/Fee	2480.1	3980	2107.4	3200.4	2727	4620	1120.9	962.3	800.6	900.9	1139.9
Earn of LGA Ente	1019.7	1190.5	1235	1346.7	1602	1504	0	0	855.6	895.2	988.1
Rent LGA Property	0	0	0	0	0	0	0	0	7.3	0	3.3
Int & Div	1.1	1.4	2	4	6	6	0	0	14.5	63.9	274.7
Misc.	52	50	65	58	106	120	727.1	750.5	0.9	13.8	5
Cap. Inv Re	228.3	250.3	300	350	500	590	0	0	1000	0	0
Total Revs.	9785.4	10961.4	14055.4	14774.5	11522.7	13459.4	6923.9	8828.9	11920.3	14558.5	26306.3
Total Exp.	4521.8	5242.7	5677.4	5794.7	6487.7	6502.3	13832.9	8301.2	11794.9	9914.6	0
Recurrent	4209	4762.2	5156.1	5218.1	5910.3	5840.3	7850.5	8301.2	10504.7	7425.8	
Capital	312.8	480.5	521.3	576.6	577.4	662	5982.4		1290.2	2488.8	
Surpl/Defic.	5263.6	5718.7	8378	8979.8	5035	6957.1	-6909	527.7	125.4	4643.9	
CPI Index	2.179	2.631	2.832	3.398	4.797	4.938	5.436	5.816	7.395	10.892	11.981
Pop. Est.	387792	397486	407424	417609	428050	438751	449720	460962	472489	484301	496408

(Continued on next page)

Table 7.6 Continued

Real Per Capita Revenue and Expenditure Measures

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Real PC Trans	6.58	4.67	8.39	6.40	2.80	2.63	1.80	2.56	2.33	2.17	3.85
Real PC Intern Re	4.73	5.57	3.53	3.76	2.57	3.31	1.03	0.73	0.80	0.59	0.57
Real PC Tot Rev.	11.58	10.48	12.18	10.41	5.61	6.21	2.83	3.29	3.41	2.76	4.42
Real PC Tot Expen.	5.35	5.01	4.92	4.08	3.16	3.00	5.66	3.10	3.38	1.88	0

Source: Unpublished data obtained from local government accounts.

villages. The University of Jos/University of Durham Geography Departments' research on the tin-mining areas has touched on the health problems of the area. Barakin Ladi has been selected as one of the LGAs to be intensively assisted, beginning in 1992, under the CCCD program. The Church of Christ in Nigeria (COCIN) is the dominant PVO provider of health care in Barakin Ladi. It has had an active rural health program in the LGA since at least 1985, although it does not apparently do as much to train community health workers as two state-wide programs run by a Catholic mission sister and the Evangelical Church of West Africa (ECWA). Barakin Ladi, then, may have more advantages than other LGAs in the state.

The self-description of health in Barakin Ladi in 1990 by an LGA official in a University of Jos/University of Durham report stresses the success of the drug revolving fund that began in 1988 with an N 100,000 grant from the FMOH, the two new and well-equipped maternities, the presence of trained basic health personnel in every village, and the massive education campaigns on cleanliness accompanied by frequent house-to-house inspection (Jos/Durham, 1991b). Wereng, the village we visited, was considered to be a village where the chief was enthusiastic about community development (interview with Dr. A. A. Adepeto, University of Jos, Geography Department, June, 1991). The quality of health care in Wereng may therefore be higher than average for Plateau State. As in Itagunmodi, improvement in government services seemed to be imminent, but not yet in place, after many years of virtually no service delivery. If a massive education campaign in cleanliness had taken place, there appeared to be a long way yet to go in Wereng. Many of the village children exhibited obvious symptoms of malnutrition and ill-health.

Other descriptions of the LGA stress the lack of preventive health measures, and the need to do much more community education and mobilization. The high water table that aids agriculture makes the provision of potable water difficult when coupled with the current low level of public awareness or concern for sanitation and protection of water supplies from contamination (Jos/Durham, 1989: 380). Consequently, the incidence of water-borne diseases is high (Akinbode, Adesina, and Akinyele, 1989).

The PHC Associate Coordinator in Barakin Ladi believes that the primary health problems in the LGA are malaria, malnutrition, diarrhea, respiratory diseases, and helminthiasis. The causes of much of the illness she analyzed as ignorance and poverty: mothers became so overwhelmed by the demands on them that they appeared to be unable to deal constructively with their many problems, and so they often were unable to prevent illnesses or treat them promptly.

The situation in Foron district in Barakin Ladi described in a 1986 report by the University of Jos illustrates the low base from which LGA PHC efforts are starting and why LGAs are expected to improve the quality of health care over state-provided systems (University Teaching Hospital, 1986). PHC was then financed entirely by the state, and policy was directed by the PHC Committee head, the Permanent Secretary of the state Ministry of Health. The operating responsibility lay with the state Health Services Management Board. However, services in the state had basically broken down. No equipment maintenance was being done because the maintenance unit had no funds; there were no roadworthy PHC vehicles; there were no drugs in government facilities and very little supervision of government staff. The report characterized what supervision there was in the state as poor: inspection visits consisted of a series of direct questions and studying available records. There was no feedback from the inspecting officer to staff members in the form of guidance or continuing education, and there were no programs in the state for in-service training. In March 1986, there had been no visit by a government doctor in the last year to Foron district. The principal health sister in the Barakin Ladi general hospital, in addition to her other responsibilities, supervised the government health facilities for the entire LGA. The mission facilities were supervised by the COCIN medical officer in Jos, but he too rarely visited Foron.

In 1986, the mission facilities in Foron district were better staffed, better equipped, and received far more community support, particularly from the very active women's association in Foron, than other rural communities in the area. However, the government basic health center had no transport and little usable equipment. There was a refrigerator and electric water pump, but no electricity, and a water-flush toilet, but no piped water. This equipment was a legacy of the 1976 BHSS initiative.

Utilization of the Foron Basic Health Center dropped precipitously in 1985 for two reasons: fees for drugs and consultations were introduced in the LGA in November 1984, and there was a chronic shortage of drugs throughout 1985. In 1984, the facility had registered 8,587 new patients, in 1985 only 557. The COCIN dispensary registered 6,548 new patients in 1985; one infers that many residents simply switched to the COCIN dispensary.

Maternal and child health care from government facilities in 1986 appeared to be almost non-existent. The report says that there was no regular post-natal care because "mothers did not bother, and staff do not insist" (ibid.: 10). The government maternity in Foron district did offer immunization, family planning services and occasional health education talks. ORS demonstrations had recently begun, but not nutrition demonstrations. In theory, the trained government health staff in the district did home visits; however, since there was no transport, they did not. One traditional

birth attendant had been given some training, but her expectation had been that the LGA would pay her a salary; she was disappointed in that, and in her inability to charge higher fees to village women as a result of her training, and had almost stopped practicing. In 1986, no village health workers had been trained in the district.

Service delivery in Barakin Ladi has improved somewhat since 1986. The big success is again EPI. EPI coverage is currently estimated at 77% for children under one year. Immunization services are available from the 12 PHC clinics and 27 outreach points. This is clearly an improvement since 1986, although there are problems with supplies and cold chain equipment.

Drug availability has improved. At least some government facilities in the LGA have had experience with drug revolving funds for a number of years. The 1986 report on Foron district said that each clinic had one. The LGA received its 1988 allotment from the FMOH to set up a DRF. Under the separate FMOH grant-in-kind it received a consignment of drugs in November, 1990. The PHC staff had hoped to implement DRFs at the health district level, but found that some of the five health districts were better prepared than others. The LGA staff meets monthly with the district health supervisors to prepare the way for moving the revolving fund to the district level.

The current transition from state to LGA service delivery has some institutional problems. Some of the LGA staff associated with the Primary Health Care department were until recently state employees. They were assigned by the state MOH to their new positions and shifted from state to LGA payrolls. Since some are very well qualified, they technically outrank the long-term employees of the LGA under whom they serve. The old and the recently transferred LGA employees are having to work together, reporting to the LGA chairman and secretary.

The LGA has a larger staff than either of the LGAs in the south we visited, and more than half were trained in the PHC-oriented Schools of Health Technology.

Barakin Ladi Health Staff in 1991

Community Health Officers	5
Nurses/midwives	20
C.H. Supervisors	17
C.H. Assistants	24
Environmental Health Officer	1
Health Education Officer	1
Aides	<u>13</u>
Total	86

In 1990, health facilities in the LGA consisted of 12 PHC clinics offering integrated services and 18 dispensaries, with total staff of 86. Government mobile clinic service is not operating due to lack of transport. There are 52 private or PVO facilities, many of them COCIN facilities. The CCCD program will carry out a baseline survey of the entire LGA in the near future.

Health Subdivisions within the LGA. There are five health zones in the LGA, each headed by a supervisor who reports to the PHC Coordinator at the LGA headquarters.

Community Links with PHC Department. In 1986, there appeared to be few community links with government PHC efforts. The district health committee met rarely and had no role in decisions. The PHC effort did not include coordination for intersectoral activities. Community development associations had made some contributions to PHC efforts, but their energies were directed primarily to physical infrastructure and education. Greater community efforts were directed to supporting mission facilities, and COCIN at that time had an active rural health program.

By 1991, the situation had improved. Committees linked to PHC activities were operating at LGA, health district and village levels. More than 50 voluntary Village Health Workers and traditional birth attendants had been trained. In 1991, seventy-five more were due to be trained by district-level trainers.

Effects of "Decentralization". Plateau State during the 1980s had clearly let government health service delivery break down almost completely in rural areas. Whether "decentralization" or an infusion of donor funds is responsible for the recent improvements is hard to say. The LGA has high staffing levels compared to the LGAs in the south we visited, and more outside aid. Incomes for at least some farmers have increased significantly, although many remain poor.

d. Primary Education in Barakin Ladi LGA

During the mid-1980s, there were 66 primary schools in the Barakin Ladi local government area serving between 25,000 and 26,000 students. At least one third of these schools were originally founded by religious missions [primarily Ekihsiyar Krista A Nijeriya (EKAN) now Church of Christ in Nigeria (COCIN)] and made governmental schools in 1970. The number of schools jumped from 66 to 103 in 1989 under the auspices of the National Primary Education Commission; the number of students in primary schools was 30,926 in 1989; 31,048 in 1990; and 32,648 in 1991. Teacher-pupil ratios varied between 25 pupils per teacher and 29 pupils per teacher during the last four years (see Table 7.7). Barakin Ladi was the only LGA of the four we studied where grade by grade enrollment

data was available over a five-year period for the entire LGA.⁶ The detailed data enabled us to undertake a limited cohort analysis of the relative progress of male and female students through the primary education system in this local government (see Tables 7.8, 7.9, and 7.10).

Table 7.7

Enrollment Data for Barakin Ladi LGA, 1986-1991

Year	Number of Schools	Number of Teachers	Enrollment	Student/Teacher Ratio
1986	66		25,760	
1987	66		25,853	
1988	66	1012	26,197	25.2
1989	103	1072	30,926	28.8
1990	107	1132	31,048	27.4
1991	107	1219	32,648	26.8

Source: Unpublished data from schools, collected by James Urwick.

Table 7.8

Total Enrollment
Barakin Ladi, 1990

Grade	Boys	Girls	Total
Grade 1	3947	3771	7718
Grade 2	3435	3187	6622
Grade 3	2578	2652	5230
Grade 4	2413	2196	4609
Grade 5	1983	1905	3888
Grade 6	1558	1423	2981
Total	15914	15134	31048

Source: Barakin Ladi Local Government Education Authority

⁶We are most indebted to James Urwick for making this data available.

Table 7.9

Barakin Ladi - Boys

Boys	School Year When Students Entered First Grade								
	1990	1989	1988	1987	1986	1985	1984	1983	1982
A: # of boys starting Grade 1	3947	4447	3504	3242	3024				
B: # of boys continuing Grade 2		3435	2917	2873	2481	2232			
C: B as a % of A		77%	83%	89%	82%				
D: # of boys continuing Grade 3			2578	2752	2287	2044	2204		
E: D as a % of B			88%	88%	93%	92%			
F: # of boys continuing Grade 4				2413	2285	1835	1948	2010	
G: F as a % of D				88%	100%	90%	88%	93%	
H: # of boys continuing Grade 5					1983	1752	1817	1840	1933
I: H as a % of F					87%	95%	93%	91%	-
J: # of boys continuing Grade 6						1558	1631	1564	1599
K: J as a % of H						89%	90%	85%	83%
% of boys continued through stream to relevant grade by 1990		$3435 \div 4447$ = 77% 1 year	$2578 \div 3504$ = 37% 2 years	$2413 \div 3242$ = 74% 3 years	$1983 \div 3024$ = 66% 4 years	$1558 \div 2232$ = 70% 4 years	$1631 \div 2204$ = 74% 3 years	$1564 \div 2010$ = 85% 2 years	$1599 \div 1933$ = 83% 1 year

Source: Unpublished data from James Urwick and Barakin Ladi Education Authority

Note: Shaded figures represent actual enrollment in 1990 (see Table 7.8)

Table 7.10

Barakin Ladi - Girls

Girls	School Year When Students Entered First Grade								
	1990	1989	1988	1987	1986	1985	1984	1983	1982
A: # of girls starting Grade 1	3771	4323	3504	3043	2897				
B: # of girls continuing Grade 2		3187	3031	2873	2415	2139			
C: B as a % of A		74%	87%	94%	83%				
D: # of girls continuing Grade 3			2652	2518	2171	1938	2077		
E: D as a % of B			87%	88%	90%	91%	-	-	-
F: # of girls continuing Grade 4				2196	2151	1792	1828	1991	
G: F as a % of D				87%	99%	92%	88%	-	-
H: # of girls continuing Grade 5					1905	1817	1599	1826	1747
I: H as a % of F					89%	101%	87%	92%	-
J: # of girls continuing Grade 6						1423	1362	1412	1437
K: J as a % of H						78%	85%	77%	82%
% of girls continued through stream to relevant grade by 1990		$3187 \div 4323$ = 74% 1 year	$2652 \div 3504$ = 76% 2 years	$2196 \div 3043$ = 72% 3 years	$1905 \div 2897$ = 66% 4 years	$1423 \div 2139$ = 67% 4 years	$1362 \div 2077$ = 66% 3 years	$1412 \div 1991$ = 71% 2 years	$1437 \div 1747$ = 82% 1 year

Source: Unpublished data from James Urwick and Barakin Ladi Education Authority

Note: Shaded figures represent actual enrollment in 1990 (see Table 7.8)

For two groups of students, we are able to track the aggregate student population through a five year period. For the 1558 male pupils and the 1423 female pupils who were in grade 6 in 1990 (see Table 7.8); we have traced their cohort back to the set of students who entered second grade in 1985. The male pupils in the sixth grade class in 1990 represented 70% of the male pupils in the second grade class of 1985. The female pupils in the sixth grade in 1990 represented 67% of the female pupils in the second grade class of 1985. Similarly, the 1983 male pupils in the fifth grade class of 1990 represented 66% of the 3024 male pupils who entered the first grade in 1986; and the 1905 female pupils in the fifth grade class in 1990 represented 65% of the 2897 female pupils who entered first grade in 1986.

At least *one-third* of the students who enter school in Barakin Ladi do not complete a full six years of primary education. The largest drop out rate occurred during this period between the first and second grade. In no year between 1986 and 1990 did the set of boy pupils in grade two represent 90% of those who had been in grade one the year previously. In 1989, the percent of male pupils moving to grade two from grade one fell to 77%. For three of these years, the percentage of female pupils moving from grade one to grade two was somewhat higher, but in 1990, the percentage of female pupils entering grade two from grade one was only 74%.

In many ways the role of primary education in Barakin Ladi appears to be more marginal that it is in Atakunmosa or Oji River. Mission schools were constructed somewhat later in the mid-northern region than they were in the south. Education is not viewed as important by local residents. A lower proportion of children are sent to schools, more are withdrawn when needed at home for agricultural labor, and as shown above, a large proportion of those who start school do not obtain even six years of primary education.

The maintenance of school buildings is noticeably deficient. Even in Foron, a prosperous village judging by the size of private houses and the number of cars and motorcycles, and a village well-known for its active community organizations, the primary school was in a deplorable state of repair and virtually unfurnished. In the decaying tin mine settlements the situation was even worse. In Bisichi, which has been hard hit by the downturn in tin mining, there was no furniture in the schools and children either carried their own stools from home or sat on the floor. In driving from Jos to Enugu we saw many primary schools with blown-off roofs along the route within Plateau State. It is hard to explain the poor condition of the school in the rich village of Foron. In the tin-mining settlements, such as Bisichi, low literacy rates of parents may be a factor. One Jos/Durham study found that 72% of the agricultural workers in its sample of tin-mining settlements had no formal

schooling (Jos/Durham, 1989: 334). Another surveyed 500 household heads in the tin-mining region and found that 81% had no formal schooling (ibid.: 381). The poor state of repair cannot be attributed to the effects of the SAP period. In 1984, a Jos/Durham study found that in their sample of schools in the tin-mining region "over 80% of the students lacked basic furniture to use in the schools while some of the school blocks had no windows, doors or, in some cases, roofs. Educational equipment and teaching aids were few or non-existent" (ibid.) The negative effects of poor physical conditions on learning that James Urwick found in Sokoto in the late 1980s also apply here (Urwick and Junaidu, 1991).

3. Wereng

a. Wereng Village and Its Setting⁷

Wereng is one of seven villages in Riyom District of Barakin Ladi Local Government. It has two sectors: Wereng Camp which we did not visit or include in our reference and Wereng Village which was the focus of our study.⁸ The indigenous population of the village is Berom. Wereng Camp, on the other hand, is predominantly Hausa, and some Hausa live in Wereng village itself. It is located about 50 kilometers south of Jos and 15 kilometers northwest of Barakin Ladi. At an earlier time, it was the center of considerable commercial tin mining. Now, tin mining continues but on a much smaller scale. One can reach Wereng on a well-traveled laterite road of about six kilometers from the Jos-Pankshing road or 12 kilometers from the Old Jamma'a-Makurdi Road. The longer road was constructed in 1983. Both roads are badly eroded in sections, but cars and motorbikes can apparently use the road year round even during the rainy season. One bridge is quite broad and in good repair and the second bridge is passable even in the rain. Roads have, however, deteriorated since the mining companies have left.

There are about 550 farm families in the village (Jos/Durham, 1991a: 1). At about eight persons per family, the population would be roughly 4400. Many residents own motorcycles and bicycles. Many individuals walking and some autos were observed on the road. The village does not have postal service, nor electricity. We did not observe any minibus service to Wereng.

⁷ We are very grateful for the extensive help given us by Andrew D. Kidd, James Urwick, and Bela Doga--members of the Jos Plateau Environmental Resources Development Program team. At a very busy time for them, they devoted several days of time driving us out to Wereng and surrounding villages, introducing us to local villagers, and making internal research documents available to us.

⁸ Wereng Camp is located across the River Wereng (known locally as "Gwot"), and there is not direct bridge linking the two settlements. It takes about an hour to travel from the main settlement to Wereng Camp.

The major economic base of the village is agriculture and livestock. One of the major problems facing the agricultural sector in Wereng is now the lack of fertilizer. Some villagers earn supplemental income from their small-scale tin mining operations. Between deforestation and tin mining and the subsequent erosion, the fertility of the soil has declined dramatically requiring increasing amounts of applied fertilizer. The price of fertilizer is now 60 naira per bag (likely to be 50 KG in size), but it is extremely difficult to get an allocation of fertilizer through the various government agencies that are involved. Wages paid to day laborers have increased from 1986 to 1991 from six naira per day to 20 naira per day. An agricultural workday is defined to span from 7:00 a.m. to 1:00 p.m. An employer is also be expected to furnish a mid-day meal for the workers. Partially offsetting the rapid rise in the costs of fertilizer and wages, there has been a rise in the price of maize which is a major market crop. Local farmers indicated that since 1986, the price of maize has risen from approximately 1.5 naira per mudu to three plus naira per mudu in 1991. Maize is the favored crop in Foron, and Irish potatoes near Wereng.

There are three wells in the Wereng area that have concrete rings for protection from pollution. The majority of the wells are open faced and experience severe pollution problems. According to the medical assistant who runs a local private clinic in Wereng water-borne diseases are a major problem in the area. He indicated that he has treated cases of typhoid and worms of all types. Malaria is also a serious problem in the area. The village recently constructed a new water well with concrete sleeves down to about ten feet to obtain good drinking water. The material cost was about N 600 for the concrete collars and the work was contributed by villagers. The concrete collars were paid for by the villagers in proportion to their access to that well. The average cost per household head was 20 naira. The fee schedule was decided upon by a committee composed of the heads of the various wards.

b. Resource Mobilization in Wereng

We did not find as much village level resource mobilization activities in Wereng as we found in the two southern villages we visited. As we discuss below, two sections of the roof at the Wereng Primary School blew off several years ago and one section was only recently replaced by the parents of children attending the school. The other section is still open to the skies and cannot be used at all for teaching purposes.

The Chief of Wereng is actively attempting to encourage further levels of resource mobilization at the local level. He is working closely with the Jos-Durham team who are preparing background

materials that may help in regard to future resource mobilization efforts. He has also encouraged the development of a private health clinic as discussed below.

c. Health Care in Wereng

Physical Description. The village has both a government dispensary and a private facility. The private clinic is in the center of the village near the market area. The dispensary is located on top of a steep hill at the outskirts of the village, not a convenient location. It was probably placed at the outskirts of Wereng so it would be accessible to both Wereng and the next village but it is not easily accessible to either. The dispensary, built in 1977, is similar in its layout and substantial construction to the dispensary in Itagunmodi.

The village in the middle of the rainy season was as unsanitary as other reports had led us to expect. From observing two groups of children, we could see incidence of major health problems: eye infections, ring-worm and other scalp conditions, sparse hair, and poor bone development. In the neighboring district (Foron) a UNDP/ILO team recently found that only 36% of the children measured could be classified as adequately nourished on all counts, and all of the women who were studied were anemic (Akinbode, 1989: 219).

Health Professionals. The owner of the relatively new private clinic and dispensary indicated that he came from another village but had now lived in Wereng for four years. He initially contacted the Chief about the possibility of moving to Wereng in order to establish the clinic. The Chief interviewed him and then discussed his coming with the ward heads (mai-angwas). To assist him in establishing a clinic, the Chief sold him a plot at a good location in the middle of the village for a low price as a form of village contribution. He was also allowed to buy a piece of land to farm nearby at a very good price.

He constructed the clinic building with his own funds and purchased all of the equipment and drugs. The clinic seemed to be among the best we observed in rural areas. He had a laboratory which included a microscope which he used to examine blood and stool samples, and he had a separate room for inoculations and injections. Another room was set aside for consultations. One room with a bed was available for overnight stays. He indicated that he planned to expand the clinic by adding additional beds.

He charges individual patients for services. He also purchases drugs and medicines in the private market and dispenses them in the village with a "modest" mark-up in price. For example he indicated that he had purchased medicine for hookworm for N 7.50 and sold it for N 8.50. He

claims to distribute without charge some of the produce from his farm to the people in the village who were suffering from malnutrition.

Apart from being licensed to sell drugs, he is apparently not supervised by the government. When we asked the Chief about the private clinic, he indicated considerable satisfaction with the services that were being provided and told us that villagers used the private clinic while not using the government dispensary for anything other than a headache and fever.

When we arrived at the government dispensary at 1:30 p.m., the door was open but no one was inside. While we were inspecting the premises the dispenser arrived on a motorcycle. (We did not ascertain whether it was his own; given the LGA's transport problems it seems unlikely that he would have had exclusive use of a government motorcycle.) He had been assigned to this post in April 1991 and began work on May 17th. The official paper work that transferred responsibility to him from the previous dispenser had not yet been completed in the middle of June even though he had complained several times to the LGA. The official who preceded him left this dispensary with no proper hand-over of official papers and records. No furniture, other than a dilapidated set of shelves, was left in the dispensary. Since arriving the new dispenser has acquired a table given by the Chief and a bench given by the church.

The dispenser worked previously at a health clinic with a staff of nine, including two nursing sisters. He indicated that he had requested the transfer because he wanted to be closer to his natal village to farm.

The dispenser seems over-qualified for his current position, but properly trained to deal with the enormous public health problems in Wereng. He first received a Grade II Teaching Certificate and taught primary school for three years. Then he attended the School of Health Technology in Jos for three years. He is now studying to be certified as a Community Health Officer, the highest PHC certification.

The dispenser indicated that he had been talking with the chief about mobilizing the villagers to put better health practices into action. He wanted to improve sanitary practices by urging farmers to build latrines a proper distance from their wells, to boil water, to use soap, etc. Also, he hopes to upgrade the equipment of the dispensary to increase what it can offer. He has brought in his own stethoscope, blood pressure cap, and butane tank for sterilization. He told us that he had started an inoculation program for measles, as he has observed a rather high incidence of measles in the village. (Assuming he is right, this is inconsistent with the high reported EPI coverage rate for the LGA.) He goes on his motorcycle to pick up vaccine in a small cold box from the Barakin Ladi Health

Department, immunizes that day, and then returns any unused vaccine that night. When he first arrived he had no visitors at all. Now he has up to three patients a day.

In terms of health problems observed in the village, he indicated that malaria, malnutrition, and measles were the most prevalent, followed by tuberculosis and gastroenteritis. He referred people directly to Barakin Ladi General Hospital, but some villagers prefer to go to hospitals in Jos or in Vom (Vwang).

When asked about the revolving drug program, he indicated that, when he worked in the Fan District Clinic, the clinic had collected some drugs from the LGA that were sold to patients at a subsidized rate. The clinic requested drugs based on the number of patients and the distribution of health problems. However, they frequently could not obtain what they needed from the LGA and had to go and search for drugs from private pharmacies. He had not found much change in the recent availability of drugs.

Residents and Health Care. The community development association in Wereng has discussed possible health projects, but at the time of our visit had not reached consensus on any project that was within their means (interview with Andrew D. Kidd, University of Durham). The University of Jos/University of Durham project that includes working with Wereng villagers would provide some material aid and technical assistance, so it is clearly in the village's interest to reach consensus on a project as soon as possible. The initial discussions between villagers and the Jos/Durham fieldworkers had indicated that improving health conditions was one of the village's highest priorities.

Conclusions about Health Care for Barakin Ladi and Wereng. If the new community health-trained dispenser puts some energy into PHC efforts in Wereng and can work with the chief, the private practitioner and the community to improve health conditions from their present abysmal level, then the government will be providing some meaningful health service to the village. The government dispensary has not been well utilized for some time. The health center where the dispenser worked before had apparently learned to provide itself with drugs in the absence of adequate supplies from the LGA store. The PHC department in the LGA seemed to be less well organized than others we visited; this could be because the integration of LGA and ex-state personnel was harder to accomplish. In the other LGAs state personnel had been established longer in their posts, and were unquestionably in charge.

In spite of their poverty and the long distances involved in travelling to hospitals, the villagers in Wereng seemed to show the same preference that we saw in other LGAs for going straight to a hospital if their treatment could not be handled in the village. This is presumably a rational choice

given the problems that government facilities have had in recent years. It seems fair to assume, however, that the poorer villagers see no option but to go without modern health care.

Community mobilization in this village was less effective than in the villages in the south, for a number of reasons including the dominant position of the chief in local decisions. The fact that, in spite of the availability of some aid and technical assistance from the Jos/Durham project, they could not reach agreement on a realistic health project indicates both their inexperience with the project process and problems in the village political process.

d. Primary Education in Wereng

Visiting the primary school that serves Wereng is a relatively depressing experience. The roof blew off on one section of the primary school in 1988 and a second section in 1989. One section was replaced by the community during the spring of 1991 after they had given up hope of getting the local government council to do it. The classrooms under the new roof were, however, not yet devoted to teaching because the community had hired a carpenter to repair the broken furniture of the school in this covered area. The newly roofed classrooms will be put into use when school starts in the fall of 1991.

In June, 1991 only about half of the students were attending school at one time, and classes were divided between a morning and an afternoon session. When we arrived at the school in the late morning, the headmaster was away and the level of discipline at the school was considerably less than we witnessed at Itagunmodi. Many children roamed around the outside of the school prior to being formally dismissed for the day, and few of them wore uniforms.

We interviewed eight teachers on the day of our visit to the school. Of these eight teachers, three-quarters were born in villages within the boundaries of Barakin Ladi and educated in local schools. One of the teachers had attended the Wereng Roman Catholic Mission School. None of the teachers had certificates beyond their attendance at teachers' college. Two were working part-time toward an advanced certificate. Seven of the teachers live in Wereng or Kuru Station which is immediately adjacent and one of the teachers lives in Riyom which is nearby. Of those paying rent, their average monthly rent varied around 30 naira per month.

Six out of the eight teachers indicated that they liked teaching in Wereng, but the reasons they gave for their preference all related to their capacity to live near family, farm, and cope with personal life more effectively here than in other potential locations. All eight of the teachers reported that they found it extremely difficult and demoralizing to attempt to teach in the environment of this school dramatically illustrated by the overcrowding necessitated by the destruction of the roof. Beyond the

problem of coping with crowded and short sessions, they all mentioned the problems they faced with the lack of teaching materials made available by either the parents of the children or the local government. In the words of the teachers themselves:

- I don't like to teach in a school where the students don't attend.
- I would like to go somewhere where parents can give us more of the cooperation we need.
- The atmosphere here is very bad for teaching. No roof. No textbooks. No writing paper. No teaching aids. No uniforms. Lots of students drop out.
- The government should not neglect the plight of the teacher. The problem is nation-wide, not just Barakin Ladi. Barakin Ladi is a relatively good teaching assignment compared to some places.

Lack of textbooks and lack of teaching aids was a recurrent theme in all discussions with teachers in all of the schools we visited. In Wereng RCM, the teachers reported the number of students in their classes that had textbooks as shown below:

Grade	Number of Students	Number with Textbooks
1a	35	9
1b	31	6
2	30	6
3	24	12
4	40	10
5a	40	0
5b	32	21
6	42	16

We were able to obtain detailed enrollment data for Wereng RCM from the Barakin Ladi Local Government Education Authority and undertake a cohort analysis for this school similar to the analysis presented above for the unit as a whole (see Tables 7.11, 7.12, and 7.13). What this analysis reveals is that the proportion of students in Wereng who receive a full six years of education is much less than the average for Barakin Ladi. Further, many children enter school *after* the first grade and cannot obtain the advantage of earlier work on which to base their own continued growth. For example, 53 boys (66 girls) started first grade in 1986 and 84 boys (88 girls) showed up for second grade in 1987. Even a more dramatic problem occurred the next year. Twenty-seven boys (44 girls) began primary grade one in 1987 and 83 boys (77 girls) attended second grade in 1988. Far more than half of the students in second grade had not attended first grade.

The percentage of students finishing at least five years (the longest period we can compute given the data that is available) is also low. For girls, only about one-fourth of the girls in first or second grade in 1985 or 1986 were in fifth or sixth grade in 1990. A similar drop-out rate exists for boys

Table 7.11

Total Enrollment
Wereng, 1990

Grade	Boys	Girls	Total
Grade 1	43	72	115
Grade 2	70	70	140
Grade 3	41	46	87
Grade 4	50	44	94
Grade 5	82	17	99
Grade 6	19	11	30
Total	255	260	515

Source: Barakin Ladi Local Government Education Authority

who were in second grade in 1985; only 19 out of 75 completed (25%). Fifty-three boys started grade one in 1986 and were joined by 31 additional boys in their second year class. This dropped down to 50 boys in grade 3; 40 boys in Grade 4; but jumped back to 82 boys in Grade 5. Not only is attendance erratic between schools, attendance is quite low in those seasons when families need children to share agricultural labor duties. The day we visited during the rainy season, for example, there were only 22 out of 32 students in Grades 5 and 6 of 35 students in one of the Grade 1 classes.

C. Localities in Anambra State

1. Local Government in Anambra State

Anambra state was created in 1976 when East Central state was split. Part of the colonial Eastern Region, it occupies the eastern plains of the Niger River. Its 17,314 square kilometers comprise an open woodland region in the north and semi-tropical rain forest in the south. Although Imo State is considered the Igbo heartland, Anambra's population (projected to be 7.6 million in 1990) is predominantly Igbo. About 80% of the people live in rural areas and farm.

Table 7.12

Wereng - Boys

Boys	School Year When Students Entered First Grade								
	1990	1989	1988	1987	1986	1985	1984	1983	1982
A: # of boys starting Grade 1	43	81	71	27	53	-			
B: # of boys continuing Grade 2		70	57	83	84	75			
C: B as a % of A		86%	80%	307%	159%	-			
D: # of boys continuing Grade 3			41	80	50	65	33		
E: D as a % of B			72%	96%	60%	13%	-		
F: # of boys continuing Grade 4				50	40	55	14	44	
G: F as a % of D				63%	80%	85%	43%		
H: # of boys continuing Grade 5					82	52	51	38	41
I: H as a % of F					201%	94%	264%	86%	
J: # of boys continuing Grade 6						19	35	31	43
K: J as a % of H						36%	68%	82%	105%
% of boys continued through stream to relevant grade by 1990		70 ÷ 81 = 86% 1 year	41 ÷ 71 = 58% 2 years	50 ÷ 27 = 185% 3 years	82 ÷ 53 = 155% 4 years	19 ÷ 75 = 25% 4 years	35 ÷ 33 = 106% 3 years	31 ÷ 44 = 70% 2 years	43 ÷ 41 = 105% 1 year

Source: Unpublished data from James Urwick and Barakin Ladi Local Government Education Authority

Note: Shaded figures represent actual enrollment in 1990 (see Table 7.11)

Table 7.13

Wereng - Girls

Girls	School Year								
	1990	1989	1988	1987	1986	1985	1984	1983	1982
A: # of girls starting Grade 1	72	72	63	44	66				
B: # of girls continuing Grade 2		70	55	77	88	50			
C: B as a % of A		97%	87%	175%	133%				
D: # of girls continuing Grade 3			46	73	56	72	39		
E: D as a % of B			84%	95%	64%	144%	-		
F: # of girls continuing Grade 4				44	31	46	8	36	
G: F as a % of D				60%	55%	64%	21%	-	
H: # of girls continuing Grade 5					17	52	35	42	26
I: H as a % of F					46%	113%	437%	117%	-
J: # of girls continuing Grade 6						11	36	33	27
K: J as a % of H						21%	102%	75%	103%
% of girls continued through stream to relevant grade by 1990		70 ÷ 72 = 97% 1 year	46 ÷ 63 = 73% 2 years	44 ÷ 44 = 1% 3 years	17 ÷ 66 = 26% 4 years	11 ÷ 50 = 22% 4 years	36 ÷ 39 = 92% 3 years	33 ÷ 36 = 92% 2 years	27 ÷ 26 = 104% 1 year

Source: Unpublished data from James Urwick and Barakin Ladi Local Government Education Authority

Note: Shaded figures represent actual enrollment in 1990 (see Table 7.11)

Igbo traditional culture ensured access to land for all community members but allowed individual holdings as well, and rewarded the exceptional achievements of individual men. Rich men could take the "Ozo" title; exceptionally good farmers became "Eze ji." The hierarchy of age grades was also important, but no single hierarchy dominated village decision-making (Enemuo, 1990: 71-77).

Women and slaves had no political rights before independence, but all free adult men had a (weighted) voice in community affairs. As Chinua Achebe noted, in recent years a traditional chieftaincy has become a status symbol among financially successful Igbo--there are now at least 800 kings in Imo and Anambra states, most of whom are city dwellers five days a week and traditional rulers on weekends (Achebe, 1983: 48). There are trade-offs involved in this new enthusiasm for traditional titles: succession/stool disputes may divide villages but the financial and institutional inputs from the new chiefs may increase the village's welfare.

Community Mobilization. The Igbo states are famous for their community associations, which have a very long history. Now Igbo communities have "town unions" or Community Development Associations (CDAs) with well-defined structures and horizontal and vertical relationships. Two to six CDAs form a Development Area Committee (advised by traditional rulers). The chairs of the Development Areas are members of the Local Government Development Committee chaired in turn by the chief executive of the LGA, with the LGA Secretary and heads of the Works, Agriculture, Health, Education and Community Development departments as ex officio members. The Local Government Traditional Rulers Advisory Council advises the committee (Enemuo, 1990: 139-148). Membership of the CDA is more or less compulsory for both inhabitants and non-resident members of the community.

General meetings take place at least once a year, with fines for persistent non-attendance. The CDAs are well-versed in the project process; the general meeting is the opportunity for all to discuss ongoing and proposed projects. If consensus is not reached, the decision rests with the majority. Each project has its committee responsible for awarding and supervising contracts; members of the CDA with relevant skills or contacts will sit on the committee. At the general meeting a progress report and the accounts are publicly aired. The committee can be warned or disbanded if it does not satisfy the community; it must also satisfy the CDA's audit committee (Enemuo, 1990, confirmed by our interviews). Enemuo concludes that CDAs choose projects within their means, usually on the basis of clear priorities, available funding from government programs, or to keep up with other communities (Enemuo, 1990: 158-174).

Having decided to undertake a project the community has a number of revenue sources apart from available government funding. The two most significant are the community levy and the "launching." The "launching" is a well-advertised event where large contributors can shine as public benefactors. The levy is agreed on at the general meeting. Usually it is a flat annual fee, with women contributing at half the men's rate. Enemuo gives the example of Adazi-NNukwu, a town development union with a N 500,000 five-year development plan (1976-1980) that implemented a graduated, progressive annual income-based levy (ibid.: 167-168). Other sources of revenue include interest-free loans from rich "sons and daughters," fines for breaking community rules and traditions, rents from markets and town-halls, and charges for exploiting the village "patrimony," or natural resources. Communal labor is also well-organized. The free-rider problem is addressed by the debt collecting squad, which first informs non-payers of their indebtedness and sets a payment date, and then either collects the amount owed or impounds property. The property can be auctioned off, but almost invariably the debtor's family ensures that the debt is paid (ibid.: 162-174). The Chairman of the Akpugoeze Development Association, the parent of Ofemilli's CDA, confirmed that in Akpugoeze there was also a graduated "income tax" and similar revenue raising procedures.

Enemuo (1990) points out that a measure of the legitimacy and effectiveness of the communal levy is that individuals who evade government taxes make huge contributions to their communities through CDA mechanisms (1990: 238). This also reinforces Peter Ekeh's (1975) designation of the community as the "real" public and the modern government as the "artificial" public. That well-understood laws are enforced meets the criterion used in IAD of a set of working rules. The CDA appears also to interact effectively with parts of the modern government hierarchy: the LGA top officers, the PHC unit of the LGA, and DFRRRI to our knowledge. Our information indicates that CDA procedures in Western Nigeria are similar. We did not find in Nigeria examples of communities managing or operating ongoing services for themselves; projects, rather than services, are the norm.

2. Oji River

a. Local Government and its Setting

Oji River is composed of seven autonomous villages and was established in 1976 from segments derived from three prior divisions. The outer boundaries of the LGA have remained stable ever since 1976, and there were no boundary disputes related to external or internal boundaries at the time of fieldwork. The only changes in LGA structure that have occurred since 1976 relate to the size and structure of the chief executive and council (whether appointed or elected). The changes in structure

followed those that occurred throughout the entire Federation. The LGA headquarters is located on land donated by several of the component villages. Oji River is located about 45 minutes west of Enugu, south of the Onitsha-Enugu Expressway. The villages near the highway appeared affluent; however, the village visited was in the most remote section.

b. Resource Mobilization in Oji River LGA

Of the four rural LGAs studied, Oji-River has the smallest population. Allotments constitute the lion's share of this LGA's revenues; over the last five years they have averaged 90% of their total revenues. With the exception of 1990, all of Oji-River's transfer payments have come from the Federation Account.

The financial data on Oji-River is spotty, and complete information on own-source revenues is available only for the last three years. With this caveat in mind, we see from Table 7.14 that Oji-River has a more balanced set of revenue sources than do the other three rural LGAs. Excluding the interest and dividend category, which contributed 31% to internal revenues in 1990, the most important sources were: earnings from enterprises, 21%; community taxes, 15%; and licenses and fees, 13%. A similar pattern is observed in 1989; however, the order of importance changes somewhat.

Fiscal administration may be a factor which limits Oji-River's development and the ability to absorb new governmental functions and responsibilities. This assessment is predicated on two general observations. First, as previously discussed, the ordinary function of bookkeeping was a labored task in the LGA. Only limited information was available in several areas, and often the records were incomplete or inaccurate. Trouble at this level of management raises serious questions about the LGA's capacity to administer a program as complex as primary health care services. Second, over the last three years, income from interest and dividends has contributed more to Oji-River's internal revenues than all the other own-source revenues except licenses/fees. The buildup of receipts from government investments raises a question about Oji-River's ability to plan public expenditure programs.

c. Health Care in Oji River LGA

District Health Statistics. Oji River LGA is amply supplied with health facilities. There is a state general hospital in Oji River town, a School of Health Technology that uses the LGA as its training practice area, a Roman Catholic hospital and a famous Anglican leprosarium with a health clinic open to the public. There are private clinics, maternities, pharmacies and doctors. Many women still use traditional birth attendants (TBAs); the Public Health coordinator at the LGA, who is herself a trainer

Table 7.14

Oji-River
Local Government Revenues and Expenditures: 1980 to 1990

(N 1000s)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Transfers	1590.3	2778.3	1468.9	2727.7	1075.1	2716.6	2459	3232.4	4621.9	3742.1	3923.2
Federal	28.5	1237.9	491.6	117.2	569.8	2716.6	2459	3232.4	4621.9		3902.3
State											20.9
Internal Revenues	80.2	124.2	88.3	96.6	183.5	148.2	225.5	228.4	281.9	242.2	231.9
Taxes	36	37	28.3	31.4	80.9	0	0	0	42.6	39.2	33.7
Tenement Rate	0	16	2.8	7.9	24.1	31.9	0	0	14.4	34.4	20.3
Licenses/Fees	24	41.1	33.2	32.9	35.3	37.9	225.5	228.4	120.1	45.8	29.9
Earn of LGA	0.2	0	0	0.9	43.2	53.6	0	0	57.6	57.5	48.5
Rent LGA Propert	0	0	0	0	0	0	0	0	14.6	17.8	14.2
Interest & Divid									32.6	32.6	72.1
Misc.	20	30.1	24	23.5	0	24.8	0	0	0	14.9	13.2
Capital Invest Rev									1000		
Total Revenues	1670.5	2902.5	1557.2	2824.3	1258.6	2864.8	2684.5	3460.8	5903.8	3984.3	4155.1
Total Expenditure	1686.2	3020.3	1865.9	2345.2	3738.4	590.6	418.9	522.8	0	0	3389.9
Recurrent	152.3	2795.7	1675.9	2122.2	3176	555.8	418.9	522.8	0	0	3131.3
Capital	1533.9	224.6	190	223	562.4	34.8	n/a	n/a	n/a	n/a	258.6
Surplus/Deficit	-15.7	-117.8	-308.7	479.1	-2479.8	n/a	n/a	n/a	n/a	n/a	765.2
CPI (Rural)	2.03	2.452	2.645	3.268	4.554	4.823	5.049	5.588	5.556	10.945	12.039
Pop Est. (1,000)	81.5	83.9	86.5	89.1	91.8	94.5	97.3	102.2	105.3	108.4	111.7

(Continued on next page)

Table 7.14 Continued

Education Expenditures: Selected Years

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Education										3565.5	4046.9
Recurrent									35.4		0
Capital										102	136.7
Teachers Sal										3463.5	3910.2
Tot £ Pupils								18549	15569	18603	15780
Real Per Capita Revenue and Expenditure Measures											
Real PC Trans	9.61	13.51	6.42	9.37	2.57	5.96	5.01	5.66	7.90	3.15	2.92
Real PC Inter Rev	0.48	0.60	0.39	0.33	0.44	0.33	0.46	0.40	0.48	0.20	0.17
Real PC Tot Rev	10.10	14.11	6.81	9.70	3.01	6.29	5.46	6.06	10.09	3.36	3.09
Real PC Tot Exp.	10.19	14.68	8.16	8.05	8.94	1.30	0.85	0.92	0	0	2.52
Real Per Pupil Exp.										17.51	21.30

Source: Unpublished data obtained from local government accounts.

of trainers of TBAs, has scheduled a training program in late 1991 for them. The LGA operates seven Primary Health Centers and one dispensary, which are inspected monthly. No community in the LGA is now in the process of building itself a facility for the government to staff. The village we visited, Ofemilli, because of its isolation, had similar access to health care facilities to the other Nigerian villages we visited: there was a government facility in the village, and private and secondary or tertiary care at least half an hour away by car.

The LGA seemed to have adequate staffing for the number of government facilities in the LGA. Most have PHC qualifications.

Health staffing in Oji River

Community Health Officers	2
Community Health Assistants	25
Community Health Aides	20
Senior Pharmacy technicians	5
Pharmacy technician	1
Nurses/midwives	6
Public Health Superintendent	1
Clerical staff, etc.	<u>5</u>
Total	65

Anambra State formally devolved PHC responsibilities to the LGAs in August 1990. In theory, the 1,461 state PHC staff were transferred to the LGAs; however, in order to allow an orderly transition with no drop in quality, the state volunteered to pay PHC staff salaries through December 1991 (Anambra State Ministry of Health, 1991: 33). Fifty eight of Oji River's 65 PHC staff are, therefore, paid by the state. In terms of hiring and firing, the State has recommended following national policy: that the LGAs control civil service grades one through six, and the Local Government Service Commission manage grades above seven (Anambra State Ministry of Health, 1991: 37).

There were virtually no records at the LGA (the PHC Coordinator is new and her predecessor left no records, not even the base-line study to qualify for model LGA status, which Oji River did in 1986). There is some indirect evidence (the apparently low use of FMOH-supplied drugs in government facilities) to suggest that government facilities are not being used much for health care, although the EPI program appears to be very successful.

A UNICEF EPI review team encountered the same difficulties with data collection at both the state and LGA levels that we did (UNICEF Anambra Office, 1989: 16). With more time to probe at

their disposal they discovered that (1) the Ministry Statistics staff was two years behind in collation and reporting; (2) much of the data collected had limited value for decision-making; (3) most health staff lacked the skills to carry out simple analysis of their own data (EPI targets); (4) health staff received little feedback to their reports (ibid.). Oji River's EPI unit was an exception in its record-keeping: the UNICEF team observed that their records met established standards; however, only one of four facilities visited in Oji River was integrating the vaccination campaign records into its vaccine register. (The team was taken to four of the seven facilities carrying out immunizations; Ofemilli was not one of them.)

The UNICEF review team commended the LGA highly in 1989: "dynamic leadership by the PHC Coordinator (the predecessor of the current Coordinator), the favorable geographical distribution in terms of population, and communication, the presence of dedicated health staff, and responsive communities are establishing a solid base for Primary Health Care." Training of voluntary Village Health Workers (VHWs) had not begun at the time of their visit in October 1989; in June 1991 there were 42 trained, and eight scheduled for training in August.

A base-line survey of family planning and PHC awareness in eight model LGAs carried out in February 1991 confirmed the effectiveness of PHC efforts in the LGA.¹ Ninety-nine percent of the respondents claimed to have had their children immunized; 94.4% could produce immunization cards (Anambra State Ministry of Health Family Planning Project, 1991: 86). Seventy-seven percent had access (not defined) to two or more health facilities; only 2% to none (ibid.: 87). There was a high awareness of family planning; however, in this predominantly Roman Catholic area, most users were using natural methods (ibid.: 89). Household sizes were smaller (68% in households of 5-8) and education levels higher (only 13% with no formal schooling; 27% with at least some secondary education) than in the other three LGAs we visited (ibid.: 78). Another success story in the LGA appears to be the awareness and use of ORT. At the time of the survey in February 1991, 95% of respondents knew how to prepare salt-sugar solution. Sixty-eight percent treated cases of diarrhea at home with home-made solution (8% used drugs; 28% took children to health center) (ibid.: 85).

These results indicate either a big improvement in treatment methods and awareness since the UNICEF review team's visit in October 1989, or an unrepresentative sample. The UNICEF team had found two years earlier that of the mothers who treated cases of diarrhea at home (34% of their

¹Based on a random sample from a universe which is not stated. The 250 respondents to the 30-item household questionnaire were 88% female.

sample), only 18% of mothers used sugar-salt solutions; 67% used no treatment; 15% used other treatments. Of those who sought outside treatment; 24% went to pharmacists; 17% to health centers; 11% to hospitals; 9% to private doctors, and 3% to herbalists (UNICEF Anambra Office, 1989: 7). At health centers, the use of multiple drugs (5.65 drugs per case in a small sample of 20 case records) is, as the UNICEF team pointed out, unnecessary and potentially dangerous (ibid.: 8). It is also expensive. A team recommendation to the Oji River staff was to change treatment methods; the father in Ofemilli who complained about how expensive the government maternity facility was, may have been referring to the use of multiple drugs when he referred to the cost.

The indirect evidence of low usage of government facilities comes from the two Drug Revolving Funds: the LGA facilities appear to have sold only a small amount to the public, implying low demand, although there are complicating factors. Like all LGAs, Oji River received an N 100,000 grant to initiate a DRF. They received the money in October 1989, and they bought drugs, but to date they have taken in only N 40,000 against that purchase. The complicating factor is that the councilors awarded the contracts injudiciously; the LGA paid a high price, and, as a resident of Ofemilli noted, drugs in the government facilities were more expensive than those from private sources. There is evidence of a learning curve: the PHC Coordinator is now secretary of a new DRF committee. However, they do not appear to be cooperating with other LGAs, nor are they aware of the bulk purchasing arrangements that the Christian health associations have developed.

The second DRF fund was initiated in April 1990 when the LGA received 42 pre-packed mixed cartons of essential drugs as a grant-in-kind from the FMOH. Eleven cartons (two to each of the three busiest facilities and one to each of the other five) were distributed to the LGA facilities; to date (June 1991), no facility has needed additional cartons. Separate accounting systems are kept for the two batches of drugs. This second batch of drugs has been priced very low; it is quite clear, however, that these low prices have not been well-publicized in Ofemilli. In fact, the senior staff member during our visit was reluctant to announce the prices publicly. For whatever reasons, there does not appear to be a great demand for the drugs that the LGA facilities provide.

Politics appears to have played a role in siting some facilities in the LGA, including the one in Ofemilli. In Obune the community split on the issue of the site and built two facilities, one in the town center and one on the periphery. The LGA commissioned the one on the periphery; fortunately, the group in favor of the central location persuaded the School of Health Technology to use the central facility to send their students to do their practicals. Akpugoeze, Ofemilli's mother village, had a health center in a central location; it burned down a long time ago, and the maternity in

Ofemilli was sited there through the influence of a "big man." Some of the LGA PHC staff felt that it was not sited appropriately. When asked about any plans for upgrading facilities in the LGA, the PHC staff indicated that the first priority was to get the Akpugoeze health center back in operation. This indirectly confirmed our impression that the maternity in Ofemilli is inappropriately large for the community it serves and for the limited services it offers.

The EPI program appears to have been carried out very successfully, even in the context of the generally successful effort in Anambra. (The UNICEF team commended even an LGA with a generally poor PHC set-up on its EPI mobilization results (ibid.:17). In Oji River, the EPI effort began in 1986 when the full EPI complement of equipment, including a vehicle, arrived. Health workers were trained on the job. Now everyone on the team knows how to do steam sterilization and how to immunize (except for BCG shots which must be administered by a nurse). In 1988, the FMOH organized National Immunization Days; in 1989 and 1990 the state organized them. Public awareness was achieved in 1986 by giving public health talks in all communities and by making announcements in churches, schools and markets. Town leaders were briefed and given the schedule; each community was visited on non-market days and the town-criers announced the EPI visit on the day. The PHC Coordinator estimates that 80% of both babies and pregnant mothers are now immunized. (The UNICEF team estimated 70-80 coverage of 12-23 month age in October 1989.)

UNICEF has continued to provide some funding. In 1990, the unit received N 10,000, half of which went to repair the vehicle (which is not running currently). The rest went for repair of the cold storage equipment, for training and for routine EPI activities. In 1991 UNICEF provided N 4000 for a mop-up campaign. The LGA allowed N 160 for the hire of a vehicle for the week of the campaign. The EPI Unit can reach all communities in a week; they indicated that during that week they mobilize transport (mostly bicycles and motorcycles) from many people on an exceptional basis. Now they feel that they can carry out immunization on a routine basis. In Oji River town they immunize daily after a health talk on (1) the immunization schedule; (2) family planning; (3) oral rehydration therapy, and (4) breast-feeding until age two while introducing semi-solids at 4 months. A team member attended one of these health talks; it appeared to be thorough but relaxed and friendly, with questions and laughter. In the other health centers talks/immunization are scheduled once a week; in the smallest facilities like Ofemilli, once a fortnight.

The LGA unit is not using weight-for-age cards, although they do use immunization cards. During mass immunization campaigns they screened for the malnourished babies and took mothers aside to request them to bring the babies in for special attention and talks. They report a high level

of awareness in mothers of the symptoms of malnutrition, thanks to a well-understood poster. When we asked whether malnutrition had increased or decreased in recent years, they agreed that malnutrition was not now and had not been a major problem. The biggest health problems in the LGA are onchocerciasis and malaria. Diarrhea, the third mentioned, had decreased dramatically with the promotion of home-made ORS, and they have not had any recent outbreaks of the diseases that EPI involves. (The UNICEF review shows that the incidence of measles had dropped significantly in Anambra by the mid-1980s (UNICEF Anambra Office, 1989: 5).

Effects of "Decentralization". The transition from state to LGA appears to be smooth from an organizational point-of-view; what will happen when the LGAs have full responsibility for paying the PHC staff is less clear. At the LGA level the PHC staff appeared to be outstandingly competent and energetic in their technical specialties. Like the other LGAs staffs, however, they were allowing price confusion to dilute the effectiveness of DRFs. Record-keeping was very poor.

d. Primary Education in Oji River LGA

There are 61 primary schools in Oji river. Data related to enrollment and number of teachers was provided to us by the Federal Ministry of Education for the following three years:

<u>Year</u>	<u>No. of Students</u>	<u>No. of Teachers</u>	<u>Student/Teacher Ratio</u>
1988	15940	494	32
1989	18108	724	25
1990	16722	686	24

We had two additional sources of information on primary education at the LGA: a well-informed member of the Local Government Education Authority (LGEA) and the mute testimony of piles of teaching materials in the absent director's office. The LGEA staff member corroborated Mrs. Obayi's view that the two years of PSMB management were the best years in recent memory. From 1983 through 1988 teachers had a terrible time getting paid. In 1989, things were better and in 1990 the system worked well. Now, with the change they hear the LGAs complaining that there's no money, and the uncertainty worries them. So far this year they have been paid on time, but not at the new minimum wage. The LGAs have flatly declared that there is no money for capital projects or teaching materials.

The LGEA staff member said that the English textbooks for Form 5 that were on the floor in the office (about 300 flimsy books) had arrived about two weeks ago and would be shared between all the schools. Last year they received a similar shipment of math textbooks which were shared out. (The share for each school is 10-15 books.) There were three large wooden crates, a couple of small bales and thirty-odd posters (from an Indian supplier): this was the science equipment that arrived last year. A decision had not been made on how to distribute it. The PSMB had also given them in 1989-90 a typewriter, a cyclostyling machine, and report card blanks. The PSMB had supplied teaching materials (chalk, etc.) and some furniture, which had been shared out. Books for the LGA headquarters library (about 500, mostly for primary school readers) had been shared between schools because the library, which will be located at the LGA headquarters, has not been constructed.

This year they have received very little from the new Anambra State Specialized Education Authority (ASSEDA); they have requested teaching aids but they know that ASSEDA does not have much this year. They still have a bit of last year's chalk supply; when it runs out teachers will have to buy their own because the LGA has indicated that it will not pay, and headmasters have no allowance for supplies and materials. (The new guideline that the states will take responsibility for teaching materials and maintenance has clearly not become operational, from both his and ASSEDA's Director, Mrs. Abayi's, evidence.) Teachers are already buying their own exercise books.

In terms of community development efforts, there are no schools under construction now; the PSMB built one that opened this year. The major repair task this year has been to replace the many roofs that were damaged in a bad windstorm about three months ago. Most of the schools were insured; some insurers have inspected the damage and paid the claims, some have not. If the community is too poor to contribute for the repairs, the LGA will do it; it is a high priority for the LGA at the moment.

The furniture provided by the PSMB was only a small amount. Some communities are providing classrooms with furniture; some are not. Where the community doesn't, students with parents who can afford the cost bring their own desks and chairs to school; poor children sit on the floor.

3. Ofemilli Village

a. Ofemilli Village and its Setting

Ofemilli is a village of about 200 households that is one of six villages comprising the Akpugoeze settlement. The other five villages are Amagu, Umudim, Umudkpara, Abo-Abo, and Egbeagn Anoma Ohechem. It can be reached from Oji River LGA headquarters by driving 24

kilometers on tarmac road to Inyi. From Inyi to Ofemilli is eight kilometers by dirt road. The quality of the state-maintained road to Inyi varies from smooth to extremely rough in sections of large potholes and eroding edges. Inyi is the nearest marketing center for Ofemilli. The LGA and the village both contribute to the maintenance of the dirt road connecting the village to its marketing center. There are two steep hills between Inyi and Ofemilli. Until recently, the village was stranded during the rainy season as it took about three days of sunshine to dry the road so it was passable to vehicular traffic. Recently, DFFRI has allocated a considerably sum (N 1 - N 1.5 million) for road repair in this area. The residents of Ofemilli and the other villages served by the same road have also imposed a levy upon themselves to the tune of 210,000 naira to invest in regrading, graveling and improving the road bed. It is a three-part levy: (1) each of the 21 wards served by the road has been assessed 2000 naira per year for the past five years; (2) the richer residents of the village have been assessed a separate fee on a graduated income basis; and (3) all other villagers have been assessed on a flat rate of N 50 per man and N 15 per woman. Over the past year, this has amounted to about the raising of N 5 million from the village itself for spending on the road.

Each ward is responsible for the physical work of building and maintaining the road bed in addition to their responsibility for mobilizing resources. The funds and labor are mobilized through the efforts of a representative, inter-village road committee. In discussions with numerous village residents about priorities they stressed unanimously that roads were their very highest priority. They indicated that roads would be followed by roads, followed by roads, on down to the 20th level!

The reasons that they gave for this strong priority are:

- 1) Education: teachers and others who might serve in or come to the village dread coming because of the uncertain and difficult roads. Now with the opening of the new Agricultural College in Ofemilli, plus the Secondary School and the four primary schools in the settlement there are many teachers who need to get in and out.
- 2) Food production: the area is the "live wire" of food production of Oji River. Ten to 15 thirty lorry-loads of palm nuts are exported every market day (every four days). The Chief of the village is also a large rice producer. The village is inaccessible to lorries in bad weather. Once the larger transport vehicles get to Inyi, they do not want to go beyond to Ofemilli. There is no bus service to Ofemilli; some residents have tried to get some form of public transportation organized without success.

There is no public electricity system in Ofemilli. One wealthy member of the community does have his own power generator. Electrification is occurring in the region, so it may not be long before wires reach this community. An Akpugoeze age grade has just promised to donate the poles. Residents of Akpugoeze are applying to become one of the next 200 towns in the State to receive a

loan from the State for rural electrification. There is a major power station near the Oji River headquarters. There is a postal agency in the village, but no telephone or telegraph service.

b. Resource Mobilization in Ofemilli

In addition to road-work, a second major example of their community development efforts is their construction of a very large government maternity facility in the village. In order to obtain government staffing, villagers worked with the LGA and the State Ministry of Health to construct the facility according to state provided specifications that are standard for maternities. The community health nurse in Ofemilli indicated that the plan was the current layout used in all modern maternities in Anambra state. It was explained to us that the specifications were such that an upgrade from a maternity to a cottage hospital was easily feasible.

The maternity was constructed in 1983 by the villagers. In order to purchase the building materials, the Development Committee of the Village imposed a levy of 50 naira per male and 25 naira per female member of the village. This was collected over a period of time rather than in one lump sum. Members of the Development Committee indicated that there was no one in the village who did not contribute their levy. Until last month, the village paid a night watchman N 120 per month. The money was raised by an N 2 per delivery charge plus funds provided by the village. Last month the LGA took over paying for the night watchman.

c. Health Care in Ofemilli

Physical Description. The health center/maternity is a very well constructed facility that is probably inappropriately large. It has rooms for all maternity and health center functions but no running water or electricity. It is located about a ten-minute walk from the road through the village down an eroded track that is no longer usable by ordinary vehicles. It is the only government health facility for the entire Akpugoeze settlement, which is isolated from the rest of the LGA by poor roads. There is a staff of five (three Community Health Assistants and two Community Health Aides).

Unlike many rural villages, Ofemilli does not appear to have a major problem with water supply because villagers can obtain water 12 months a year from nearby springs. They do not have problems with guinea worm or other water-borne diseases. Obtaining a well was definitely not something that male villagers considered to be a high priority item that they wanted to invest in, but having an "urban" piped water supply at some point in the future was mentioned after roads and electricity.

Residents and Health Strategies. The Health Center/Maternity in Ofemilli began working with the drug revolving funds in 1990. Since then they have had no problem with receiving a regular

quarterly supply of drugs. As indicated earlier, there are two DRFs in the LGA and confusion exists about the pricing of drugs. In spite of the facility's size and staffing, the drugs supplied by the facility are the same as in the Itagunmodi dispensary: aspirin, paracetamol, chloroquine, procaine, and dressings. As in Itagunmodi, the staff has set up their own revolving fund for dressings. The records in the facility were heaped on a couple of shelves and did not appear to be in good order.

Between 40 and 50 babies are delivered there each month. In addition, the staff indicated that they are trained to undertake first aid care and to refer patients to other clinics for more advanced problems. During our two visits, we saw only one patient using the facility, a woman in labor.

We heard negative comments about the management of the facility. The villagers are charged N 1 per year for a health card, which is a source of resentment. Part of the resentment is due to the time and effort required to get the card and to keep it available for future use. The procedure for getting drugs is what residents indicated scares people away. Acquiring drugs through the maternity takes a longer time and was more expensive than from a private chemist.

Initially, the facility had fulfilled the villagers' expectations. They remembered that from 1983 to 1985 there was no charge for treatments and drugs were highly subsidized and easily available. There were minimal birth charges and charges for injections. After 1986, there was a change. Most of the cost of drugs was shifted to the patient. The birth charge at the local maternity is now 40 to 50 naira. A villager did point out that having a child in an urban hospital or a private maternity was far more costly.

The villagers were aware of the training program for voluntary Village Health Workers. Although no one from Ofemilli had gone, four people from Akpugoeze had attended the two-week training program in Oji River town. What residents remembered was that the LGA had promised the VHWs medical kits, and had not given them.

Conclusions: Health. In spite of the many things that the LGA PHC staff appear to be doing well, the actual service that villagers in Ofemilli, and the larger Akpugoeze settlement, are receiving from their government facility is no more satisfactory than in the other villages we visited. The main reason appears to be lack of supervision and feedback: if residents are not happy with the quality of service, the LGA staff ought to be aware of it, if only through the apparently low utilization of the facility. It also seems strange that a facility of its size that serves a large and isolated community (the Akpugoeze settlement) should not offer more than minimal treatment of illness. It would seem that the highest private costs in the LGA are unnecessarily borne by residents of one of the poorest areas.

d. Primary Education in Ofemilli

The school was built in 1945--financed by the Roman Catholic Church and built by the community. It was taken over by the government in 1970 after the civil war. Prior to 1970 housing was provided for the teachers. This has not been true since the civil war. When the school has been damaged, the government has not been quick to repair it. Thus, the village has taken on most of the responsibilities for repairs.

At the Akpugoeze school in Ofemilli, they have four classes that are all conducted in the same large, rectangular classroom. Painted blackboards line the walls on both sides. The ever-present attendance charts are also painted on the walls. About three or four long benches with attached writing shelves are clustered in each of the four locations where a class is taught. As many as 120 children and their teachers will use the same room simultaneously. The teachers at the school indicated that the lack of furniture in the classrooms was a major problem that they faced.

The former Headmaster complained to our team that, in general, no one controls the teachers anymore and he thought there was a real problem of discipline because so many teachers are now women. When we asked what would the PTA do if there were a problem teacher, he responded that the PTA would make very sure that there were a replacement teacher willing to teach in their village before raising any questions about trying to get someone transferred out. He and the villagers agreed that there was no current discipline problem in the village school. Thirty-two out of 34 of their students passed the school leaving exam last year, and one passed with distinction.

Land is in surplus, therefore teachers are offered land and the opportunity to grow crops for their own use as well as to farm for cash crops. The Akpugoeze Progressive Union (APU) awards scholarships for secondary school to no less than three students from Akpugoeze settlements each year. The current project for the PTA this year is the construction of a pit latrine for the school. This project is well along and the current Headmaster thought it would be completed by the end of July and ready for the new year. They are already beginning to plan projects for next year. The most important is to try to improve the furniture that they have in the classroom.

D. Localities in Sokoto State

1. Local Government in Sokoto State

Sokoto State, with about 10.94% of the country's total land area, has an estimated land area of 101,057 square kilometers and a total estimated population of 8.84 million in 1990. Sokoto State is the seat of one of the most researched pre-colonial empires in the West African subregion. The empire, known as a *caliphate*, centered on Sokoto, was the consequence of a major religious

movement which swept through the West coast and Sudanese Africa from the early 19th century until the British conquest almost a century later. The Sokoto caliphate extended over an area of about 150,000 square miles and was made up of thirty emirates with numerous sub-emirates (Usman 1979: 34). Each of these emirates incorporated over two dozen pre-existing kingdoms. After British conquest of the northern parts of the country, the British colonial administrative system was simply imposed on the caliphate system in what is controversially known as the 'indirect rule system.'

Sokoto State has continued to play a pivotal role in the politics of Nigeria. The last civilian president (Alhaji Shehu Shagari) hailed from Sokoto State. The Sultan of Sokoto is regarded as the leader of the Islamic religion in Nigeria as the direct descendent of the founder of the Jihad and the Sokoto caliphate, Uthman dan Fodio. (The new federal university located in Sokoto has been redesignated after dan Fodio.)

Before the nation-wide reform of local government in 1976, the local government system followed the old emirate structure. There were only five Native Authorities in the entire state. The 1976 reform created a total of 19 Local Government Areas. In 1981, the civilian state government created a total of 34 Local Government Areas but these were soon remerged into the 19 LGAs in 1984. In 1989, Sokoto was redivided into 37 Local Government Areas. With three exceptions (Sokoto LGA, the capital; Jega; and Argungu), all the LGAs comprise rural communities. A 1980 national sample survey showed that Sokoto State had an urban population of only 5% compared with the national average of 14%, 92% of the population subscribed to the Islamic religion, had only 45% of its 6-11 population attending school and a monthly average income of N 60.00 against a national average of N 80.00 [National Population Bureau, n.d.(d)].

The state of infrastructure: roads, water, schools, health, and electricity, is very poor in Sokoto. For instance by 1979, there were only 14 maternities in Sokoto State, the comparable figures for Plateau, Anambra and Oyo States at about the same time were 62, 38 and 161 respectively. Yet the Sokoto facilities are disproportionately found in Sokoto City. Seven of the 31 hospitals/clinics in the State are located in Sokoto City (Idachaba et al., 1985).

Compared to the ambiguous situation in southern states, local governments in Sokoto have been saddled for some time with major responsibilities, such as primary education and primary health care. Before the emergence of the Primary Schools Management Board, each Local Government was completely responsible for primary education (schools maintenance and teacher salaries), and basic health. The LGA financial base is, however, very weak.

2. Bodinga Local Government Area

a. Local Government and its Setting

Bodinga LGA was one of the LGAs created in 1976. It had a 1963 population of 212,561 which is projected to have grown to 414,020 by 1990. Bodinga is a predominantly rural LGA. The major occupations of its people are farming and pastoralism (cattle, sheep, goats, donkeys, camels). Each Local Government Area has district and village heads. Originally, Bodinga had six districts with the following estimated 1990 population composition:

Bodinga	-	42,298
Danchadi	-	88,229
Dange	-	61,854
Dingyadi	-	44,100
Shuni	-	152,947
Sifawa	-	24,597

In 1981, under the civilian state government, Bodinga was split into two LGAs. This decision was reversed by the military in 1984. The 1981 boundaries again became LGAs after the 1989 redrawing. In June 1991, Bodinga had four districts and district heads and 18 village heads. The Local Government has a staff strength of 612, the two highest staffed departments are Education (285) and Health (127). These two departments have about two-thirds of the total staff of the LGA.

b. Resource Mobilization in the LGA

Bodinga Local Government Area, like so many rural LGAs in the Nigerian federation, is heavily dependent on revenue transfers from the federation account. The latter account for as much as 95% of the recurrent revenue of the LGA. In the last three years (1988-1990) for which actual figures were available, federal transfers accounted for 95%, 85%, 93.3% respectively. In absolute amounts, these federal allocations have actually declined from N 7.4 million in 1988 to N 4.9 million and 4.8 million respectively in 1989 and 1990.

Federal monies are shared to Local Governments in Sokoto State on the following basis:

Population	-	45%
Equality	-	45%
Land Area	-	10%

A number of deductions are made by the Federal Pay Office off the top before distributing funds to Local Government Areas. These include:

10%	-	stabilization fund (discontinued January 1991)
2%	-	emirate councils
2%	-	loan fund

1%	-	common services (conferences, overhead expenses of the Local Government Departments)
1%	-	training

The State Government is required by law to give 10% of its internally generated revenue to the LGAs. For 1987-1989, this amount ought to have been N 7-10 million, but the State Government claimed to have given N 5 million in 1990. Both the Secretary and Treasurer of the Bodinga Local Government dispute that any State Government transfers have ever been paid to any Local Government in the State in the last five years. The State claims that it uses the above formula in sharing these funds to Local Governments.

The internal revenue sources have also been declining generally. Some rates that used to be collected have now ceased (see Table 7.15). The State Government, reportedly, has been discouraging some of the Local Governments that started to rate property, claiming that important policy issues are involved. Bodinga LGA is not one of these LGAs even though it has some property in Bodinga town that can attract property tax.

There are two surprises with respect to internally generated revenue. First, the community tax which is regarded all over the federation as a local government tax is not so regarded in this state. The tax (N 15.00) is collected with the development levy (N 5 per adult) and handed over to the State Government which is expected to return the N 5.00 Development Levy to the Local Government. Secondly, fees from commercial undertakings (markets, shops, tractor hiring, motor parks) and Interest on Dividends/Advances have become an increasingly major revenue earner for the LGA. These are not traditional revenue sources for rural Local Governments in Nigeria. The dividend monies, it was learnt on further investigation, comes mainly from the Local Government's investment of N 100,000 in the State Bank at the behest of the State Government in 1987. Though the LGA has fully contributed to the LGA Loan Funds kept at the state level, it has never succeeded in benefitting from any loans from this fund. The LGA's request in 1987 to build a market from this fund was rejected.

The major reason the State Government gives for not paying LGAs their part of the local tax is the claim that all LGAs in the state bought two tractors each in 1989, for which the State is now deducting. LGA staffs agree but claim that: (1) the LGAs were forced to buy these tractors, and (2) they are not informed of the actual deductions being made. Bodinga LGA has already paid in full for one of the tractors: N 140,000.

Table 7.15

Bodinga
Local Government Revenues and Expenditures: 1980 to 1990

(N 1000s)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Transfers	2592	2648.9	2851.5	2767.7	4687.1	3252.1	3383	3739.2	7430.1	4912.9	4820.1
Federal											
State											
Internal Rev	110.9	123.9	270.7	192.3	207.1	259.8	67.2	149.7	447.57	353.1	346.9
Taxes	52.5	0	7.8	14.8	126.9	186.2	31.8	66.1	294.7	238	126.3
Tene. Rate	2.6	1	6	4.6	2.8	6.8	0	0	0	0	0
License/Fee	24.7	121.2	252.5	163.5	54.1	38.5	35.4	35	56.7	30.2	17.2
Rent LGA Property	0	0	0	0	0	0	0	0	6.3	8.1	7.1
Earn of LGA Ente	6.9	1.7	4.4	9.4	23.3	28.3	0	0	39	34.5	116.9
Int & Div	0	0	0	0	0	0	0	0	1.87	42.1	78.4
Misc.	24.2	0	0	0	0	0	0	48.6	49	0.2	1
Cap. Inv. Re	24.2	21	44.2	60.3	36	32.5	0	0	0	0	0
Total Revs.	2727.1	2793.8	3166.4	3020.3	4930.2	3544.4	3450.2	3888.9	7877.67	5266	5167
Total Exp.	3403.4	1246.8	1351.7	366.4	1679.6	1219.3	3691.8	4190.3	8218	4769.1	4298.3
Recurrent	2371.6	900.9	739.6	366.4	1679.6	884.8	3319.4	3435	5776.5	2672.3	2853.6
Capital	1031.8	345.9	612.1	0	0	334.5	372.4	755.3	2441.5	2096.8	1444.7
Surpl/Defic	-676.3	1547	1814.7	2653.9	3250.6	2325.1	-241.6	-301.4	-340.33	496.9	868.7
CPI Index (Rural)	2.03	2.452	2.645	3.268	4.554	4.823	5.049	5.588	5.556	10.945	12.039
Pop. Est.	323436	331522	339810	348306	357013	365939	375087	384464	394075	403927	414026

(Continued on next page)

Table 7.15 Continued

Education Expenditures: Selected Years

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Education Recurrent									3447.9	120.4	
Education Capital									719.2	120.4	
Tot. Educ.									4167.1	240.8	
Real Per Capita Revenue and Expenditure Measures											
Real PC Transfers	3.95	3.26	3.17	2.43	2.88	1.84	1.79	1.74	3.39	1.11	0.97
Real PC Intern Re	0.17	0.15	0.30	0.17	0.13	0.15	0.04	0.07	0.20	0.08	0.07
Real PC Tot. Rev.	4.15	3.44	3.52	2.65	3.03	2.01	1.82	1.81	3.60	1.19	1.04
Real PC Tot. Exp.	5.18	1.53	1.50	0.32	1.03	0.69	1.95	1.95	3.75	1.08	0.86
Real Per-Pupil Exp.									1.90	0.05	0.00

Source: Unpublished data obtained from local government accounts.

LGAs have started profit-making ventures with state loans. Between 1989 and 1990, Jega LGA constructed a market with a loan of N 2.05 million from the State Government. In the same vein, Birnin Kebbi Local Government established a motel called Birnin Kebbi Motel after securing a loan of N 1.5 million from the State Government. The interest on each loan is 10%. The state Director of Finance indicated that the number of years for repayment is not specified, but where there is a suspicion or an evidence of non-repayment the state government can deduct the amount owed from the contribution it has to make towards the funding of the affected local government.

In order to qualify for a loan from the state-administered loan fund, the following conditions had to be satisfied by the LGA. The project must be viable, self financing, and revenue yielding. Only Jega and Birnin Kebbi Local Governments "qualified" for the loan by "satisfying" these conditions. Bodinga Local Government's market project proposal to the State Government in 1987 was rejected on the ground that there was no evidence of its viability.

On the whole there appears to be little incentive for an internal revenue drive by the Bodinga LGA. The tendency is to wait for "windfalls" and "manna" from the Federal Government. In 1991, it was expected that the Federal Government would make available to Bodinga Local Government N 9,589,680, and the local government itself would generate N 296,000. This is just 3.2% of federal allocations. The internally generated revenues of Bodinga Local Government represent 0.3% of Federal and State Allocations put together. While it was likely that the Federal Government would meet a large portion of its financial commitments to the local government, that of the state was less certain. In fact, the projected contribution of the state government to financing Bodinga Local Government in 1991 (N 60,540) is lower than what the local government itself hopes to generate.

c. Primary Health Care in Bodinga LGA

The roots of the Primary Health Care program in Bodinga LGA go back to 1976 when Sokoto State, like other states in the federation, executed the Basic Health Services Scheme. The state-wide construction effort added one Comprehensive Health Center, 12 Primary Health Centers and six mobile clinics. Costly errors were made. Much of the sophisticated health equipment procured under the program was distributed to communities, many of which had no electricity supply. Local participation in deciding on the implementation strategies of the BHSS was almost nil. The communities did not need equipment since the most prevalent health problems were malaria, guinea worm, and malnutrition, which could be tackled without sophisticated equipment.

In 1986, a new approach was adopted to correct the mistakes of the BHSS program. This new strategy included mobilizing the populace to bring them an understanding of what PHC entails. Five

LGAs, including Bodinga, were chosen as models for the execution of the PHC program. Bodinga has been supervised since 1986 by the Usmanu dan Fadio University Teaching Hospital. Jega LGA was under the supervision of the School of Health Technology in Jega, while the rest have been supervised by the Ministry of Health.

The medical institutions mentioned above were to mobilize the communities to accept and cooperate with the PHC program. Workshops were organized for Community Health Officers after which base-line data surveys were carried out, followed by situation analyses. The LGAs were then advised to formulate projects based on their revenue positions, including their N 500,000 grants from FMOH. Unfortunately, the base-line study carried out on Bodinga as a Model LGA was not available at the State Ministry of Health nor at the Local Government Headquarters in Bodinga nor at the teaching hospital that carried out the study and supervises the PHC program in the LGA.

Bodinga LGA has two Primary Health Care Centers. One is located in Bodinga town and the other in Danchadi, the largest district in the LGA, located 12 kilometers southeast of Bodinga. These are the only government facilities offering maternity services. There are nine dispensaries in Bodinga. There are also four leprosy clinics located in the affected areas.

Responsibility for the PHC delivery system was transferred to Bodinga LGA from the state in 1988. Although all salaries are paid by the LGA, the lower staff grades of the Health Department are managed by the LGA, while the Senior Staff (salary grades 7 and above) come under the Local Government Service Commission.

All local governments in the state, including Bodinga, were initially confused about their exact responsibility for implementing the PHC scheme. The Rural Health Superintendents or Public Health Superintendents were not qualified to administer the Primary Health Care program. The program required Community Health Assistants, Community Health Officers and Community Health Aides. This necessitated training selected personnel from the local governments. Those selected to be trained to handle the PHC program were the rural health superintendents, staff nurses, staff midwives, and Community Health Supervisors with at least four years experience in the field.

So far, twenty Community Health Assistants have been trained, not enough to meet the needs of the people in the LGA. There are 120 voluntary Village Health Workers who supplement the efforts of the Community Health Assistants. The training programs for the voluntary Village Health Workers are organized jointly by the local government and the communities. The communities recommend trainees to the local government, and the training is financed by the LGA. On completion of their training programs, the Village Health Workers return to their communities. They are not

on the pay-roll of the local government. Their services are nevertheless appreciated in those areas where there are no health facilities.

The Bodinga Local Government lays strong emphasis on self-reliance by the people in health care as far as practicable. The 75 Traditional Birth Attendants currently registered have been trained in modern techniques. Their services are considered very important because, with 18 villages in the LGA and only two maternity centers, it is difficult to provide adequate and effective services to all the villages, particularly in the rainy season when many of the roads become impassable for vehicles. Even though traditional medicine (Maganin gargajiya) is relatively popular in the area, no attempt has been made to date to register traditional healers.

The authorities in Bodinga reported only one drug revolving fund. They received a consignment of 61 cartons of drugs on 15th February, 1990. These are priced to recover the drug replacement costs only, not the administrative or handling charges. The distribution process is the delivery of one box of drugs at a time from the state to the LGA. Replacement depends on giving returns on each box after it has been exhausted. There are some drugs in the cartons that are not in common use in the LGA, including Metrifonate, which is used to treat chronic urinary infections, and mebendazole for diarrhea. Even though diarrhea is a common disease in the area, the people prefer to prepare their own sugar/salt solutions to treat diarrhoea problem than purchase mebendazole, as it is considered "very expensive."

So far Bodinga Local Government has opened twenty boxes and sold all the drugs to the dispensaries except those drugs not in common use in the area. Negotiations have been entered into with the State Ministry of Health for the latter to collect those drugs not in common use (quickly to avoid them expiring) and exchange these with the common drugs in demand. In demand are drugs for malaria, diarrhea, and ophthalmic drugs. So far, N 30,000 has been realized from the sale of drugs. It is expected that the present consignment of drugs will last for four years.

The treatment pattern in the LGA facilities reflects both the prevalent health problems and the limited care offered in the facilities. So far, 9828 patients have been treated for malaria since the inception of the Primary Health Care Scheme in the area, while 8336 patients have been treated for diarrhea. In addition, 6204 people have been treated for respiratory illnesses and 6323 treated for eye troubles in the Local Government health institutions.

The Expanded Program on Immunization (EPI) began in Bodinga Local Government in 1984. One vehicle, a new Toyota Hiace, was allocated to the LGA. The vehicle is not currently road-worthy. Transport is major problem in the LGA, resulting in the inability of the local government

health officials to visit all the villages and hamlets. During the rainy season, it is practically impossible to visit any of the villages except with motorcycles or four-wheel-drive vehicles. According to the Head of Health Department in Bodinga Local Government Headquarters, immunization campaigns are organized only when there is transport.

Officials estimate that with effective transportation it would still require a full month to visit all the nooks and corners of the LGA to inspect health institutions and to provide health education to the people. The Health Education Unit and MAMSER assist the local government in arousing the awareness of the various communities of the need to be immunized against communicable diseases. Inadequate transport for the Health Education Unit slows down the rate of progress in public enlightenment on immunization.

The Head of the Health Department indicated that there is an encouraging response to immunization. He could not supply specific figures on the number of children immunized so far; however, between March 1989 and July 1991, the following vaccines were supplied to the local government by UNICEF through the State Ministry of Health:

B.C.G.	53,000 doses
D.P.T.	81,000 doses
O.P.U.	81,000 doses
Measles	55,500 doses
T.T.	27,000 doses

d. Primary Education In Bodinga LGA

Bodinga had a total of 72 Primary Schools in 1990 with a total enrollment of 24,287, 30.1% of whom are female. Table 7.16 gives annual data from 1972 on Primary Education in the LGA (with no adjustments for boundary changes). Schools are organized by Districts. Each of the districts has an Area Officer with an Executive Officer and two to four supervisors. Their responsibility includes school supervision and the actual payment of teachers' salaries. In 1991, Danchadi District had 25 schools, Bodinga District had 17, Dingyadi District had 17, and Sifawa District had 13.

There are three types of schools in the area: Model Primary schools, Ordinary schools, and Arabic schools. All are fully funded by either the LGA or the State Government. The Model Primary schools were constructed by the State Government. The LGA is organized as an autonomous body, although it shares the same premises as the LGA. It has its own Executive Secretary, Finance Officer, and separate account from that of the LGEA. The LGEA pays a monthly bill of N 292,941.00 for teachers' salaries and their entitlements.

Table 7.16

Schools, Teachers, and Enrollment
Bodinga Local Government 1972-87

Years	Schools	Teachers	Enrollment
1972	40	187	10,522
1973	40	211	10,962
1974	40	232	11,750
1975	40	254	12,543
1976	114	294	12,967
1977	128	341	13,679
1978	141	390	13,849
1979	176	502	13,978
1980	201	606	14,389
1981	201	658	15,092
1982	201	704	15,187
1983	201	791	15,289
1984	135	679	14,389
1985	135	687	14,550
1986	133	704	16,009
1987	133	710	16,194
1988	131	824	n.a.
1989	72	n.a.	n.a.
1990	72	384	24,287

Source: Unpublished records of the LGEA, Bodinga LGA.

It is significant that Sokoto State has the highest enrollment of primary schools in the country. Several reasons were advanced to explain this situation in the State Ministry of Education. All revolved around the high profile given to primary education in the State through persuasion, major capital investments and projects such as operation 'Move Ahead' with the objective of increasing enrollment and especially meant to persuade Muslim parents to release their children/wards for schooling, mobile classrooms to provide nomadic education before the latter initiative became a national program etc. In 1985, in order to attract graduates and NCEs to teach and head primary schools in the state, the State Government promised that any public servant willing to teach at the primary school level would not lose his/her salaries and privileges. All of these efforts seem to have paid off. Primary schools enrollment has risen astronomically from 136,977 in 1975 to 704,397 in 1990. The proportion of primary school age population in school has risen to 66.4% from 46% in 1981. (The figure in 1975 is much less, around 19%.) In particular, the female pupil enrollment has increased dramatically from 43,218 in 1975, to 176,142 in 1990.

On the other hand, while formal enrollment is high, the actual attendance is low. In the Darhela village school visited, none of the 53 students registered in Class One had attended school from January 1991 to the end of July. In some other schools sampled in Bodinga itself, several of the classes have had to be merged even in the Model school. In a non-Model school, there were only 6 pupils instead of 19 found in Class Six. Similarly, in a survey conducted in the State in 1990 by the National Primary Education Commission (1990), only 238,180 pupils were in attendance (i.e. about 35% of the class were not attending). Several reasons were given for poor attendance. First, the fact that the pupils were needed on the farms during the farming season. Second, many parents remained unpersuaded of the value of education. Perhaps a third reason is the very deplorable physical state of some of the schools.

The proportion of uncertified teachers is also very high in this State. In 1990, 71.8% were classified as unqualified (i.e. did not have Grade II teachers' certificate) (ibid.). A national decision had been taken by the Federal Ministry of Education to phase out uncertified teachers in 1992, but fulfillment of this policy had to be extended to 1995 because of States like Sokoto. Several of the teachers in Bodinga Local Government Areas were uncertified. Most of the uncertified staff are Arabic teachers.

The State Government has a policy of encouraging unqualified teachers to go for in-service training but some of the teachers claim that the policy is not fully implemented as their salaries are often not paid during training. The proportion of teachers who are fully certified at the village level

was 62.5%, but the average for the Local Government was 11.2% (only 43 of 384 teachers had the minimum of Grade II Teachers Certificate). This underscores the qualitative differences between LGEA schools and the Model schools started by the State Government. Teachers are generally poorly trained in community relations, as demonstrated by the case of the headmaster in Darhela.

There are only 13 private primary schools in the State, most of which are located in Sokoto city. They charge fees between N 70 - N 120.00. These private schools are attached to institutions such as the police and the military. The State Ministry of Education is responsible for quality control and policy matters for such schools. This is in addition to giving approval for the existence of schools--they have to certify buildings, teachers' qualifications and recommended texts. Generally, the private schools have more highly qualified teachers than either the LGEA or Model primary schools.

The State Government has worked out new modalities for the administration of primary education in the State. Local Governments are responsible for salaries and pensions of teachers and non-teaching staff only. This is being paid at the new (minimum wage) rates in the State. The State Government is responsible for supervision, infrastructure development and rehabilitation. This is, however, not being carried out yet.

3. Darhela Village

a. Darhela Village and Its Setting

Darhela is the largest village of 121,362 people in the Sifawa District of Bodinga LGA. It is about 8 kilometers to Sifawa, the district headquarters which is itself only some six kilometers from Bodinga, the seat of the LGA.

Darhela is a rural community in every sense. It is surrounded by thirteen hamlets. Each of these hamlets is represented by a Hamlet Head who is also responsible to the Village Head in Darhela. These meet monthly with the district. Their functions are to pass on messages to the people from the government, stimulate community development and, most importantly, to collect the community tax (N 15.00 per head) and development levy (N 5.00), a total of N 20 per adult male above 16 years, except those regarded as destitute. These hamlet representatives are paid a commission from their collection although they are also farmers or pastoralists.

The Village Head, Alhaji Abdulahi Magaji, was appointed to this position in 1968 after the death of his father, who had three other sons--none of whom was interested in this position. The position of Village Head, while hereditary, requires the approval of the Local Government and the State Government. The Village Head is assisted in his duties by a Secretary. Both of them are on the payroll of the Local Government. The Village Head was paid N 460.00 per month, besides several

allowances. He also has income from farming. He meets daily to discuss village and district matters with the District Head in Sifawa who is also an LGA employee. There is a marriage tie between the Sifawa District Head and the Darhela Village Head.

The LGA and community governments seem fully integrated in this part of the country along prefectural lines, an indication that the "indirect rule" system has been sustained over time, in spite of several efforts to reform it at the regional/state and national levels since the end of the colonial period.

The major occupation of the inhabitants of this village is farming (barley, guinea corn, beans, onions, etc.) The village has public bore-hole water supply system located next to the dispensary. The dispensary is not far away from the model primary school. The village has no maternity or electricity supply. The closest clinic is the one in Bodinga.

b. Resource Mobilization in Darhela

Even though there is evidence of increasing wealth in this village (judged by the increasing number of new housing units and housing rehabilitated with mud/cement blocks), the village is yet to tap this wealth to its full potential for generating resources to pursue community development activities.

The dispensary and the two laterite roads to the village (11 km.) were both constructed in 1979, before the Local Government and DFRRRI respectively took them over for further renovation. Moreover, the Village Head claimed that the community had constructed 15 shallow wells through community effort. This effort was largely voluntary although males who had no money to contribute provided the labor. The women fetched water. These projects were carried out with the active collaboration of the National Youth Service Corps members. However, community activities have remained almost dormant since the early 1980s. The principal reason given for this situation by the village head is that the community could not reach a consensus. The local government has been quite active in the area: it improved the laterite road in 1988 with the assistance of DFRRRI; it built the leprosaria and maintains it; and it is responsible for teachers salaries.

The school was in a deplorable state. Perhaps part of the problem is that education occupies a low priority in the estimation of the villagers and the Village Head. When asked to indicate the priorities of the village in the presence of several adult villagers, the Village Head chose: (1) water; (2) electricity; and (3) after being prodded on education, secondary education. None of the elders present disagreed with this listing of the village's priorities. When asked why the village will still want more water as its first priority, the Village Head responded that things were usually difficult in

the dry season for this farming community. Several hamlets lacked water in the critical months. They would want to have better and more roads to ensure that inaccessible hamlets can be reached and can transfer their products to the market and get additional inputs.

We were unable to get the women's perspective on village priorities. Two elderly women were called to our meeting but they refused to talk in spite of several proddings.

We discovered that a CDA exists in this village: it is known as the Hima Social Club (HSC). It came into existence in 1976, and membership is around 500. The Secretary claims that the Club has been active in the following areas: construction and maintenance of koranic schools, mosques, hand dug wells (five), and support for an adult education program. A hall was constructed for adult education in the village in 1964 through the help of the LGA. HSC levies every member N 1.50 a month and additional amounts. The Village Head and others indicate that the living conditions of the average farmer have improved, especially in the area of health and agriculture because the people are now more open to western medicine and new seeds. SARDA (the World Bank-financed Sokoto Agricultural and Rural Development Authority) has also been very successful in the area (roads, agricultural inputs, and water). One teacher in the school, however, noted that education has not improved in the village. Similarly, mechanically propelled vehicles (motorcycles and automobiles) have declined in the village because of the high cost of repairs.

The Village Head claims that two committees have been established in the village to tackle the twin problems of education and overall development of the village. Neither of the committees has made any progress. The education committee, of which the village head is the chairman and the headmaster of the school is Secretary, has not met since the beginning of the year. The village has no town/village hall.

c. Health Care in Darhela

The government dispensary in Darhela was constructed by the LGA in 1979. It was repainted in 1990. The public bore-hole water supply system is located next to the dispensary. The closest PHC clinic is in Bodinga, about 14 kilometers away. The dispensary also serves four hamlets averaging two kilometers from Darhela.

The dispensary is of cement block construction and has two rooms: a consultation room in the front and an examination and treatment room at the back. There is little medical equipment in the dispensary. At the time of our visit, the dispensary was dusty and poorly patronized. Two haggard-looking women came to the dispensary, each holding a baby less than one year old. There is one bed

for examinations, but no facilities for admitting patients. It is a basic dispensary like those in Itaganmodi and Wereng.

The surroundings of the dispensary are not clean. At the time of our visit there was dirty stagnant water at one side of the dispensary. The major pump of the bore-hole water supply scheme is located close to this stagnant water. There are many flies in the dispensary, but the staff does not see the presence of so many flies as posing any danger to their patients and themselves, so they make little effort to check the flies and drive them off.

Health Care Professionals. The senior staff member is Malam Adamu Abubakar, who trained as a Community Health Assistant at the School of Health Technology, Jega. Malam Abubakar is assisted by a dresser (who dresses injuries). There are also two cleaners and a night guard. The Community Health Assistant was posted to Darhela six months ago. He lives in Bodinga town, his birthplace. The official hours of the dispensary are 8:00 a.m. to 2:00 p.m. Monday through Friday, and 8:00 a.m. to noon on Saturday. The voluntary Village Health Workers provide first aid when the dispensary is closed.

There have been regular supplies of drugs to the dispensary from the LGA since the 1990 DRF began to operate. The most recent shipment of drugs was received in March 1991, and was not exhausted in July of 1991. The Community Health Assistant obtains drugs from the Health Department at the LGA Headquarters. The receipts for the drugs indicate the cost of the drugs. The proceeds from sales at the dispensary are deposited with the LGA. So far, Darhela Dispensary has made returns of N 1,500 to the LGA Headquarters in Bodinga for drugs sold at the dispensary.

The most common diseases in the area are malaria, diarrhea, cough and eye problems. These diseases are seasonal. Malaria is most rampant during the rainy season (June - September), while cough and eye problems are common in the dry season. The drugs obtained from the Health Department therefore focus on these diseases. In the rainy season malaria drugs make up 85% of the dispensary's sales, and diarrhoea treatments 15%. In the dry season cough syrup is in higher demand.

Residents and Health Care. Some of the members of the community were interviewed about their use of the dispensary. They said that there is prompt service at the dispensary and that they are charged no fees for consultation with the Community Health Assistant. They are charged only for drugs that they buy from the dispensary. The respondents say that they do not boil their water now as they see no need to do so, since they believe that the bore-hole water is treated before it is made available to members of the public. Before the rural water scheme provided bore-hole water they did not boil

their water either, because they felt that it was not absolutely necessary for them to treat their water in spite of the education efforts of the Public Enlightenment team of the Health Department of the LGA and MAMSER.

Some of the community members interviewed indicate that some people have accepted the idea that they have to keep their eating utensils clean all the time to avoid outbreaks of epidemics. To them the Primary Health Care scheme seeks to minimize health hazards in the Community. The villagers interviewed claim that they now understand the objectives of the Primary Health Care Scheme, especially those that affect them directly. That is why the community is supplying labor to build the Community Health Assistant's residence in the village. The construction project, which will also include an expansion of the dispensary, is being financed primarily by the LGA. The building is being constructed with blocks and will soon reach the roofing stage.

A large portion of the villagers claim that it is not difficult for them to purchase drugs, particularly those drugs in common use. To them, the prices of the drugs in the dispensary, especially those for malaria, are affordable because they have been receiving good profits from the sale of their farm products.

Conclusions: Health. LGAs appear to have been given fewer responsibilities for PHC in Sokoto than in other states, if the evidence about the drug revolving funds is an indication. The LGA staff does not seem to have made the EPI program as much of a success here as in the other LGAs, although the other LGAs also experience transport shortages. Both from descriptions of the lack of transport and the description of the dispensary in Darhela, lack of supervision is a problem. The Community Health Assistant in Darhela does not seem to be mobilizing the community for preventive health actions, and the dispensary is clearly not a model of cleanliness.

d. Primary Education In Darhela

Only one school, the Darhela Model Primary School, exists in this village. It was constructed by the State Government in 1970 but run by the LGA like all other model schools in the state. By the time we visited the school, in the company of a State Ministry of Education official and the Secretary of the Bodinga Local Education Authority, the school had been closed down, ostensibly because of the national program of voters' registration which had entered into its second week. We were informed that six of the eight teachers were involved in the exercise including the headmaster. However, due to the strong displeasure of the State and Local Government officials, the school opened the next morning with all the attending students lumped into one class. None of these

students was in uniform. Two teachers taught but others showed up later. This episode underscores the weak supervision of schools in the State and the Local Government Area.

Physically, the school was in a bad state. The roof of one of the three blocks blew off in early 1990 and remains unrepaired. The other two blocks stank from bird faeces and appeared as if the school had not operated for a month. Several of the classrooms had neither windows nor doors. The walls were made of cement blocks but they had become dilapidated through lack of maintenance. The ceiling was down in most classrooms. The flooring had also eroded. There were no play facilities of any sort, not even a football field nor the ubiquitous school drum.

The data on enrollment had to be fished out from enrollment registers which were thrown in different classrooms and were in tattered shape. In spite of the spirited assistance of the teachers and the Headmaster, we were not able to establish enrollment data for any year besides 1990 and 1991. Diaries, school record books, files and ten copies each of textbooks supplied by the Federal Ministry of Education through the State Ministry of Education (for English Language, Mathematics, Social Studies and Hausa) were found in various cupboards in the Headmaster's office.

The school had only five classes at the time of our visit. There were no pupils for classes I and III. Last year there was no class II and the year before no class I. A total of 53 prospective students, who were registered by the headmaster during the drive for school registration, never showed up. We were informed that this was a normal thing in other schools in many villages. Out of the Primary Class, six pupils who finished last year (36 of them), only one-third (12) passed the common entrance examination. Of this number, only one student (a girl), actually went on to a secondary school located 50 kilometers away.

In all there are eight teachers. Out of these five have the minimum qualification for teaching in a primary school, although as we pointed out earlier, other schools that are not model schools are not so lucky.

There was wide acknowledgement among the teachers that the PSMB days were a bit better, especially in terms of supplies, school rehabilitation and encouragement given to parents to ensure that their children came to school, even through some of these activities were carried out by the Local Governments. Since the beginning of this year, all of these activities have stopped. Nevertheless, there has been no problem concerning their salaries. Salaries have been paid promptly at the new pay scales. The last time there was no payment of salaries was during the Second Republic, 1981-1983. Neither the Local Government nor the State Government has carried out any maintenance activities since January 1991 in spite of two complaints lodged with the Local Government.

The Headmaster, who was posted here only last January at the completion of his N.C.E. Course in Sokoto, is of the opinion that the reason the people of the community are so uninterested in schooling is the absence of any benefits which a successful pupil from the school could show in terms of jobs or higher educational qualification. The best among them have come back to teach in the same school. Five of the teachers were born in the village and live in the village, while the Headmaster and two others live in Sifawa. These indigenes of Darhela agreed with the Headmaster's contention. The frustration of these teachers is understandable given the fact that they do contribute out of their meager salaries to repair the school buildings with little encouragement from the community, the Local Government, State Government, or Federal Government.

On the other hand, it is possible to argue also that the state of the school and the absence of any facilities which could act as incentives are actually disincentives to the pupils. The impression one gets is that there is a vicious cycle at work--the poor environment of the school has lowered the morale of the teachers resulting in teacher absenteeism, which in turn results in pupils and parents withdrawing their resources and children from the school into alternative opportunities. The teachers and members of the community were unanimous in noting that school quality had fallen in the village. The teachers have been hard hit by inflation and hence most of them had become farmers. In fact one of them interviewed claims to be the owner of all the farms around the school. He has been teaching in the school since 1982. The school has no farm of its own.

Most of the pupils have no slates nor exercise books. Small exercise books, which were to be distributed to primary pupils, were not given to them and were lying on the floor of the Headmaster's office.

The Headmaster had been promoted only once (1985) from GL 04 to 05 in all of his teaching experience (1973 to present). None of the teachers have been promoted. They all felt that their chances of promotion would have been higher under PSMB since the Local Government complains of scarce funds to pay the current minimum wage-rates. The headmaster had worked in four schools altogether since 1973. Of the four postings, only once did he enjoy in-service training sponsorship and that only partially. Also, only once did he get transferred because he requested it. That was in 1982 when he transferred from Wurno to his hometown, Sifawa.

VIII. CONCLUSION

General Policy

The research team was asked to try to sort out the diverse impacts of SAP and of decentralization on service delivery in rural areas of Nigeria. While we have many reflections on the current state of rural health and educational services, trying to sort out the specific impact of SAP and of decentralization policies on this current state is difficult to do. Among the many changes in the economy, in government structure, and in policies that occurred at roughly the same time, are the following:

- oil price fluctuations
- SAP policies
- variations in governmental implementation of SAP policies
- movements toward civilian government
- changes in local government responsibilities for education and health
- changes in formulas for financing local government responsibilities

The puzzle of sorting out the individual or cumulative impact of these multiple inter-acting factors makes highly specific research or policy conclusions difficult.¹

Given the way that SAP was introduced and the inconsistency in the policies adopted in Nigeria, some aspects of the debate about its impact are impossible for a team assigned a specific service delivery focus to evaluate. Further, given both the institutional framework and the inconsistent signals and policies adopted, one might even consider it rather startling that any positive results have occurred at all. For all of this, it does appear that there are some positive accomplishments of economic reforms adopted during the past five years. These include:

- increases in non-traditional exports
- increased used of local raw materials
- increased level of agricultural productivity

Further, there appears to be an increased awareness of the opportunity costs of prior policies.

Most citizens of Nigeria would agree that the prior policies of supporting a large number of parastatal firms and a bloated public sector were largely unproductive. Poor policies were also responsible for the unresponsiveness of the agricultural sector, the stagnation of exports, and a

¹We are not alone in being puzzled about the effect of SAP in Nigeria: see Mustapha, 1991; Herbst, 1990; Olukoshi, 1992; Robinson, 1990.

widening gap between imports and exports. Thus, policy changes such as demobilization (which had been initiated in earlier years and pursued still further as part of SAP), privatization of some parts of the previous parastatal economy, and retrenchment of public employees are perceived as harsh and unnecessary when the elite is clearly still living very well.

Many aspects of the retrenchment had been initiated prior to SAP and cannot be attributed fully to structural adjustment policies. Some aspects of the retrenchment may also adversely affect the investment in human capital that is necessary to gain a viable and entrepreneurial private economy. For example, as we discuss in Section V, some retrenchment in educational expenditures had already occurred in the early 1980s in response to the reduced governmental revenues received from petroleum exports. In regard to health expenditures by government, the level of expenditure has always been low. During the late 1970s, it varied between 2% and 3% of government spending, and .3 and .5 of GDP, and between \$300 and \$400 million (in constant dollars). By 1988-89, the total health budget of the Federal Ministry of Health was only 1.5% of the total Federal budget (Morrow et al. 1991: 6). During the 1980 to 1985 period, nominal expenditures did not drop significantly. Expenditures on health were 2% in 1980 and 1% in 1985 of government spending; 0.4 (1980) and 0.2 (1985) of GDP and about 400 million (1980) and 190 million dollars (1985) (Gallagher and Ogbu, 1990). Devaluation has, however, strongly affected the value of government funds invested in both health and education. The total budget to the FMOH in 1991, for example is worth about one-half of the value of the total FMOH budget in 1981.

The connection between devaluation and the positive response to the incentives it has created for several economic sectors is less well understood and accepted as a valid measure of success. The public debate about SAP, therefore, has become diffused. But the lack of confidence that exists in the government and in the capacity of the government to keep to a consistent policy has meant that the private sector has not responded as fast as is needed to ameliorate the high dislocation costs by creating new jobs.

The very rapid set of structural and policy changes made at national level tended to reduce the stability of expectations and may have created fundamental tensions that then lead to further change and further instability. One example is Decree No. 3 related to primary education. It was announced and decreed within one week in January 1991 that the existing structure of state educational administration should be turned over to the LGAs. The prior system had been put into place only two years before and, according to all reports, it had improved the performance of primary education. Since January 1991, many proposals have been made for further changes in the administrative

structure related to education. Another example is the arbitrary change in state and local governmental boundaries that occurred late summer 1991.

There is a basic inconsistency between the overt policy to cut-back, save, and invest for the future on the domestic scene, and some international and national policies. On the expenditure side are the N 500 million or so invested in a International Conference Center at Abuja and the N 55 million for Mercedes Benzes given as gifts to foreign government officials. There has been considerable investment in showy infrastructure around the new national capital instead of repairing schools, and getting drugs into health clinics and books to school children. Driving through the national capital just prior to a visit to a rural school without a roof and without any books raises questions in an observers' mind about where cutbacks and savings have occurred and not occurred.

The extreme centralization of public revenues has led to a pattern of unceasing attention to how central revenues are divided. Local government administrations, local service units, and local people all have strong incentives to extract maximum resources from the center; they do not have good reasons to try to keep personnel and overhead costs of local government low. If "decentralization" is ever to mean anything, central governments will need to take numerous steps to cut local governments loose from the whims of the center. This will not be easy to do. Changes that might reduce dependence on the center would involve giving back to local governments the taxing powers they used to have, giving them full control over personnel and overhead spending, and giving local communities, through elected representatives, the power to shape and monitor local budgets. Obviously, exactly what powers, responsibilities, taxing authority, monitoring authority, etc., would be best assigned to state and local governments is something for Nigerian citizens and officials to decide. The strength of community development associations of one form or another throughout much of Nigeria is a major resource; however, if stronger local governments were allied to indigenous organizations and principles, increased performance and accountability could be achieved.

With these somewhat general reflections in mind, we will now turn to some more specific conclusions concerning local government, rural health services, and rural educational services.

Local Government

1. Politicization of local governance may represent a major setback for the long-term evolution of local government. Issues at a local level are rarely the same as those at a national level. The particular form of election--only two parties allowed and open voting--makes local teachers and other officials fear that if they do not support the winner of a local election, they will lose their jobs. Politicization turns jobs into patronage resources rather than public service positions.

2. The "third tier" of government is not the only form of local governance. LGAs are very large units, even under the most recent reorganization. Ward and village structures are operational in many LGAs and have evolved ways of organizing resource mobilization and public activities that could be drawn on in future evolutions. The fourth tier--or the "invisible" form of local government--could more effectively be drawn on in regard to:

- Debate and clarification of priorities
- Project planning and financing
- Accountability for payment and use of funds

Many of the community development associations have developed formulas that are used in mobilizing resources that are considered equitable by local villagers even when they involve major differentials in levels of contributions. The principles involved in these resource mobilization formulae could be used in the design of a more effective form of local public finance for the LGAs.

The "informal public economy" is not entirely invisible. It has various levels of recognition and legitimacy.² Progressive unions of one sort or another are so prevalent throughout the country that they have gained some government recognition, including formal sharing of resource mobilization activities with DFFRI and other Federal, State, and Local Governmental Agencies. Traditional chiefs are provided modest stipends in state and local government budgets. But the real weight of the governance of much of rural Nigeria falls on indigenous institutions that are adapting at various rates of speed. At the same time, more "modern" institutions, such as the PTAs at local schools, are given little scope for individual initiative. Many of the activities that they want to undertake must be approved by the Ministry before they can undertake them. Thus, in the name of equality, local initiative is repressed in many forms.

Health and Education

1. There is a mismatch between revenues and expenditure responsibilities for education and health. The basic formulas used to allocate funds for education and health are not sensitive to the cost to the LGAs of these particular services. This is currently the source of considerable internal debate.

2. Some education and health activities that have been most successful have adopted a "project" or "campaign" mode of delivery rather than being built into the regular service delivery facilities. This concentrated, occasional strategy may be more relevant for health than for education.

²and growing attention from scholars, see the very interesting paper by Sklar, 1992.

3. Some health professionals and teachers seem to be moving back to their natal villages and carrying on two income producing activities in order to survive: combining health care or teaching jobs with farming. This presents villages and LGAs with opportunities to integrate individuals with skills and commitment to the village into the educational and health care systems, while also illustrating the current problems that these salaried employees are facing.

4. The villages should not be regarded as passive recipients of education and health care services; some of them are working actively on their own behalf and have clear preferences. The problem for the LGA is that the health district or ward boundaries may not coincide with village administrative units. Primary schools may be located in somewhat more "natural" locations since many of these were earlier built by villagers and run by religious establishments. The LGAs, in order to mobilize communities, should work with the self-defined communities rather than imposed administrative units.

Health

1. Some FMOH guidelines to the LGAs for PHC implementation are quite specific and were observable during our visits. So far, the way in which guidelines have been carried out does not improve service delivery.

- Village Health Committees. LGAs are to encourage villages to establish Village Health Committees. What we saw were active PHC administrative efforts based in the LGA headquarters, and active village development committees engaged in three of the four villages in maintaining or upgrading their curative health facilities. Neither group characterized the Village Health Committees as active, and it was clear that the PHC staffs did not have available transport to participate in meetings of Village Health Committees. In two villages the dispensers were either too untrained or too new to have any impact on health committees; in the third relations between local staff and the community were not close, and in the fourth the dispenser's public health efforts seemed to be appreciated, although no one mentioned the Village Health Committee.
- House enumeration. Three of the four LGAs had completed house enumeration exercises, and the fourth had finished the principal settlements. It was not clear that any activity making use of the house numbering effort had been undertaken.
- Home-based records. No one mentioned home-based records in any of the LGAs or villages.
- Village Health Workers. All of the LGAs had trained some voluntary village health workers in 1990 (none had been trained before then) and were planning to train more in 1991. The workers did not appear to be integrated into the LGAs' ongoing PHC efforts.

2. The current success in service delivery is the EPI campaign program, not the institutions designated for PHC delivery under the 1988 PHC policy. Dispensaries, the lowest rung of the Primary Health Care system, do not deliver much useful service. We visited four villages and saw four government dispensaries, one of which also offered facilities for delivering babies. None had much in the way of equipment, diagnostic capabilities or drugs--from a curative point-of-view they were little more than first-aid stations. None of them was doing much about providing public health awareness or preventive health care either. They did not generate useful data about vital statistics or village health problems. They did not provide a link between the LGA headquarters and the village, either to alert the LGA staff to village problems or to communicate new ideas to the village from the LGA. None appeared to be well supervised by the LGA staff. Since they provided so few services, they did little to cut the private cost of health care for village residents. All appeared during our visits to be under-utilized. One facility seemed to be valued by the community, two seemed not to be, and the fourth was in the process of being replaced by villagers' efforts to build a more advanced facility. Our overall impression was that LGA primary facilities in their current form are limited in their usefulness to the point that it is justifiable to question their cost-effectiveness and relevance to health care delivery.

The big success in three of the four LGAs has been the EPI effort after LGAs adopted a campaign approach. In all the LGAs, EPI programs formally began before the first series of National Immunization Days in 1988, but positive results seem to date from the switch to a campaign approach. In three LGAs campaigns are still being carried out successfully, in conjunction with immunization availability in government facilities year-round, in spite of the chronic difficulties with transport. The campaign approach seems to offer a useful model.

Training voluntary village health workers does not seem to have made much impact on village health care, except perhaps in Sokoto. If the trainees have not received their medical kits, are not paid for their services and have no links with dispensaries or the LGA for continuing education and feedback, there does not appear to be much value in having trained them accruing to the LGA or the workers themselves.

In all of the villages, the communities have made some effort to increase the level of curative care available in the village. (Itangunmodi: building a maternity/cottage hospital; Wereng: subsidizing a private facility; Ofemilli: built a maternity; Darhela: building a dispensary extension and Community Health Officer's house.) The villagers' emphasis on curative care is not irrational: they all face high private costs for obtaining curative care that is available only at some distance from

the villages. They have no way to predict when they will need curative care in an emergency, and they have witnessed plenty of health emergencies. So far, they have not been faced with the recurrent cost implications of their construction efforts (in Wereng there are no recurrent cost implications as long as the private facility stays in business), so there has been no need for them to limit their ambitions. Even if they were to put a great deal of community effort into preventive and public health measures and the efforts resulted in less disease, they would still be rational to want as much curative care as possible close at hand if they do not have to pay the full cost for it.

The chronic difficulties that we and many others have observed with transport, record-keeping and persuading trained staff to serve in rural locations seem likely to continue to hamper PHC delivery under the current system. Perhaps a way to start thinking about better service delivery is to combine the observations about villages' skills and desires, the success of the EPI campaigns and the under-utilization of government dispensaries. As they are now organized, government dispensaries would have to be far better supervised, staffed, managed and equipped in order to give acceptable curative and preventive service. Perhaps mobile clinics plus more use of, and remuneration to, the trained village health workers would provide residents with about the same level of "first aid" that they currently enjoy, plus integrated curative and preventive services at regular intervals that would cut their private costs of obtaining routine and non-emergency care.

As Oji River LGA demonstrates, the PHC department does not have to own enormous numbers of vehicles to carry out campaigns because vehicles can be borrowed or rented. In Nigeria there seem to be enough private for-profit transport operations that LGAs could contract with safe and reliable operators to reduce the LGA's exposure to capital losses and interrupted service delivery when government vehicles break down.

3. The campaign approach offers effective service delivery for a number of reasons:

- The top LGA staff manages and supervises the effort, and is clearly accountable for successful completion. Because the campaign is a discrete event, it can be evaluated, and some of its results quantified, more easily than day-to-day operations.
- The top staff gets out of the LGA headquarters and sees what is happening in the villages and at government facilities.
- All the necessary components have to be assembled (transport, staff, vaccine, equipment, etc.), placing clear responsibilities on the LGA staff.
- Campaigns are essentially projects. Just as the villages appear to be comfortable with a project approach to improving village conditions, the PHC staff members that we interviewed seem to be comfortable with the "project" nature of campaigns. It may also

be easier for external donor agencies to help with campaigns than with day-to-day operations.

- The LGA staff learns to work with the local systems (through clergy, teachers, chiefs, etc.) for publicizing the campaign schedule and learns local preferences for scheduling to create an event that people will attend (nonmarket days, etc.)
- There is an opportunity for synergy: the Village Health Workers and others can be brought into the operation, and more than one health objective can be accomplished.
- Since top staff head the effort, and the same team visits many sites, villagers are uniformly getting the best care and most up-to-date information available.
- The private cost of health care is lower for villagers when they do not have to travel.
- Since most villages do not have electricity or piped water and most health facilities have little equipment, the campaign approach of bringing everything necessary is appropriate.
- The campaign approach involves teamwork; this may be a better and cheaper way to train and supervise lower level staff than posting them to isolated facilities and trying to supervise them from the LGA headquarters. It maximizes the use of the top staff, not only in managing operations, but in supervising and educating staff.
- One of the reasons for the acceptance of immunization has been that villagers could see that the incidence of measles dropped when a large proportion of babies were immunized during the National and State Immunization Day campaigns. The campaign approach offers the possibility of demonstrating cause and beneficial effect through treating or educating large numbers of people in the village at once.

On the negative side, campaigns are considered to be expensive, although under-utilized government facilities are certainly also expensive. Record-keeping under campaign conditions, and then integrating the records into facilities' records, is more work than keeping a single set of records (but record-keeping is not being done well now). The campaign approach misses individuals who can not attend during campaigns, but does not discriminate against poor people. The campaign approach is not appropriate for all health problems. What we are recommending is that it could be used more, in conjunction with donor programs perhaps, because more health care could be delivered directly to the villages through campaigns than through the dispensaries as they currently operate, and probably at less cost than bringing the dispensaries up to adequate standards.

4. LGA PHC staffs and chairmen should be looking harder at utilization rates of government health facilities and asking village residents why they are not using the facilities. Health care clearly is a priority in the villages we visited. A dialogue between the village and the LGA about what is possible given LGA finances and village priorities seemed to be one of the objectives of the PHC

initiative that has not yet been brought down to the village level. Mobilizing the villages through the Community Development Associations, which appear to have great legitimacy, seems more likely to produce results than setting up new committees. Administratively, the LGAs would probably prefer to deal at the health ward or LGA PHC Committee level; however, since villages see themselves as discrete units, the LGAs should accept that reality and work from there. It is the CDAs that build health facilities, and who will need to be persuaded to support public health projects instead of curative facilities that the LGAs may not be able to afford to run.

5. Record-keeping and data analysis were poor in all the places we visited. However good PHC staff are at their professional specialties, there should be incentives offered to keep good records, and sanctions for failing to do so. Until it becomes clear what organization supervises, hires and fires health staff, it may be difficult to enforce better record-keeping. A workbook, similar perhaps to the one developed for district-level planning and budgeting for schools in Ghana, might teach staff how to use their records for analysis as well as why it is important to keep them. Since good record-keeping is important to both the LGA and the FMOH, each organization's forms and incentives/sanctions should be designed to reinforce each other.

6. The response of the FMOH and the World Bank to the widespread drug shortages of the mid-1980s and the continuing problems of the FMOH drug procurement system was to set up drug revolving funds, first on a pilot basis in urban hospitals in 1986. The FMOH gave one-time grants to the states and LGAs in 1988 (although the LGAs that we visited appeared not to have received the funds until 1989). Since the FMOH Central Drug depot was unable to supply drugs, the LGAs were left to learn for themselves how to procure drugs. There appears to have been little coordination between states and LGAs, between groups of LGAs, or between government and the PVOs. The recommendations of a 1987 study funded by FMOH, the World Bank and WHO on how the private sector could assist the government to procure and distribute drugs efficiently were not put to use.

The points about DRFs that emerged from our interviews were:

- LGAs are operating more than one DRF, with separate accounting systems for each. This is creating confusion. Many of the LGAs could benefit from the innovative way that the regional health authorities in Ashanti region in Ghana were operating their DRF, working with multiple costs and government and private suppliers. (See Fiadjoe et al., 1991.)
- The LGAs are apparently not paying much attention to feedback from the lowest government facilities about the demand for drugs.
- Many local people still resent paying for drugs in government facilities.
- We did not see evidence of widespread exemptions for drug charges for the indigent.

Any assumption that the PVO sector in Nigeria provides a model of efficiency was negated in our interview of a CHANpharm official. The Christian health facilities that are members of CHANpharm (Christian Health Association of Nigeria Pharmaceuticals), a bulk-purchasing agency, have been experimenting with drug revolving funds since 1988. In 1987 the debts of the health facilities to CHANpharm threatened the viability of the system. An external donor provided grants for three years (largest in the first year) to each facility to initiate a DRF. Record-keeping was reportedly poorly enforced; many of the facilities are now in financial difficulties again, and CHANpharm has not been able to document what was done with the grants. They are hoping to find another donor, but recognize that health facilities will have to be required to manage their DRFs better.

7. Health care consumers' costs would be lower if they had better information about up-to-date professional consensus about how to treat common diseases and if the LGAs supervised treatment in their own facilities. Over-prescription is expensive and dangerous. The Health Committees of the LGAs are in a position to begin to educate the population and exhort private practitioners to avoid "more is better" practices.

8. The new PHC system does not seem to include a feedback mechanism from the LGAs to the FMOH, or between LGAs to share strategies and experience.

Education

As we discuss in Section 5, the growth in enrollment since the mid 1970's when university public education was proclaimed has been impressive. But, when one looks deeper into the educational statistics and visits schools without roofs, without books, without pencils, and with demoralized teachers, one recognizes that more has been accomplished on paper than in the school room. Nationally, only about one-half of the children who start primary grade I pass out of primary Grade 6. Some of the children that show in enrollment figures attend only one or two years of schooling--not enough to gain basic literacy or numeracy skills.

There are elements of a vicious circle here. Students who do not gain effective skills, do not obtain employment in higher paying positions. Parents who make decisions about human capital investments are not willing to forego their children's labor input in agricultural pursuits when they cannot see positive returns coming in the future from the investment. Without a growing economy based on enhanced human capital, it is hard to obtain resources to improve education (even though more effort could be made as we argue above). Nor are parents as willing as they used to be to buy student's teaching supplies and to repair local schools.

In some respects the quality of primary education may have slipped backwards during the 1980s with some acceleration since SAP. Truly universal primary education is a goal well worth striving toward. The benefits of literacy in the form of enhanced human capital, reduced morbidity and fertility rates, and increased earnings are well documented (for example, see *Advancing Basic Education and Literacy*, 1990; King, 1990). But promises made to citizens do not produce literacy. Nor do buildings (with or without roofs). Nor do increased budgets alone.

Literacy (and numeracy and other skills) are imparted by motivated teachers and co-produced by the children themselves as encouraged by families, friends and siblings. The skills to build and maintain schools and housing for teachers exist in all Nigerian villages, but villagers have already built local schools only to lose control of them to a government that promised to provide better education in the future. Parents used to supplement teachers' salaries with local foods, as well as housing. Parents also had some voice in decisions concerning the retention of teachers who did not teach effectively.

All of these ties to the local community are greatly attenuated. Parents are even discouraged from building better facilities (or supplementing school revenues) by having to obtain state level approval before they attempt to improve local conditions. Without some *stability* in the governance of primary schools and an increase in the morale of primary school teachers, the illusive goal of universal literacy may continue to elude achievement for a long time into the future. These problems have been exacerbated by the incapacity of formal governmental units to keep promises made to citizens. Now that funds are extremely tight again, local villagers are being called on to come forth with the resources to rebuild the very schools they had earlier built and maintained.

Governmental policies appear to have led to an increase in the cost of books to the point that only a few children in many classrooms have the requisite book. The current policy of changing expensive textbooks annually seems particularly inappropriate given the burden this places on the poorest of parents. In all of the schools we visited, textbooks were extremely scarce. Rarely were there enough books that each book could be shared by just two children rather than three or four. Keeping the same textbook for a five-year period would enable books to be passed from older children to younger children with several positive results:

- 1) greatly reduced annual cost of books,
- 2) teachers could be really familiar with the books being used,
- 3) older siblings in a child's household would be familiar with the book a child was assigned, and could potentially be of help if there were questions or difficulties.

A policy to encourage the publication of school books in Nigeria at a low cost and some stability in the books assigned for use would greatly reduce the cost of books and increase their availability. Donor assistance to establish a publication industry in Nigeria that produces low cost school books, could make a far more important contribution than many other forms of investment in capital.

In general we would have to conclude that the incentives facing most public officials and citizens are not conducive to improved performance of rural public services, even given the economic improvements that can be attributed to SAP. Health workers and school teachers have faced a drastic reduction in the value of their salaries as well as immense uncertainty about their future. State and local governments are still subject to unpredictable structural and policy changes initiated by the central government. Their boundaries, authority, responsibilities, and tax bases can be changed at will. Why should a state or local official try to develop a unique local program that would build local capital and local tax base? Such efforts can be whisked away with a national or state decree before opposition can be mounted. This lack of autonomy may change with the return of civilian rule, but the tradition of arbitrary change from the center has permeated the Nigeria experience under both civilian and military regimes.

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