

**USAID GOVERNANCE INITIATIVE IN NIGERIA:  
A STRATEGIC ASSESSMENT OF PRIMARY  
HEALTH CARE AND LOCAL GOVERNMENT**

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## ACRONYMS

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

## EXECUTIVE SUMMARY

1.1 In October of 1992, a three week reconnaissance was undertaken to evaluate the needs and possibilities for improving governance within Nigeria's Local Government Authorities (LGAs), particularly as they related to the country's primary health policy which focussed on community health or primary health care.

1.2 The findings were reported in "Local Governance and USAID Health Projects in Nigeria" (November, 1992), and were further tested and elaborated during a seven-week strategic assessment of LGAs and PHC governance during October - November, 1993. The 1993 study broadened the areas of coverage to include the North and Middle Belt in addition to the South West, and focused as well on the issue of inter-governmental relations. In addition, the report also explored in a preliminary way the implications of the November 18 change of government back to the military in Nigeria for proposed project initiatives.

1.3 The major findings of the report include:

- 1.3.1 PHC continues to be the optimal policy to reach Nigeria's large, poor, often rural population with basic health care, particularly in USAID's priority areas of child survival and family planning.
- 1.3.2 Nonetheless, PHC is still experiencing serious challenges in providing reliable, quality services in many parts of Nigeria.
- 1.3.3 Many of PHC's challenges grow from operational, supervisory, financial and public-linkage problems directly attributable to shortfalls in good governance at Local Government Authorities (LGAs), and in under-developed and/or poorly articulated relationships among the three tiers of government, particularly as these relate to PHC. The governance problems include lack of transparency and accountability; organizational and managerial inefficiencies, and lack of policy pluralism and public participation.
- 1.3.4 Many of these problems are to be expected in a system which has moved rapidly from a highly centralized administration of health care and basic services to decentralization of both, and from an urban-oriented, curative health focus to a preventive, public health system. The team strongly believes the evidence of Nigeria, and elsewhere, is that Nigeria's strategy is nonetheless the correct one, and the issue is one of implementation rather than redirection. Nigeria remains far too vast and diverse to administer services from the center, and there is consensus that if primary health care is to succeed it cannot be organized and managed apart from the community it attempts to serve.

## **PREFACE**

This report is a result of a mission conducted to study the issues of democratic governance as they relate to USAID/Nigeria's public health program. It was prepared under a buy-in to the Decentralization Finance and Management Project contracted to Associates in Rural Development, Inc. (ARD) by the USAID Office in Lagos, Nigeria.

The study team was composed of Dr. James Wunsch, Team Leader, Dr. Dele Olowu and Dr. Sylvanus Ikhide both of Obafemi Awolowo University, and Dr. Oyewole Owolabi of Herds Medicare, Ltd. The team worked in Nigeria from 6 October to 25 November, 1993, including field site visits to seven local government authorities, four states, three federal zonal offices, and several federal offices in Lagos. A few follow-up interviews were conducted in January 1994.

The team would like to extend its appreciation for the support of the USAID Affairs Office staff in Lagos, to the Government of Nigeria, to NCCCD project personnel, and to the many citizens of Nigeria who gave their time to provide the team with valuable information on primary health care and governance in Nigeria.

### 1.3.5 Specific problems facing LGA-PHC grow from:

- Poor practices in planning, programme development and budgeting;
- Underdeveloped managerial skills among many PHC personnel, non-existent and inappropriate management information systems, and ineffective assessment of personnel and facility performance;
- Weak supervisory linkages within LGA-PHC programmes and between LGAs, states and federal zonal offices (federal deconcentrated primary health care support facilities);
- Underdevelopment and under-utilization of existing local structures of community participation in PHC policy and programme formulation and adaptation;
- Thinness of professional skills, both health and organizational-managerial, among LGA-PHC personnel;
- Under-commitment of LGA political leadership to Nigeria's PHC policy and programme, leading to shortage of finance, transportation, supplies and the like;
- Absence of norms of service, standards of performance, technical assistance, supervision and the like from superior (state, zonal, federal) organizations;
- Underdevelopment of local revenue sources and systems to compliment and expand resources beyond federal and donor budgetary allocations.

1.3.6 These several problems must be seen in perspective. First, the fundamental strategy is sound and necessary to bridge the vast gap hitherto found between Africa's semi-urban and rural dwellers and the urban groups which have dominated government and captured most public services. Second, to build a sound basis for long-term democracy it is necessary to broaden real power sharing in the country and expand the number of those familiar with democratic processes and procedures. Third, it is necessary that grassroots take initiative if development is ever to get moving. Local government is one way that initiative can be taken. Fourth, these problems are remediable, given training to upgrade the personnel, continuing education to follow-up the training, and flexibility to pursue policy changes. Finally, this strategy has shown staying power. It had the sustained backing of both the Babangida and



Shonekan governments to PHC specifically and to decentralization of administrative responsibilities to local governments in general. It is as yet unclear what the new government will do in this area, though it hitherto has left the administrative structure and service functions of LGAs untouched. (Primary education has been returned to the states, a decision taken in principle by the Shonekan government.) As long as Nigeria's government remains committed to PHC, the LGA will most likely continue to be an essential actor in health administration.

- 1.3.7 It should also be kept in view that many LGAs have made significant progress in resolving these problems, improving governance and delivering improved health services to their populations. Ojo in Lagos State, Barkin-Ladi in Plateau State and Kaura Namoda in Sokoto State are models. These examples demonstrate that the LGA-PHC structure can be made to work quite well with appropriate resource inputs, strengthened personnel and proper relations/attitudes between governmental agencies and supportive superior levels of government. In some measure this last role has been filled by USAID via CCCD and NCCCD in these example LGAs.

1.4. On the basis of these findings, the strategic assessment team therefore recommends USAID proceed with the activities outlined in the NCCCD Project paper of February, 1993. These include development of four centers of: training, continuing education/extension, and policy-related research. They would train PHC, LGA and community leaders through a practically oriented, applied curriculum, and in the key areas of community assessment, planning, programme development, budgeting, management, supervision, community mobilization and leadership, local revenue sources and systems, and primary health care policy and strategies. The centers would follow the training with extension services/continuing education in the field, and research on relevant policy areas such as local revenue, area vs programme methods of supervision, inter-governmental relations, etc. The four centers would be located at, but independently administered from, existing centers of local government and public administration at four, regionally diverse, Nigerian universities. Target LGAs would include the NCCCD "focus" LGAs, and move beyond them as the program expands.

- 1.4.1 In addition, centers will also sponsor workshops annually aimed at improving and reviewing intergovernmental relations in the management of primary health care in Nigeria.

1.5 The events of November 18, 1993 affect but do not fundamentally alter the nature of the proposed activity nor the need for it. Of course with the dissolution of LGA political bodies and in the absence of any schedule of elections to replace that cadre, attempts to train the political level must be placed on hold and, eventually, possibly canceled. What must be kept in mind, is that the basic LGA and PHC organizational structure continues to carry responsibility for the delivery and support of health, and continues to face nearly all the

problems/challenges noted above. Thus the need continues and most key personnel continue in place. It is also possible that the new government will announce a programme of re-democratization shortly.

1.6 USAID's governance strategy, it will be recalled, includes the five key dimensions of accountability, transparency, managerial and organizational efficiency, policy pluralism and legitimacy. The events of November 18 hamper our ability to pursue all these goals but the strategic assessment of LGAs PHC suggests that much can still be accomplished in the areas of efficiency, transparency and accountability. These efforts, if pursued, will help sustain a favorable environment for democratic governance when Nigeria's people return to civilian rule. An important aspect of this is to strengthen the capacity of local government in Nigeria to function independently from the central government. The proposed governance activity is founded precisely on this agenda, and if effected should strengthen LGAs: both as a means by which Nigerian people can provide some of their needs with reduced dependence on the military-dominated centre, and as a source of political pluralism as Nigeria eventually returns to democracy.

## I. USAID HEALTH AND GOVERNANCE INITIATIVES IN NIGERIA

### A. Introduction and Overview

In October of 1992 a three-person team executed a preliminary survey of Nigeria's Local Government Authorities (LGAs), with particular attention to the Primary Health Care (PHC) Program. Its purpose was to assess the quality of governance at the LGAs, to analyze its impact on PHC, and to evaluate whether or not USAID could assist in strengthening LGA performance. This activity was reported in "Local Governance and USAID Health Projects in Nigeria" (November, 1992). The report found serious short falls in LGA planning, budgeting, management, supervision and public participation. It recommended a series of applied training, continuing education/extension, and policy research activities to begin strengthening LGA performance. The report was accepted by USAID and such a program was included in the "Nigeria Combatting Childhood Communicable Diseases Project" (NCCCD), which began operation on October 1, 1993.

As part of the start-up activities in the Democratic Governance/Local Government Authority (DG/LGA) component of NCCCD, a second team convened from early October 1993 for seven weeks of research to refine further and develop findings and proposals of the 1992 survey. Specifically, the 1993 activity was to:

- Expand the number and geographic distribution of sites visited in order to test and deepen the 1992 findings using a broader and more representative sample of Nigerian LGAs;
- Explore in detail the inter-governmental relations dimension of LGA governance and PHC operations, with particular attention to the roles of the state ministries of health (SMOH), the National Primary Health Care Development Agency (NPHCDA) and the zonal offices of NPHCDA;
- Broaden the finance and medical coverage of the team by including economic and medical expertise;
- Begin contacts with Nigerian institutions which would be likely collaborators in project activities;
- Begin to explore other management training activities which affect governance in LGAs, particularly as they relate to PHC.

The team included the following persons:

- Dr. James Wunsch, Creighton University and Associates in Rural Development, Inc: Team Leader and Public Administration Specialist (on 1992 team);
- Dr. Dele Olowu, Obafemi Awolowo University: Local Government Specialist (on 1992 team)
- Dr. Sylvanus Ikhide, Obafemi Awolowo University: Public Finance Economist; and
- Dr. Oyewole Owolabi, Herds Medicare, Ltd., Medical Doctor and Public Health Specialist.

## **B. Research Strategy**

The team began its work with interviews at USAID, the NPHCDA and the Federal Ministry of Health. It then prepared several open-ended interview formats (see appendix A), and performed field research in the South-West, the Middle Belt and the Far North. Site visits scheduled for the East were canceled during the general strikes and disturbances of the November 15 - 19. The team hopes to follow-up this report with several site visits to the East in early 1994. The following sites were visited, either during the 1992 or 1993 field research:

Ife Central LGA, Osun State  
Egbeda LGA, Oyo State  
Atakunmosa LGA, Osun State  
Akinyele LGA, Oyo State  
Ojo LGA, Lagos State  
Barkin Ladi LGA, Plateau State  
Pankshin LGA, Plateau State  
Yabo LGA, Sokoto State  
Kaura Namoda LGA, Sokoto state  
NPHCDA Headquarters, Lagos  
NPHCDA Zone "B" Office (Ibadan)  
NPHCDA Zone "C" Office (Kaduna)  
NPHCDA Zone "D" Office (Bauchi)  
Oyo State Ministry of Health  
Plateau State Ministry of Health  
Bauchi State Ministry of Health  
Sokoto State Ministry of Health  
Plateau State Bureau of Local Government  
Bauchi State Bureau of Local Government  
Sokoto State Bureau of Local Government

Numerous site visits to LGA health facilities in selected rural and urban areas were also performed. There, staff were interviewed, facilities were inspected, and records were assessed. The team also assessed the availability of LGA budget and expenditure records, and PHC related documents (base-line surveys, general plans, work-plans, budgets, personnel rosters, monitoring and evaluation data, PHC reports, and minutes of community based committees), and examined them where they existed and could be found. The team emphasized several topics in its LGA and PHC site visits. These included:

- Quality of PHC organization, management, supervision, and record-keeping particularly in personnel, finance and equipment;
- Quality of PHC health site management, including appropriate and reliable staffing, medication availability, existence and upkeep of medical equipment, opening during scheduled hours, appropriate prescription of treatment given diagnosis reached, and rate of public utilization;
- Existence, quality and actual implementation of PHC work-plans, base-line surveys, program designs, planning and performance reports;
- LGA performance in general in problem identification, program development, planning, budgeting and budget implementation;
- LGA support for PHC activities via budget or other means;
- Relationship between LGA/PHC and SMOH and zonal NPHCDA Offices, including training, continuing education, supervision, site visits, other technical assistance, and other contacts.

In State and Federal interviews, the team emphasized:

- Perception of LGA PHC performance by state, zonal and federal personnel;
- Relationship between SMOH, zonal and federal offices and LGAs, as perceived by state and federal personnel;
- Current and anticipated activities by SMOH, zonal and federal personnel vis-a-vis LGA/PHC programs;

- state and federal personnel view of the adequacy of SMOH, zonal and federal resources vis-a-vis their perception of LGA PHC needs.

### **C. Purpose of Research and Report**

In the report that follows we attempt to do several things:

- Assess quality of PHC organization and management;
- Assess quality of LGA organization and management;
- Assess the impact of these factors on PHC operation and LGA governance;
- Assess the role played by superior governmental organizations in PHC operations at the LGAs;
- Suggest a number of policy issues which need to be explored to improve PHC operations at the LGAs; and,
- Suggest a series of training and extension activities to remedy organizational and managerial short-comings at the LGA and PHC, and improve LGA governance.

The report itself is organized into ten chapters. In the next chapter, we examine Nigeria's government initiatives in decentralization to local government and in the health sector. We also identify USAID initiatives in the health sector and explore how governance issues can be applied to strengthen decentralization and health care delivery in Nigeria. In Chapter three, we review the current status of health care conditions and assess the implementation of PHC policy. In chapters four, five and six we examine the management and organizational issues related to PHC: planning and work programming; budgeting and financial sustainability; and monitoring, evaluation, and supervision. In chapters seven and eight we focus on grass roots participation and intergovernmental relations issues respectively and how these can be used to improve PHC delivery in Nigeria. In chapter 9 we attempt to identify the primary causes of these problems. In the final chapter, specific proposals and project activities are articulated.

## **II. LOCAL GOVERNMENT DECENTRALIZATION, DEMOCRATIZATION AND GOVERNANCE IN THE HEALTH SECTOR**

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

Perhaps due to its size (population of 85.5 million) and ethnic diversity, Nigeria, in spite of long years of military rule, has remained Africa's only example of a federally governed state.<sup>1</sup> However, the federal structure at independence was one that was highly centralized at the level of the three large regions. Since the mid-1960s, when the military first took power, there has been a progressive effort aimed at restructuring the federal structure and decentralizing the political system. The three regions were first broken up into 12 states; today there are 30 states. Similarly, since the mid-1970s, there has been a sustained effort at restructuring and revitalizing the system of local government. Two hundred ninety-nine (299) local government units were originally created in 1976; today there are 593.

Efforts at political and administrative decentralization have had tremendous implications for the management and delivery of health services in Nigeria. In the past, the national health care system manifested several weaknesses associated with the centralized delivery of services; it was urban-oriented, with less than 30 percent of the population having access to the most rudimentary curative services administered by rural dispensaries and maternities; and there was minimal community involvement in the health care system. Health care was defined essentially in terms of hospitals, the management of which was under the federal and state governments. Local governments' historical responsibilities in the health sector declined precipitously as several of the health clinics and the few hospitals built by local governments in the colonial era were taken over by state governments. LGAs were left only with responsibilities for dispensaries and maternities.

The initiative in strengthening and democratizing local government structures within the framework of the Nigerian federal system goes back to 1976. The decentralization and democratization of local government was regarded as a part of a five-point program for the restoration of civil rule after about a decade (1966-76) of military rule.

Some gains were made along this direction during the Second Republic although there were severe problems also, especially from state governments. The latter diverted federal transfer funds meant for local governments but passed through them and refused to hold elections to local government councils. Instead they appointed party faithful, refused to pay state statutory allocations to local governments, and did not comply with the constitutional mandate which devolved specific responsibilities to local governments.

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<sup>1</sup> Tanzania uses federal principles but can hardly be referred to as a federally governed state in the conventional sense. South Africa may also become federally governed from 1994.

From 1988, the Federal Government began to take a number of steps aimed at ensuring that local governments became more effective. These actions included the following:

- Abolition of the state ministries of local government and their replacement by bureaus of local government matters within the deputy governors' offices, the latter to serve as an information clearing house for local governments as well as render other technical assistance to local governments (1988).
- Direct payments of federal allocations to local governments instead of passing them through state governments (1988).
- Reform of local government political/management structures. Each local government was now to have 4 "operational" or line departments (Works, Education, Health, Agriculture) and 2 "service" or staff departments (Personnel Management and Finance and Planning) (1988).
- Creation of new LGAs in 1987, 1990, and 1991, bringing the total number to 593 in 1991.
- Creation of the office of local government auditor (1988).
- Announcement of local government autonomy with respect to operational and financial matters. Local government budgets were to be approved by local government councils, not state governments (1990).
- Increase of local government revenues allocated from the Federation Account from 10% to 15% (1990) and subsequently in January 1992 to 20%. State government allocations from the same fund dropped from 34% to 24% while the federal government retained 50%.
- Transfer of primary education and primary health care to local governments (1990).
- Adoption of a presidential or strong-mayor system universally in all local governments. In effect, this meant the complete separation of executive and legislative branches (1991).

Most of these changes as well as those incorporated in the 1989 Constitution (system of recall and other electoral reforms, etc.) were justified on the basis of the need to strengthen local governments, and to democratize them further by aligning their structures with what existed at the national and state levels.



## **B. FGN Policy Initiatives in the Health Sector**

There were also a number of important developments in the health sector during this period.

First, whereas the 1976 local government reforms and the 1979 and 1989 constitutions stated that local governments were to provide and maintain health services in collaboration with the state governments, local governments became increasingly saddled with the sole responsibility for providing and maintaining primary health care services. Hence, local governments were became key players in the federal government's policy of basic health services scheme (BHSS) of 1976-80 and its successor, the primary health care (PHC) program (1984-present).

Second and more important than all of the above, was the articulation of the new national health policy by the federal Ministry of Health in 1988. The focus of the policy was a community-based health system in which primary, secondary and tertiary health care are organized at local, provincial and national levels, with each mutually supporting the other. Actually as far back as 1986, a total of 52 model LGAs were selected as pilot project sites for strengthening PHC at the LGA level. Each was given 0.5 million naira, together with material and technical assistance to reorient and develop the local health system. Each of these model LGAs was linked with a college of medicine or school of health technology to assist with the training of local government health officials.

Up to 1986, most state governments managed and delivered PHC. In June 1988, however, under the leadership of the Federal Health Minister, (Professor Olikoye Ransome-Kuti) who had a longstanding interest in the development of community-based health care, the federal Ministry of Health directed state governments to devolve all PHC responsibilities to local governments over a three-year period terminating on June 30, 1990.

State governments had responsibilities under the new health policy for the supervision and coordination of PHC and for playing an advocacy role. The federal Ministry of Health carved the country into 4 broad zones for the purposes of supervision. Each zone is under the leadership of a zonal coordinator. These zonal coordinators now form the core personnel of the newly created National Primary Health Care Development Agency (NPHCDA). PHC activities revolve around 10 core functions:

- public education
- improvement in nutrition
- adequate safe water and basic sanitation
- \*maternal and child health care, including family planning
- \*immunization <sup>2</sup>

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<sup>2</sup> \* Received most attention.

- \*prevention and control of endemic and epidemic diseases
- \*provision of essential drugs and supplies
- elderly and handicapped care
- accident and injury care

Below the LGAs, district and village health committees are established to provide inputs such as information, suggestions for improvement, complaints, control, etc., for the new system down to the grassroots level.

To conclude this section, it should be pointed out that in reality four of these broad PHC functions have received the most attention. The reason for this is that they are the ones that donor agencies have focused on.

### **C. USAID Policy Programs in Nigeria Related to Primary Health Care**

Since 1983 USAID has focused its development assistance to Nigeria on primary health, with particular emphasis on family health services (family planning) and child survival activities. USAID has also contributed substantially to primary health care through its Primary Health Care Support Project. All these areas have supported primary health care, the first two through support of specific health program areas and activities, and the last by supporting Nigeria's decentralization of public sector primary health activities from the federal and state governments, to local government authorities. The latter funds have helped support the Federal Government's special allocations to "model" and "willing" LGAs.

Currently, USAID's health activities are organized under two broad projects. Nigeria Combatting Childhood Communicable Diseases (NCCCD), the follow on to the earlier CCCD Project, and Family Health Services (FHS). CCCD and NCCCD have been active in supporting the Expanded Program of Immunization (EPI), development of health information systems, health education, research on malaria epidemiology, and support for better case management of diarrhoeal diseases and acute respiratory infections. It has focused its activities in a dozen LGAs, where support for training, vehicles, equipment, etc., have been offered at an expanded level. It has also supported numerous small scale research projects pertinent to project concerns.

FHS has focused its activities on building support for policies favorable to family planning, increasing awareness of family planning options, and strengthening the ability of both public and private sector entities to organize, manage and coordinate family planning efforts, including training, development of management information systems (MIS), monitoring and evaluation (M & E) Systems, and commodity management systems.

At the bottom line, both projects depend on effective LGAs to deliver the services necessary for the attainment of their goals. And, in their respective ways each project has strengthened various aspects of LGA performance: via direct support of specific health

projects (i.e., EPI); by developing a more favorable environment for primary health care services in general (i.e., national education efforts, support for M & E and MIS, building support for favorable policies); and via direct support for LGA capacity, by supporting training, the development of networks of trainers and the "focus" LGA program.

The decision by USAID to include an LGA "governance" component in its 1993 - 1999 NCCCD project represents a logical extension of this strategy. The LGA governance sub-project will target the entire cadre of LGA personnel, professional and political, who lead or affect PHC at the LGAs. From district supervisors (where they exist) to key administrative officials (PHC Coordinator, Director of Finance, Director of Personnel) to key political figures (LGA Chair, Vice Chair, Health Supervisors), the activity will provide a program of applied training in organization, supervision, management, planning, budgeting, community mobilization, program development, facility assessment and the like. It will be followed by extension and continuing education activities led by training center personnel, and undergirded by applied research in selected policy areas. Its objective will be to upgrade the general governance ability of LGAs, with particular emphasis on upgrading PHC. In its focus on PHC and strengthening and sustaining Nigeria's decentralization effort, it reflects continuity in AID/Lagos policy, and should undergird and sustain the entire existing portfolio of health-related activities.

#### **D. Governance and Local Government Authorities**

As the lessons of experience in governance have gradually accumulated over the past several decades, USAID's understanding of the requirements for good governance have also grown. Earlier attempts by USAID to address governmental performance tended to be uni-dimensional: to focus on management and administration, or electoral systems, or accounting and auditing practices alone, rather than building on their potential to reinforce one another and contribute to improved governmental performance in general. Recently, and as noted in such documents as AID's *Democracy and Governance Policy Paper* (October 1991) and the Africa Bureau Working Paper on *The Concept of Governance and Its Implications for AID's Development Assistance Program in Africa* (June 1992), USAID has emphasized the multi-dimensionality of improved governance, and begun to tailor its programs accordingly.

Governance, while certainly a concept still evolving, is currently seen to focus on the effective management of public affairs. Proponents of "governance" strategies see this as being achieved by generating a set of rules which are: (1) accepted as legitimate; (2) have the purpose of promoting and enhancing societal values sought by individuals and groups; (3) and which emphasize the following qualities:

- managerial and organizational efficiency;
- accountability;
- legitimacy and responsiveness to the public;

- transparency in decision-making; and
- pluralism in policy options and choices.

Effective governance strategies must therefore be multi-faceted and balanced among these several features, and pay heed to the need to *institutionalize* rule-governed relationships among citizens and officials to stabilize and sustain these values. While different societies will of course set different goals and pursue different social values, the governance strategy argues that achievement of these goals will still require the "rules" to be seen as legitimate by the public, and to embody the five principles of effective governmental organization and operation identified above.

For example, a "governance" strategy would support elections, but argue that elections alone would be unlikely to lead to improved governmental performance without attention to the other dimensions. Similarly, it would emphasize the need for managerial and organizational efficiency, but argue that efficient organizations are likely to drift into the pursuit of organizational or personal interests unless there exist effective structures of accountability, such as elections, among other mechanisms.

Governance approaches also emphasize the necessity of multi-faceted strategies within each dimension. For example, accountability in primary health care has at least three aspects: to clients, perhaps through local committees and local elections; to professional peers through professional norms, values and expectations; and to superior organizations able to assess technical competency and services and provide guidance, assistance, and, occasionally, require improvements where needed. Each form of accountability covers aspects of professional performance that the others have difficulty in measuring and enforcing. For example:

- Peers and superiors often are not present during the delivery of services to clients, nor can they measure overall community satisfaction with facility performance; Patient input is needed here;
- Patients are usually not competent to assess whether proper sanitary practices are pursued, appropriate medications are prescribed, people act within their competence, etc, while superiors are often not present; Peer input is important here;
- Peers and patients often lack the perspective, information and leverage to evaluate and improve overall area-wide, health performance; to assess LGA support for health services; to set and demand adherence to externally set norms of service and performance; and to reinforce professional norms through continuing education and the like; Supervision by superiors is important here.

Each of these varying mechanisms of accountability complements the other. Each also balances biases built into the other. Public accountability alone, for example, may lead to demands for excessive investment in physical facilities and curative medicine, and under-investment in less immediately but equally important areas such as health education, sanitation, etc. Similarly, external accountability, because the costs of gathering and analyzing data are high, tends to emphasize aggregate performance and reaction to emergencies, rather than information useful for steady, continuous facility and personnel-oriented supervision and improvement.

Governance strategies, thus, stress the need to build a number of qualities (accountability, efficiency, etc) into political arrangements; and generally to address each of those qualities in multiple ways.

The team reached a number of conclusions in assessing LGA performance in PHC through a "governance" framework.

*Management and Organizational Efficiency:* There are serious short-falls in this dimension along a number of criteria. These include problem identification, planning, program development, budgeting, monitoring, evaluation, supervision, quality control, efficient allocation of resources, maintenance of equipment, use of personnel. As Chapters 4-6 show, there are serious deficiencies in most LGAs in these areas.

The results of these deficiencies show up in a gradual erosion of the quality and reliability of PHC services throughout the LGAs. As chapter three will review in detail, many health facilities we visited were closed during normal business hours, had insufficient critical drugs (often no supplies of key drugs such as ORT and anti-malaria drugs), dilapidated equipment, poor to non-existent record keeping, staff which did not appear at appointed hours, dirty facilities, grounded supervisors because of broken transport, key M & E data often ungathered, some data suspect, no forms to record on and report data, broken cold-box chains, unavailable imprest funds to facilitate supervisory visits, critical equipment (generators, transport) misappropriated by other LGA personnel, and the like. Routine business does not go on as it should, and the more complex managerial activities such as performance evaluation, program appraisal and redesign, staff redeployment, capital planning and the like, have rarely even begun.

The critical public linkage aspects of governance, accountability and transparency, are difficult to develop when managerial and organizational efficiency make it unclear what reasonable expectations are, and make the routine business confused and confusing.

*Accountability:* PHC at the LGAs lacks accountability at three levels. The public generally lacks mechanisms to hold PHC itself or the LGA in general accountable, as the committees generally meet intermittently, serve more as top-down communication structures than bottom-up control structures, and are seen by PHC personnel more as mechanism to

channel public action than to guide PHC operations at the LGA level. Elections have yet to connect public evaluation of health performance with candidates, campaigns, or public programs.

Professional or "lateral" accountability exists to some extent but is generally fairly weak, possibly because of: limited numbers of highly trained health personnel to help define and maintain professional standards; use of short training programs for many service delivery personnel; the limited number of health supervisory personnel generally in the field; the large number of people working at jobs above their training or grade; and the dispiriting impact of insufficient supplies, poor and broken equipment, limited supervision and technical back-stopping, and the like.

Hierarchical accountability has been weakened by the limited role allocated to the SMOHs, the long reach from federal zonal offices to LGAs, the ambiguity of the LGA and state roles vis-a-vis one another, and the limited personnel, transportation and other resources hitherto held by the states.

Weak accountability for PHC is reinforced by lack of accountability by LGA governments in general. Public involvement is still underdeveloped in LGA affairs, there is as yet no clear culture of municipal "good government" in Nigeria, standards of LGA performance are not clear, and neither the states nor the Federal Government appear to be closely watching LGAs for poor administration, failure to provide services, corruption, and the like. The local government auditors created since 1988 have remained largely ineffective due to absence of skilled staff and their poor conception of their own work.

In brief, accountability is an area of governance in need of dramatic and significant improvement in several dimensions, at both PHC and LGA levels.

*Transparency of Decision-Making:* Decision-making at LGAs in general, and in PHC in particular, is singularly opaque. "Transparency" means that there is information available to the public and its agents that allows the people to see:

- What decisions have been made by their public officials;
- How those decisions were executed;
- What consequences those decision led to;
- How policy has changed overtime; and
- Who made those decisions?

A public which has such information will be able to assess the priorities of its representatives, their performance in implementing those priorities, and their propensity to improve their performance. With these assessments, a public (or, more likely its agents in the media and organized intermediary groups) will be able to hold its public officials and representatives to account.

Because the allocation of resources is so central to what any government does, and in particular to local governments whose primary activity is to deliver services, a clear budget process, a comprehensible budget document, and close correspondence between budget vote and expenditure, along with clear and accurate expenditure records, are probably the most important requirements for "transparent" government. Also important is a well organized planning process which the public can access and assess to learn what direction its government is traveling. Finally, public hearings on both and public records of budget proposals and votes are also useful for transparency.

At the other "end" of the policy and administrative process, information regarding the performance of public organizations and programs is necessary to assess the quality of the decisions made, and to build support for policy changes (as well as policy continuity).

These are, of course, yardsticks on which few (if any) government units anywhere would achieve a perfect score. However, as described in Chapters four, five, and six, with the exception of two or three exemplary LGAs (which have received massive donor assistance), planning and supervision are so weak to be virtually non-existent, and the budgeting process is so hidden and the result is so inaccurate that it is virtually incomprehensible.

As a result, the public lacks valid and reliable indicators of what its government proposes to do, what it did, and how well it did it. Opaqueness rather than transparency is thus the rule, and even those LGAs which operate better in spite of poor management are still hurt by this, because their opportunity to build linkages and legitimacy with the public is reduced.

*Other dimensions of governance:* Policy pluralism and legitimacy/responsiveness to the public are not yet well developed, either at the LGA in general or with PHC in particular. The early life of the current system, its growing pains, the weakness of management, accountability and transparency have limited the development of these two dimensions. With PHC at the LGAs lacking a clear and reliable image, and their heavy dependence on the federal government for funds and policy initiatives, it is reasonable to hypothesize that legitimacy, a dimension not researched in this study, is still underdeveloped.

Policy pluralism, the articulation of diverse viewpoints on the goals and performance of public programs, is certainly not yet well developed. This is in part a result of the short life of PHC as an LGA focus activity. It takes time for any dramatic policy initiative to reach good working order, and during that time administrators are generally more concerned with building a program and trouble-shooting problems than with exploring policy pluralism.

Nonetheless, early signs are not encouraging for policy pluralism in LGA PHC. As chapters three and seven illustrate, though a public health committee structure has been established and exists in some level throughout Nigeria, it is not at all clear that it is operating reliably and well. Meetings are often infrequent, it is not clear the information from village committees is flowing upward effectively, nor is it clear that PHC staff are particularly open to or responsive to what information they do hear.

To review and summarize this section, it should be noted that using the "governance" approach to LGAs in general and to PHC in particular leads one to conclude that there are good reasons to be concerned regarding the likelihood of effective performance.

Accountability, transparency and managerial and organizational efficiency operate far less well than they should. Policy pluralism and legitimacy/public responsiveness are as yet underdeveloped, partially because of the "youth" of LGAs and PHC, partially because of weakness of the other dimensions of "governance" at the LGAs, and partially because it is not clear that the structures to enhance these dimensions (LGA health committees) are working particularly well.

Having noted these problems of governance at the LGAs and in PHC in particular, it is important that the problems be seen in perspective. There is much room for improvement, but what Nigeria has done in local government in general and in primary health care in particular in only a few short years is still remarkable. It is unlikely any other state in Africa has gone so far in building such a grassroots base for democracy; few have done more in providing basic health care to their millions of rural, poor inhabitants.

If PHC facilities are yet to reach an ideal, they offer the very first instance where Nigeria's poor majority has had access to vaccinations, maternal and child health care, family planning, and care for widespread, basic diseases and injuries. For many persons in Nigeria, this is one of the first services the state has *ever* delivered. The speed of the system's construction, the scale of its geographic coverage, and the negative economic context must be seen as responsible for many of its "growing pains."

Similarly, Nigeria has moved in only a few short years from a highly centralized, entirely top-down system of local administration to constructing local governments with real authority, able to make their own mistakes and able to begin walking a learning path along those mistakes. These changes are significant, and echo the calls of virtually all analysts of African governance over the past 20 years: the state was too centralized ever to hope to succeed, either in development or in democracy. Thus, even though *much* more remains to be done to reach the potential offered by both PHC and the LGAs, significant achievements have already been made.



The essence of this report is to identify approaches to tackling these "governance" as distinct from the technical "health" problems. After reviewing the major problems in greater detail in Chapters three to eight, we go on to identify some recommended strategies in Chapter nine.

### **III. PRIMARY HEALTH CARE IN NIGERIA: ACHIEVEMENTS, PROBLEMS AND RECURRING CHALLENGES**

In this section, we will highlight the major achievements of PHC in Nigeria and identify the major problems and challenges. When the new health policy was initiated in 1986, it was with the expectation that health would be available to all by the year 2000. After seven years of implementation and with seven years to the end of the program period, one can legitimately raise the question--how much has been achieved and how much remains to be achieved? Fortunately, a number of agencies--USAID, the World Bank, UNICEF, etc.--have completed excellent reviews of the health situation in Nigeria. They and the team's field research form the basis for this chapter.

On the whole, current conditions of PHC at the LGAs are mixed. On the one hand, facilities have been expanded, personnel trained (though often only superficially), basic health services are available, and a more complete understanding of Nigeria's health situation and needs have been achieved. Yet, as several recent studies have shown (World Bank sector assessment, EPI sustainability study), achievements have been less than hoped. Indeed, a good case could be made that, given its personnel base and resources from petroleum exports, greater levels of achievements should have been attained.

#### **A. Health Status Conditions and the Primary Health Care Response in Nigeria**

Available data (1991, 1992) derived from vital statistics, recent surveys (DHS 1991) and special studies reveal excessive mortality and morbidity as well as widespread malnutrition in severe forms among under-five children and reproductive-age women all over Nigeria. Infant mortality rates average 91.4 per 1000 live births (range 82.7-109.8), child (1-4 years) mortality rates average 109.6 per 1000 (range 66.6-151.2), under-five mortality rates average 191.0 per 1000 (range 143.7-244.4). Maternal mortality rates are of the order of about 10-15 per 1000 live births across the main geographical regions of the country. Compared with normal populations where 3% of the population may fall two standard deviations below the mean, the percentage of Nigerian children across the regions that fall two standard deviations below the mean are 9.1% (range 5.5-12.1) for the wasting that reflects acute malnutrition; 43.1% (range 35.6-51.9) for the stunting that reflects chronic malnutrition, and 35.7% (range 26.9-44.6) for the underweight that reflects thinness. According to a recent estimate, more than 31% of Nigerian pregnant women are probably malnourished. Life expectancy of birth for Nigerians is as low as 49 years for males and 53 for females, compared to 70 years and above in developed countries.

In order for Nigeria to meet the targets set for the year 2000 at the World Summit for the Child in September 1989 (i.e., infant mortality rate less than 50 per 1,000 live births and under-five mortality rate less than 70 per 1,000 live births), there must be improvement in reduction of infant mortality rate by 82.8%; and under-five mortality rate by 172.9%.

The primary health care approach focuses on the health needs of these population groups. They are the most vulnerable or at greatest risk of mortality and morbidity, and they are the least able, for geographical, political, social and financial reasons, to take the initiative in seeking health care.

Analysis of cause-specific morbidity and mortality shows that most of the mortality in under-five children arises from five main sources: (i) conditions associated with the birth process; (ii) diseases preventable by immunization; (iii) acute infectious diseases; (iv) malnutrition and (v) acute epidemic diseases. These in turn arise from risk conditions that increase the probability of death or illness. They range from such general factors as poverty, illiteracy, and lack of basic infrastructural amenities like potable water. They also include more specific factors like tetanus infection or late attendance in labor. To reduce these maternal and child health problems, a PHC strategy must focus on family planning, prenatal care, nutrition, immunization and case management of acute childhood illness (fever/malaria, acute respiratory illness, diarrhea).

### *1. PHC System Structure*

Management of primary health care is the responsibility of the LGAs under the national health policy. In its ideal is organized in six levels: family/household, the community, the health facility, the LGA (Health Department), the state government (Ministry of Health) and the federal government (Ministry of Health and National Primary Health Care Development Agency). The state and federal levels are to provide respectively, technical support (training, logistics and supervision) and policy guidance. The federal government also provides most of the financial support to the LGAs. PHC facilities within LGAs are organized in a hierarchy of four levels: Level -1: Village/Volunteer Health Workers; Level -2: Health Clinics; Level -3: Primary Health Centers; and Level -4: Comprehensive Health Centers.

PHC activity areas include: registration, health education, growth monitoring and nutrition, illness diagnosis and treatment plan, immunization, family planning, pregnancy care, delivery and postnatal care, quality control, drug dispensing and dosage administration, competent handling of PHC workers (supervision), special care for high risks, referral support, community outreach and monitoring and evaluation of PHC service.

Current Status of PHC System Performance with respect to PHC Targets toward 2000  
Reliable data from available sources, principally the Nigerian Demographic and Health Survey (NDHS 1992), have been used to compute and prepare Table 1. It shows the current status of PHC systems across the country by the targets to be achieved by the year 2000.

**Table 1**  
**Current Status of Nigerian PHC System**  
**With Respect to PHC Targets 2000AD**

<b>PHC Component</b>	<b>% Target Achieved as at end of 1992</b>
EPI Coverage	54.5%*
Antenatal Care	48.4%
Nutritional Status: Pregnant Women	34.4%
Nutritional Status: Children	39.7%
Attendance at Delivery	52.3%
Contraceptive Prevalence	38.0%
Access to Health Services	43.3%
Access to Portable Water	NA
Access to Laterine	NA
Availability of Essential Drugs	NA

\* There has been report of a decline in EPI coverage since this data item was obtained.

LGAs in Nigeria have made mixed progress toward the year 2000 goals. Nonetheless, some progress has been made in nearly all LGAs. The signal achievements of a few leaders, such as Barkin Ladi, Karen Namoda and Ojo, suggest that the goals are feasible and the policy is sound.

The rest of this chapter will explore both achievements and constraints in effecting PHC by the LGAs.

## **B. LGA PHC Systems: Achievements, Problems and Recurring Challenges**

### ***1. Policy Environment for PHC Implementation in LGAs***

The major policy achievement of the national PHC effort in the past seven years is the adoption of the primary health care approach as the focus of health care in Nigeria LGAs. This responsibility has been incorporated into the National Health Policy. Beginning with 52 LGAs in 1986, all the 593 LGAs in Nigeria currently have put a PHC system in place, even though there are differentials in the extent to which LGAs have carried these out. According

to a 1992 study, commitment to the political, administrative, and technical leadership varies from an overall "average" to "very low." Within any given LGA, the commitment to PHC varies among the political (holders of elective positions or appointed by such holders), administrative (generalists managers who may not necessarily have a health background) and technical (managers with specific health-related skills) leaders. Much of the lack of commitment is due to poor understanding of PHC (Herds 1992).

Other problems include:

- A relatively low priority for health in resource allocation at LGA, state and federal levels in the face of the fall in oil prices and the severe economic recession in Nigeria. As a result, drugs, vaccines, and equipment (e.g., for EPI) are still frequently in short supply or not available at all in a majority of LGAs in the country.
- The transfer of responsibility for PHC to LGAs is frequently reported by state and federal officials to have made coordination of PHC services and the enforcement of guidelines more difficult.
- Many LGAs have lost significant personnel in the process of transfer of responsibility for PHC to LGAs and have been unable to fill the gaps so created.

## 2. *Institutional Relationships*

### *Family and Household Focus*

PHC services delivered in most LGAs are not yet focused on the family/household. This has led to LGA shortfalls in such areas as house numbering and household registration. Even where these have been done there is little evidence that the records have been analyzed for appropriate use in PHC facilities and community outreach activities.

### *LGA-State-Federal Relationships*

A significant achievement of the national primary health care program is the establishment of a variety of networks, between and among these governmental agencies, which have the LGA PHC system as their common pattern for PHC implementation.

LGA-State relationships through:

- direct bilateral relations
- the State Council on Health

LGA-State-Federal relationship through Federal Zonal Health Offices  
State-Federal relationship through:

- National Council of Health on LGA matters
- Zonal Health Offices

These structures provide a framework with the potential to take advantage of the relative strengths of each level in organizing, managing, learning, and coordinating PHC. As Chapter eight will discuss in detail, there is much to be done to reach this potential.

Institutional linkages also exist at the LGA/sub-LGA level. Most of the LGAs have established one or more of the PHC Development/Management Committees at Village/Ward, District and LGA levels. The full spectrum has been established in up to half of the LGAs. Probably less than 10% of the LGAs do these functions as well as intended. Since they are meant to address a cardinal feature of PHC implementation at LGA level (i.e., peoples' participation), strengthening this dimension is critical.

Linkages are frequently weak within the LGA itself. For example, PHC planning and budgeting either do not exist, or when they do are poorly or not at all integrated into the LGA budgeting process.

### **3. *Management Capability***

Numerous problems exist in management of PHC at the LGAs. These include:

- Planning, programming, quality control, problem identification and solving and the like are haphazardly done by most LGA PHC staffs. Conscious and systematic programs to perform these functions are virtually nonexistent.
- General managerial skills are quite low in most LGA PHC programs, particularly in the areas of personnel management and facility supervision. Little data is being gathered pertinent to these functions.
- Training programs are intermittent, not systematic, often too brief to achieve desired goals and lacking in follow-up.
- Field supervision is generally sporadic, and lacks any overall plan. Often it is virtually nonexistent. Vehicles are frequently out of service because of break-down or lack of funds for fuel.
- Donor involvement (Bamako Initiative, UNICEF, USAID, etc.) has led to improved management in some areas as per donor requirements, but preempted LGA PHC decisions re program priorities.

- No cost-effectiveness or utilization studies could be found through which LGA-PHC personnel have assessed their programming.
- Guidelines for supervision have been developed by the federal Ministry of Health, but are not in use in most LGAs.
- Resources do not appear rationally balanced among supply, salary, and capital budgets, so personnel and facilities lack supplies and sometimes facilities lack personnel; other facilities appear to be overstaffed.
- Poor "housekeeping" exists at most health facilities, including erratic opening and closing hours; poor record-keeping; unreliable staffing (particularly by upper ranks); epidemiological data in disarray; lack of cleanliness; dilapidated, broken, and poorly maintained equipment; absence of basic medications, infestation of rodents and insects, etc.
- There was evidence of poor (occasionally dangerous) medical practices at health facilities.
- Health personnel are frequently working one or two steps beyond their training and professional grade. Clinical skills are particularly weak. Supervisory clinical skills are also often weak.
- Budgets poorly reflect actual expenditures by PHC, and must be frequently revised.

**4. *Participation of the Private Sector, Communities and Non-Government Organization***

Mobilization of community development association clubs, etc for appropriate involvement in LGA PHC operations has shown promise in some LGAs. The various forms of activity or inputs they have made include:

- Membership of village, district, or LGA PHC management committees.
- Donation of resources to PHC work, including bicycles, PHC facility buildings, and furniture.
- Through their complementary programs, they have promoted effectiveness of PHC services (e.g., food production of the better life for women, and nutrition aspects of the maternal and child health services of the LGA PHC program).

- Traditional leaders in the LGA community have helped in community mobilization and encouraging target beneficiaries, especially women to utilize PHC services. They have been helpful in resolving disputes and conflicts that occasionally arise in the course of PHC work within the structures of the LGA system.
- However, LGA PHC personnel have not made comparable use of community organizations in setting local program priorities, trouble-shooting health problems, assuring facility quality control, etc.
- Relations between PHC office and community committees appear haphazard and disorganized, including absence of minutes, reports or other records of the committees' activities.
- There is some evidence of declining confidence by members of committees that their deliberations and recommendations are taken seriously.

**5. *PHC Awareness and Support: Community and Political***

The team noted that awareness of the PHC approach has expanded significantly in the last seven years in all LGAs even if only of selected aspects of the LGA PHC system (e.g., immunization, prenatal care, or case management of acute illness). However, it was observed that LGA political leaders appear frequently either incompletely to understand the PHC strategy or to have a limited commitment to it. Moreover, LGA political leadership raise virtually none of the resources to support PHC, either through local taxes or user charges. There is heavy reliance on federal transfers and donor funds. More often than not, vehicles, generators, and health-related funds are under pressure from political leadership for non-medical and occasionally personal use.

**C. *Conclusions***

Although the transfer of responsibilities for primary health care to LGAs has occurred on paper, what that means in the field remains unclear. Similarly, how to strengthen it remains a major challenge. However, there are severe limits on the extent to which a SAP-led economy with few resources can effectively sustain an autonomous LGA PHC system, despite the availability of external donor assistance. In the face of these fiscal constraints, proposals for sustainable development of the LGA PHC system in Nigeria must emphasize the organizational potential which exists within the LGA PHC system.



In the light of our recent experience on the field, a key aspect of this change is the interlocking network of institutions capable of strengthening the LGA PHC system. Among other concerns, this requires attention to the relations which exist within PHC departments at the LGAs, relations between PHC and the LGA in general, participation by the grassroots, and the support of other levels of government. It is to these issues that the next several chapters will turn.

#### IV. MANAGEMENT ISSUES IN THE PRIMARY HEALTH CARE SYSTEM: PLANNING AND WORK PROGRAMMING

Planning is defined as the conception, articulation and implementation of a set of projects intended to enhance the standard of living in a political entity over a period of time.

A comprehensive plan sets its target to cover all major aspects of the national economy. A partial plan covers only a part of the national economy - industry, agriculture, health, the public sector, the foreign sector and so forth.

The need for planning arises largely because productive resources are scarce relative to the demand for them, and because complex organizations require a managerial "blueprint" to organize their resources toward their goals. Planning thus entails an attempt to effect by direct and indirect means the greatest volume and the best possible allocation of resources to reach the goals set by the people through their governments. The elements of a typical plan would include the setting of objectives, the articulation of resources, a time horizon and in most cases definite (quantitative) targets. By so doing it becomes easier to channel scarce resources towards the achievement of goals thus - eliminating waste and enhancing efficiency.

##### A. Types of Planning: An Overview

Plans can be classified according to the time horizon or the specific tasks that the plan is meant to tackle. In terms of time horizons, plans could be classified as perspective (15 - 25 years), rolling (1 - 3) years, or as annual plans. A prospective plan is "a blueprint of developments to be undertaken over a longer period." It does not imply one plan for the entire period of 15 - 20 years. In reality, the broader objectives and targets are to be achieved within the specified period of time by dividing the prospective plan into several short-period plans for four, five or six years. This may then be broken into annual plans. Plans of either kind are further divided into regional and sectoral plans. Regional Plans pertain to regions, districts, and localities which may be further split into sectoral plan for agriculture, industry, health, etc. These sectoral plans are further divided into sub-plans to cater for each unit or each task e.g. work plans/ program plans. A prospective plan reflects long-term targets, while the current plans and sub-plans are necessary support for the former to achieve those targets.

Every year in a rolling (three-year) plan, three new plans are made. First, there is a plan for the current year which includes the annual budget. Secondly, there is a detailed plan for the second year, and less specific plans for the follow-on third year. It is changed every year in keeping with the requirements of the economy, as well as changed needs, priorities, resource flows and emergencies. It contains targets and techniques to be followed during the plan period.

Also, a prospective plan for 10, 15, or 20 or even more years may be presented every year in which the broader goals are stated and the outlines of future development are forecast. The annual one - year plan is fitted into the same year's new three, four or five year plan, and both are framed in the light of the prospective plan.

Conceptually, a rolling plan is devised to overcome the rigidities encountered in fixed, five year plans. Within the rolling plan, there are plan targets, projections and allocations that are not fixed for the three- year period but are liable to revision every year in keeping with the changing conditions of the country. It not only provides greater flexibility but also a clearer perspective and a better view of the priorities. Being flexible, a rolling plan is more realistic than a fixed plan. It takes into consideration unforeseen natural and economic changes which may affect the planning unit. Financial and physical targets can be revised in keeping with these changes.

With the onset of the Structural Adjustment Program in Nigeria in 1986, the Federal Government decided that the medium-term plans (the five- year plans) were no longer appropriate for Nigeria, especially because of the volatility of the oil market, the main foreign exchange earner. Thus in 1990 - 1992, the first rolling plan for Nigeria was prepared. The 1990 - 1992 Rolling Plan was expected to be reviewed at the end of 1990 and then rolled over and thereafter regarded as the 1991 -1993 plan, and so on. A rolling plan could cover five or more years just as it does three.

## **B. Decentralization and Planning in Nigeria**

It has been the practice in Nigeria for national development plans to have three components: namely federal, state and local governments. At the national level, the goals and objectives are set. Specific guidelines are given to state governments to follow. The state on its own transmits the guidelines to the local governments and advises the local governments now to articulate projects and programs within the defined national goals.

Within this framework, the process of project selection and combination is still largely determined by officials at the local government levels. There is however no organized way by which ordinary people indicate their preferences. Furthermore, in most cases, projects are not carefully appraised to ascertain their viability.

Subject to the national guidelines, the officials at the state level determine the size and the project mix of the development plans of local governments. The projects accepted are subsequently printed as an integral part of the state plan. Like all tiers of government, the annual budget remains the instrument for implementing the plans. The annual capital expenditure programs are expected to derive from the plan. An observable general trend, except in a few cases, is that the ability of local governments to implement their capital projects is largely dependent on the size of the statutory allocation from the federation account rather than their internally generated revenues.

An institutionalized arrangement for monitoring plan implementation is virtually absent at the local government level. The state apparatus sometimes covers the local government. In most cases, local governments rely exclusively on the state apparatus. Furthermore, the quarterly progress report and the annual budget provide the basic information for project monitoring. In so far as they are inaccurate or unreliable, monitoring is compromised.

### **C. Plan - Budget Link and Coordination**

The budget is supposed to provide an operational link to, or serve as the basic instrument for implementing a plan. The budget should be an instrument with which the government carries out the full range of activities within a specified time period, usually a year. Thus the budget is seen as the "financial counterpart" of the public sector plan. Both the plan and the budget are political documents in the guise of economic documents in two respects. First, they reflect fundamentally political decisions. Second, they are more often than not regarded by chief executives as guides rather than as directives.

One major observation made during the field visits is the apparent lack of coordination between the annual budget figures for 1990 - 1992 and the rolling plan for the corresponding period. This was particularly reflected in the 1991 budget figures. One of the cardinal objectives of the rolling plan when it was launched in 1990 was to narrow this wide gap between plans and budgets. It was to reduce to a minimum distortions in annual budgets which tend to lead to supplementary budgets and virements. In Akinyele Local Government for the year 1992, for example, the provisions made for the construction of a primary health care facility and a health centre was 200,000 Naira in the annual budget. However, the actual financial outlay during the period was 526,408 Naira! The extra funds had to be raised through supplementary budgets.

While a plan and the accompanying budget probably should not be regarded as inviolable documents by governments, it is expected that a rolling plan could be an instrument for narrowing deviation and distortion. Indeed, there are still currently, in Nigeria's LGAs a number of factors that could lead to substantial plan-budget deviation. The first is the validity of the assumptions used in plan projections. Where the basis for the plan projections no longer hold because of unexpected developments, e.g. shortfalls in revenue sources, the plan is thrown out of gear. Other instances could arise where funding is provided for what was originally not in the plan or budget. This has been a major source of deviation in LGAs budget-plans in Nigeria.

A second factor is the important role, short experience and instability of LGA leadership. This weakens the link between plans, budgets and expenditures. Our observations confirmed the overall domineering role of chairmen of local governments. We found that regardless of whether a project was in the plan or not and whether provision had previously been made in the budget or not, if it was high in the scale of priorities of the chairman or sole administrator, adequate funds would be provided for it. Thus the execution of a plan will depend on the commitment of the rulership. Local Governments like Barkin Ladi, that

have done very well in the execution of the PHC programs, are LGAs where the chairman has a strong commitment to health care delivery and values the information gathered by the PHC personnel.

A third possible cause of plan instability is the absence of a clear public role in the process. At the local levels, people at the grassroots have no direct input into the plan. The final version is not subject to any kind of referendum. At the national level, frequent changes of government and the shifting policy stance do not make for continuity as there are changes of priorities with every incoming administration.

Normally, the rolling plan and budget should be closely related. Whereas the budget will be prepared for the coming year, the rolling plan will be prepared for the next three years. The terminal year of a plan will be continuously shifting. A major advantage of this framework is that the prevailing circumstances can significantly improve the projections, since more realistic figures are likely to be used. Our visits to the field show that most directors of finance of LGAs are either unaware of this procedure or have deliberately chosen to ignore it. Details of the 1990 - 92 rolling plan in the LGAs were not available, according to the LGA director of finance. However, the rolling plan allocation was indicated next to the corresponding items in the 1991 capital allocation budgets in most LGAs. No such arrangement was observed in respect of 1991-93, or 1992-94. The idea of a rolling plan at least at the LGAs may have become moribund after the initial enthusiasm.

#### **D. Planning for Primary Health Care**

A primary advantage of decentralization is the opportunity to work with smaller units to enhance efficiency. Just as the local governments are supposed to come out with plans, the various departments of the LG are also expected to develop plan and projections which will guide implementation and aid decision-making. The primary health care department is a major service unit of the LGAs.

Planning is important in PHC for a number of reasons. First, the resource scarcity typical of any developing country has been intensified by SAP, the drop in oil prices, and the competing pressure from other social service programs. Therefore, the few available resources must be deployed to maximum use. Secondly, monitoring and evaluation is a cardinal aspect of disease control and eradication. This also requires planning. At every stage, plans must be formulated, achievements evaluated and new frontiers opened up. Thirdly, inputs into the health sector come from various and sometimes unrelated sources. Planning is necessary to co-ordinate these sources.

A number of plans exist in the health sector: work plans, program plans, etc. Workplans are normally prepared by the local government health department and donor agencies. They cover specific areas of activities in the health sector. Program plans are program-specific: e.g. Watsan covers water and sanitation and is a plan targeted at particular

states of the federation. It is a program initiated by UNICEF and the World Bank, with inputs from state and local governments for the provision of water and sanitation services within a specified number of LGAs over a period of time. Both depend on baseline data collection to identify problems and set priorities.

#### **E. Baseline Data**

The key instrument for planning in the health sector in Nigeria was to be the "Baseline Survey". It was undertaken by the 52 model LGAs prior to the take off of the PHC program in Nigeria in 1986. The survey was to indicate the health conditions present in each LGA just before embarking on the PHC. The survey was designed to be used to identify health priorities and plan community health education interventions.

Thus, the baseline survey is supposed to serve as a platform for meaningful planning for health, and as or a kind of reference point in assessing achievements and progress in health care delivery. However, only a few of the PHC departments visited could furnish us with copies of their baseline survey. The PHC co-ordinators were quick to point out that the surveys were filed at the State Ministry of Health (SMOH). But since the LGAs need to use this survey in mapping out operational strategies, that the SMOH might not be the appropriate repository for the surveys. Many activities designed to grow from the survey have not been done. For example, house numbering and placement of home-based records were expected to flow out of the surveys. While most LGAs visited have done the house numbering, the same cannot be said of the home-based records.

Another example of a planned activity usually not done has also been the 100 household survey. It is supposed to be adapted for routine monitoring. The survey is designed to cover 100 households nearest health facilities and targeted at mothers of children under 5 years.

Some surveys have been undertaken by specific LGAs for definite purposes. Such surveys include the facility assessment survey currently undertaken by the Barkin Ladi Local Government. The survey was conducted primarily to obtain information about case management and education practices among health workers in the LGA. The emphasis was placed on obtaining information about immunization and diarrhoea (fever case management and the availability of necessary equipment and supplies. A similar survey was recently conducted by the PHC unit of the Deputy Governor's office in Sokoto State to obtain an on-the-spot inventory of health facilities in the state. This survey covered such important areas as number and type of facilities by location, the number of health personnel by categories and materials available at each facility.

One survey that is of particular relevance to planning was also recently conducted by the Barkin Ladi L.G.A, titled "a survey of Mothers' Knowledge and treatment practices related to Primary Health Care with emphasis on Immunization, Diarrhoea and Fever". The

survey was conducted to obtain information about knowledge and treatment practices related to PHC among mothers of children under 5 years in the LG in respect of the diseases highlighted-immunization, diarrhoea, nutrition, and fever.

These examples are, unfortunately, the exception rather than the rule, and in fact little effective base-line work has been done in most LGAs.

Health Information Systems (HIS) are also important in the planning process. The planning, monitoring and evaluation of health services have historically been hampered by the shortage of reliable data. The role of HIS is to co-ordinate the compilation and analysis of data accumulated by the different departments within the SMOH and to disseminate the data to the responsible ministries/departments so that they in turn can share this information with the LGAs. Together they should be able to plan for the health needs of the state or local government. Since the core of HIS is accurate data gathering, the role of the M&E unit of the PHC department is important.

Unfortunately, however, one of our findings in the field is that data collection in LGAs is largely rudimentary. The LGA PHC department in most cases has an M&E unit headed by an assistant co-ordinator. Often he/she is the only officer in the unit. It is doubtful whether the level of training that these officers have is sufficient to cope with the demands of data gathering and analysis. Most state PHC offices visited complained that data do not flow from LGAs to their offices. On the other hand, LGA monitoring and evaluation officers complain that forms for assessment are rarely made available from SMOH. Furthermore, field personnel observe that PHC personnel are erratic and unreliable in collecting the data they do gather. Most disturbing is the absence of feedback from SMOH from the data that LGAs supply to the state health (statistics) department. Under these circumstances, particularly recalling the absence of base line data, it is doubtful if any effective planning can be done.

From our field observations, it is obvious that the only time most LGA PHC departments undertake surveys or gather HIS data is when it is made a pre-condition for obtaining matching or non-matching grants from the Federal Government or donor agencies. This is clear from the baseline surveys as well as the 100 households survey. Given the importance of such surveys for effective planning for health, the respective authorities may have to think of sanctions to impose on defaulting LGAs in this regard. This may not be too difficult to implement given that LGAs depend on the Federal Government for close to 90% of their revenue, and allocations are done on a monthly basis.

## **F. Work Plans**

Work plans are important for the health care delivery system. They usually run for a single year and are either area or problem focused. Work Plans could be initiated by LGA health departments in respect of particular program e.g. immunization. More often than not, most work plans are the outcome of collaborative efforts between donor agencies and recipient LGAs. As a matter of fact one condition for the release of funds by donor agencies is the submission of a well articulated work plan by the recipient LGA. The main elements of such work-plans include a statement of objectives, activities to be undertaken, the duration or time-frame, location of the activities, the responsible officers and, most of the time, the budget outlay. For donor programs, the budget is specific requiring such details as contribution by agency, counterpart contribution by local and/or state governments, and the time of release of such funds. The best example of work-plan was at the Barkin Ladi L.G.A. The Barkin Ladi LGA Child Survival Activities work-plan is a collaborative arrangement between the LGA and CCCD, a USAID project. There was also a similar, workplan for the state ministry of health, also linked to NCCCD.

The most important example of program planning is the 1992 work-plan to enhance PHC service delivery by the Barkin Ladi LGA. This work plan is a comprehensive PHC development plan. It includes work-plans for planning, monitoring and evaluation, MCH/FP/nutrition, disease control and watsan, education and women activities, and essential drugs, equipment and supplies. Each sub-plan has a statement of objectives, activities to be carried out, location, time, responsible officer and the budgetary allocation. The assistant coordinator for each unit is the officer in charge of the coordination of the plan under the overall supervision of the PHC co-ordinator. Outside Barkin Ladi, we could not find a PHC development work-plan, though we were told that such work-plans existed.

One of the weakest links in the PHC chain as it is currently run is planning and the information gathering activities which support it. The following handicaps in planning were identified in the field:

- i. **Inadequacy of executive capacity:** The numbers of trained staff are few. This is a major handicap. One factor responsible for this is the lack of job permanence. M&E officers who have been specially trained for this job are often deployed to other areas of health care delivery where their services may not require the skills acquired in their M&E trainings.
- ii. **Resource constraints:** Lack of vehicles (cars & motorcycles) to go and collect data from facilities.
- iii. **Unstable political climate** which may result in changes in policies and slow down implementation of plans. Such changes may also lead to the removal of a large number of experienced officers. This situation is often re-enacted when new local governments or states are created.



- iv. Poor information gathering techniques which may hinder the flow of data resulting in paucity of data.
- v. Low-involvement of communities in plan formulation and implementation. Communities are not often involved in the identification of priorities and so when such projects are being implemented it is difficult to enlist their support. This may weaken the expected results or in some cases lead to premature termination of projects.
- vi. Lack of co-ordination of plans especially among different donor agencies which often results in duplication of efforts and waste of resources.
- vii. A general low appreciation of the managerial advantage offered by planning along with an under-developed budgetary process to utilize what planning is done.

## **G. Conclusion**

The potential value of planning in PHC has got to be achieved in Nigeria. Weakness in planning begins at the LGA in general and is reflected through the PHC department. LGAs do not gather overall information regarding local problems, develop plans from that information and use them in defining budgets. PHC has been weak in gathering and/or using available base- line data as well as HIS. Lacking these data, PHC departments, as a rule, develop no overall PHC plans for their localities to use in the budgetary process, and little to guide detailed work-planning. In the few instances where comprehensive work plans, base line data and HIS exist, they appear largely related to the donors or occasionally, the federal government. Here, resources and requirements from outside have brought this about.

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## V. MANAGEMENT ISSUES IN THE HEALTH SYSTEM: BUDGETING AND FINANCING

Since the reform of Local Government in 1976, Nigeria's fiscal structure has undergone a number of rapid changes as attempts were made to allocate and reallocate expenditure responsibilities and tax powers among the federal, state and local governments. The situation has not been helped by incessant and often arbitrary adjustments in the boundaries and numbers of states and local governments.

To the adherents of decentralization, lower levels of government perform more efficiently than higher levels of government. Local governments are presumed to perform more efficiently than state governments, while state governments will perform better than the central government. In contrast, the advocates of concentration believe in the opposite. What perhaps cannot be denied, is that certain governmental functions are more efficiently performed by lower levels of government whereas others are carried out better by the state or federal government. This observation together with the supposed ability to adapt governmental activities to the preferences of people at the lower level may explain the decision of Nigerian authorities to shift Primary Education and Primary Health Care (PHC) services to LGAs since 1990.

However, this transfer has placed heavy responsibilities on the LGAs and calls for a re-examination of the budgetary and financial management capacity and processes at the LGAs. A number of questions readily come to mind, given the likelihood that LGAs have to be strengthened and their efficiency enhanced to enable them cope with their new responsibilities. For instance, what should constitute appropriate budgetary processes in the LGA? To what extent are LGAs able to link budgeting to problem identification, priority setting and general planning? Who takes spending decisions and what checks and balances exist in the spending process to forestall excesses on the part of LGA functionaries? What level of expenditure efficiency exists and how adequate are the revenues of LGAs to enable them cope with a decentralized financial management arrangement? And finally, how do the LGAs rate on the issues of transparency, timeliness and accountability in their financial management. These and other issues raised in this section are pertinent for financial sustainability as it pertains to the general area of decentralized governance in Nigeria and the impact of decentralization on health programs in particular. Our analysis is based on data collected from nine (9) LGAs visited during the course of the fieldwork.

## **A. Budgetary Procedure**

The techniques of budgeting range from the traditional line item-budgeting, to the Program, Performance and Budgeting System (PPBS) and the Zero-Base budget. A few of Nigeria's states have experimented with the PPBS approach, but the traditional line item budgeting remains the popular approach in Nigeria. This approach was legitimized by a Federal Government directive in 1984. It is basically an annual incremental approach. The new year's estimates are usually based on the previous year's expenditure pattern and not necessarily on the justification of each expenditure item. Budgeting at the local government level involves the following main processes:

- i) Issuance of a call circular by state governments to their respective local governments. Among other things, the circular will specify the guidelines which local governments are expected to follow in the annual budget preparation, expected priorities, revenue expectations from the Federal Account and state governments, the basis for projecting internally generated revenues, percentage allocation of expenditure among its various components, etc. Call circulars are normally sent out to LGAs in October of the year preceding the budget year.
- ii) Preparation of advance proposals and draft estimates by the various LGA departments.
- iii) Collation of the drafts from the various departments by the Director of Finance to ensure that they conform to standard guidelines as enunciated in (i) above.
- iv) Consideration of draft budget by the executive arm of the Local Government.
- v) Presentation of the draft budget by the LGA chairman to the legislative arm of the LG (the elected representatives of the people) for ratification.
- vi) Promulgation of the budget by the chairman after ratification.
- vii) Implementation of the budget, by a Finance and Implementation Committee usually consisting of the Chairman, the Vice Chairman, the Director of Personnel Management and the Director of Finance and Supplies. The composition of the committee varies from one local government to the other. Its function is to meet at least once in the month to monitor the implementation of the budget.

A major shortcoming of the procedure outlined above is the absence of a key element identified in the introduction; that is, the need to maximize a crucial advantage of a decentralized financial management process by allowing inputs from the local community. Decentralization allows for more effective collective decisions. Only in Yabo LGA (Sokoto State) did we find a semblance of community input into the budgetary process. Here, elected representatives were consulted in preparing the drafts, and on the capital projects they considered the main priorities

in their wards. These projects were then ranked depending on priorities of the Local Government and the availability of funds. This weakness is in part an outcome of the line-item budgeting process. It also grows out of the simple failure to involve the public and its representatives in the budgetary process.

The non-involvement of the local community results in inadequate priority - setting for projects and activities. Moreover, the weak public involvement in planning as well (such planning as does occur), weakens the link between planning and budgeting, both prospectively and retrospectively. Lacking much of a broad constituency for either, both can be ephemeral. What little evidence we saw showed that there is no linkage between the budget and the 3-year rolling plan for 1990-92. The budget of course, is supposed to be the means of implementing the plan. The absence of public involvement is parallel by the weak role allowed to the professional departments. This may also have accounted for the poor state of PHC budgets. The department of PHC has no input into the final local government budget. These proposals are rarely given serious considerations. Since budgeting is considered as a routine exercise for which the budget officer is responsible, serious considerations are not given to the submissions of the PHC coordinator. No wonder therefore that one finds facilities located where they are seriously underutilized, supplies inadequate to needs, and personnel often poorly deployed vis-a-vis needs. This also has serious implications for quality control.

In most of the LGAs visited the budgetary process starts with the Director of Finance and Supplies and ends with the LG Chairman. There is an overpowering influence of the Chairman and near irrelevance of the legislature, particularly in councils dominated by a single party. This has implications for priority setting in the LGA and raises serious issues of accountability.

Health sector projects are not always seen by political leaders as vote-catching endeavors. Given the desire of chairmen of LGAs to be returned to office, the building of roads and culverts seems to receive more attention than the construction of health clinics or the supply of drugs. If the public and professionals were more involved in planning and budgeting LGA leadership might be more responsive to what most observers believe is a real public desire for better health facilities.

## **B. Post-Budgetary Processes**

Other important observations in respect of the budgetary process has to do with post-budgetary procedures/mechanisms for ensuring compliance and accountability. LGA supervisors of finance are supposed to provide financial reports in the form of monthly/quarterly revenue and expenditure reports, pay-roll summaries, internal audit reports and monthly bank reconciliation statements. In almost all the LGAs visited those reports were not available. Specifically, the annual financial statement for the immediate past year was available only in one local government. No local government could produce a copy of a

recent internal audit report for our observation, yet the state directors of finance claimed that auditing of local government accounts do take place from time to time and that copies of such reports are sent to the local government planning department and to the inspectorate and monitoring division of LGAs, in the deputy governor's office. Our efforts at following this did not yield any fruitful results. There is a LGA auditor for all LGAs in each state but it is largely ineffective.

### **C. Expenditure Efficiency**

The efficiency discussed here concerns how expenditure allocations are made between different expenditure items in the budget. Expenditures are normally classified into two categories - recurrent and capital expenditure. While the former is meant for the servicing, sustenance and maintenance of the existing human and material resources of government, the latter deals with the acquisition of new assets. Recurrent expenditures are often further broken down into personnel and overhead costs.

Major trends in expenditure patterns are summarized on Table 2. Although the data covers only a period of 3-4 years (1990-1993), the analysis is indicative of the general pattern of LGA expenditures. The first observation from Table 2 is the disproportionate portion of LGA revenue that is committed to recurrent expenditure. For six of the nine LGAs in our study, over 50% of total revenue is committed to paying salaries and wages and meeting with the daily running of the LGA. The immediate consequence of this is that after paying salaries and wages, LGAs have very little left for capital projects. A close examination of the composition of recurrent expenditure indicates that while it may be true to say that salaries constitute between 60-65% of total recurrent expenditure in Ife Central, Barkin Ladi, Akinyele, Atakumosa and Pankshin Local Government, this is not the case of Kaura Namoda and Yabo Local Governments. In these two LGAs, personnel costs constitute less than 30-35% of total recurrent expenditure. The question cannot but be raised as to why overhead costs constitute such a sizable proportion of LG recurrent expenditures in these LGAs. On the average, it is about 40-45% in Pankshin and Barkin Ladi, even though it is lower than the disposition of funds for wages and salaries.

The point being made here is that contrary to the widely held notion that the major culprit in the bloated size of recurrent expenditures of LGAs is personnel costs, and at times unexplainable increase in certain items of overhead costs could also be a major factor. Thus even where LGAs like Pankshin and Barkin Ladi are able to curtail their expenditure on salaries and wages, there has been no corresponding impact on their total recurrent expenditures because of huge outlays on non-personnel costs.

The problem here is of a dual nature. Most LGAs have too many personnel and not enough provision for supplies, equipment maintenance and operational inputs. However, where the recurrent budget is skewed towards non-personnel items, emphasis is rarely given to the ones enumerated above! Rather, "miscellaneous", travelling and entertainment, etc,

**Table 2**  
**LGA's Expenditure Patterns**

	Percentage														
	Personnel/ Total Expenditure			Overhead/Total Expenditure			Personnel/Total Recurrent Expenditure			Overhead/Total Recurrent			Recurrent/Total Expenditure		
	A	AE	E	A	AE	E	A	AE	E	A	AE	E	A	AE	E
	'91	'92	'93	'91	'92	'93	'91	'92	'93	'91	'92	'93	'91	'92	'93
Akinyele	40.2	41.3	41.8	8.2	7.9	10.3	70.1	68.9	69.6	29.9	31.0	30.3	60.1	68.1	63.7
Atakumosa	39.2	48.1	47.2	9.2	10.2	10.7	72.2	69.2	70.3	28.9	32.0	29.7	67.1	63.8	62.1
Barkin Ladi	38.1	50.1	46.9	27.7	15.2	37.9	55.1	72.0	55.2	39.9	21.8	44.7	53.8	69.5	64.7
Ife Central	58.2	33.4	41.7	8.1	6.3	19.2	75.4	45.6	58.2	21.5	58.5	41.7	77.2	73.2	68.5
Kaura Namoda	17.2	12.1	19.5	17.2	12.1	19.5	28.8	19.8	30.1	71.7	80.5	69.8	59.8	62.7	64.7
Pankshin	53.6	48.3	49.1	53.6	48.3	49.1	62.2	62.5	59.2	36.1	34.6	31.9	55.1	58.1	56.0
Yabo	12.6	18.1	17.9	12.6	18.1	17.9	24.2	26.0	26.2	75.2	73.4	73.7	47.8	39.2	31.5

A - actual  
 AE - approved estimates  
 E - estimates  
 Units are in millions of Naira

claim a large chunk of the budget. These two different but equally inefficient patterns result from two frequently seen problems in African public-sector budgeting. First, is the existence of a large number of non-professional and often idle staff who in most cases do not have the required input (material and human) to operate and meaningfully contribute to the output of the LGAs. Pressures, cultural and political, exist to maintain them on staff regardless of their low contribution to output. Second, there is a lack of close scrutiny of the budget, by professional and public constituencies, particularly of overhead costs. The first calls for the need for human resource audits, particularly in professional and skilled departments like the health department. The latter underscores the need for transparency in budgeting. For instance, one may want to find out why items like "miscellaneous" often with large votes still feature so prominently in the overhead (line) budgets of most LGAs.

Again, the budgetary process itself could be one important source of these expenditure lapses. Because of the incremental nature of the line-item budgetary process, the tendency has been to retain certain items of expenditure and to increase them from year to year even when they might be difficult to justify. What is called for is the adoption of a program-type budgeting or at least a systematic analysis which identifies each activity in terms of both performance and funding levels. And herein lies the crux of the matter. The kind of analysis called for here requires the input of professionals in the budgetary process. Most finance departments of LGAs are manned by unqualified staff, at least regarding training in finance. This is even more so with regards to PHC. Most PHC coordinators have no budgeting and planning training. It thus becomes an easy way out for them to abdicate their budgeting to the finance department of their LGAs. In a charitable scenario, this might explain the poor treatment health receives in LGA budgeting.

Health is a major priority in most LGAs. All the Chairmen (except one) and directors of health interviewed during the course of this project agreed that health was their first priority. However, in terms of funds allocation, health came third after education and in most cases general administration. For instance, in Ife Central, capital expenditures on health for 1992 were 8.09% of total allocation coming a distant 3rd after roads and bridges (47.9%), and general administration (11.3%). The situation was not very different in 1991 when health capital expenditures came a distant fourth after general administration (27.1%), Commerce, Finance, co-operative supplies (6.7%), and town and county planning (7.1%).

The picture that emerges from Table 3 points out, contrary to the claims of LGAs that health is a major priority, that the practice may be quite different. For instance, in all the LGAs visited, health expenditures as a percentage of total expenditures have gradually declined over the years, with the exception of Yabo Local Government Area. Also, capital expenditures in health as against the total for services (education, health information, social development, sports and culture, fire service) have also declined. Capital expenditures on health as a percentage of total expenditures on health have not shown any significant increase. It has actually declined in some local governments.



Personnel costs remain a substantial portion of total expenditures on Primary Health Care. In Akinyele, Atakumosa, Barkin Ladi, Ife Central, Pankshin and Yabo, it claims well over 55% of the total resources available for primary health care.<sup>3</sup> A careful analysis of this component of health care actually reveals that the greater part of the costs incurred on personnel in the health sector goes into the payment of the salaries and wages of the non-professionals in this department. It is arguable that the health sector may require the services of highly skilled and specialized personnel more than the unskilled staff on which it presently spends a greater part of its resources. This again calls for the need for an appraisal of the staff requirements of the health departments of LGAs. The fact that this issue has not been systematically looked at any LGA is significant in itself as an indicator of the state of planning and budgeting. In 1991, personnel emoluments for workers on GL.07 and above in the Health Department of Pankshin Local Government was N903,960.00 whereas for the same period workers on GL. 01-06 in the same LG collected N1,710,650.00. This scenario is re-enacted in almost all LGAs visited. What this calls for is a staff auditing in order to determine the appropriate level of staff required to sustain PHC in the LGAs.

#### **D. Revenue Adequacy**

In addition to PHC, the Nigerian constitution expects local governments to be responsible for the following activities: formulation of economic planning and development for their areas, provision and maintenance of cemeteries and burial grounds, social welfare, public conveniences (roads, drains, refuse disposal) and primary, adult, and vocational education. By their very nature, most of these activities cannot be provided at full cost to all consumers. They are public goods and have a high social rather than purely economic content. Local governments do not have adequate resources to cope with the supply of these services, even with the substantial increase in the proportion of federally collected revenues deployed to local governments from barely 10% in 1986 to about 20% in 1992.

Of the three traditional sources of revenue available to LGAs, (taxes, cost recovery, and grants), grants remain the most significant. Three types of grants are normally identified - specific or tied project grants mostly from donor agencies (these do not enter into normal budgetary operations), statutory allocations from the Federation Account, and special grants from the federal and state governments.

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<sup>3</sup> In many LGAs, (recurrent) expenditures on primary education are not included in the LGA budget because of the existence of an autonomous unit, the Local Government Education Authority which deals with Primary Education Matter.

**Table 3**  
**LGA's Health Expenditure Patterns**

	Percentage														
	Health Expenditure/ Total Expenditure			Personnel Cost in Health/Total Expenditure in Health			Capital Expenditure in Health/Total Health Expenditure			Personnel Costs in Health/Total Personnel Costs (LGAs)			Capital Expenditure in Health/Total for Services		
	A	AE	E	A	AE	E	A	AE	E	A	AE	E	A	AE	E
	'91	'92	'93	'91	'92	'93	'91	'92	'93	'91	'92	'93	'91	'92	'93
Akinyele	10.2	9.8	76.0	60.1	60.8	71.2	38.1	32.9	40.3	6.8	10.1	11.3	15.8	17.1	18.9
Atakumosa	11.2	10.8	8.9	58.1	70.1	72.2	0.3	31.8	34.7	10.0	9.8	11.2	19.3	16.1	15.8
Barkin Ladi	12.5	11.1	8.8	48.6	78.7	73.9	22.9	16.8	36.1	15.9	17.1	14.2	20.8	6.5	8.1
Ife Central	4.9	3.6	9.6	59.6	52.4	61.2	36.9	47.5	37.9	5.1	5.8	14.2	11.9	13.4	13.6
Kaura Namoda	16.7	15.5	15.6	34.7	26.5	39.7	43.9	45.7	37.2	33.6	37.9	31.6	67.6	43.5	36.6
Pankshin	15.7	11.3	14.6	70.3	69.5	63.9	17.7	26.4	18.5	23.7	16.3	19.0	31.2	37.4	39.7
Yabo	8.4	9.2	10.9	45.2	50.2	57.6	40.9	14.2	17.3	30.0	32.1	35.2	30.8	32.4	38.1

A - actual  
 AE - approved estimates  
 E - estimates  
 Units are in millions of Naira

**Statutory allocations** from the federation account continue to account for between 75-90% of total local government revenues (see Table 4). This varied significantly among LGAs reflecting the federal allocation formula and the taxable capacity of the LGA. The major problem with this source of revenue is its unreliability. Federally collected revenue depends on the vagaries of the world oil market for its stability. The criteria for the allocation of federally collected revenue are minimum responsibility (or equality of local governments), population and social development. As of 1991, the social development factor included the number of health facilities, the number of schools and primary school enrolment, land mass and contingency. These criteria when applied yield different amounts to local governments and could severely affect the ability of some LGAs to implement policies in the health and other sectors.

The excessive reliance on the federation account has also negatively affected the internal revenue generation efforts of LGAs. This may be responsible for the observed correlation between higher transfers and declining internally generated revenues. Perhaps because statutory allocations and grants are easy sources of revenue to local governments, they have made little effort to raise revenue from local sources.

**Internally generated revenue** remains a minute percentage of total LG revenue, ranging between 1-3.5% in the LGAs reviewed during our visits (See Table 3). The amount of total LGA expenditures covered by internally generated revenues remains abysmally low; in most cases it is less than 3% (Table 4). Interestingly, our investigations revealed that there are many potential sources of revenue which local governments can explore:

- i) Proceeds from public utilities or services provided by the local government e.g. water supply, motor parks, and transportation.

This involves some user charges on services rendered. For instance, at Atakunmosa LGA, the rich granite resources are carted away without any charges by builders/contractors. They could provide a broad source of revenue. But our interviews revealed that the LGA is not willing to levy any charges on granite. The story is not any different for another Local Government where a thriving abattoir that serves a major metropolis exists. Apparently, the LGA had never thought of exploring this abattoir as a source of revenue. Even when the team suggested this potential revenue source, the LGA was reluctant to explore the idea.

**Table 4**  
**Local Government Revenue Patterns**

	Percentage											
	Statutory Allocation/Total Revenue			Internally Generated/Total Revenue			Internally Generated/Total Expenditures			Taxes/Total Revenue		
	A	AE	E	A	AE	E	A	AE	E	A	AE	E
	'91	'92	'93	'91	'92	'93	'91	'92	'93	'91	'92	'93
<b>Akinyele</b>	92.9	96.1	90.9	7.0	3.8	9.0	31.2	2.2	1.3	4.1	1.6	1.9
<b>Atakumosa</b>	64.8	71.3	97.0	35.1	28.6	11.8	4.4	2.7	2.7	5.1	4.3	1.9
<b>Barkin Ladi</b>	96.7	96.0	97.7	3.3	4.8	2.2	3.3	4.8	2.3	2.3	1.2	8.2
<b>Ife Central</b>	96.7	96.6	94.2	9.5	7.3	5.1	9.6	5.3	5.7	1.9	1.1	1.3
<b>Kaura Namoda</b>	92.3	94.3	91.5	7.1	5.8	8.4	6.3	2.5	7.6	3.4	2.3	2.4
<b>Pankshin</b>	95.5	74.8	1.5	4.6	2.9	2.6	4.2	3.1	2.1	2.4	1.7	5.4
<b>Yabo</b>	94.2	96.2	97.1	3.5	3.2	1.3	2.9	2.8	1.3	2.1	1.9	1.7

A - actual

AE - approved estimates

E - estimates

Units are in millions of Naira

The issue of user charges particularly in the health sector has remained controversial. We realize that where social objectives are involved, life line rates may be a necessary consideration. But where efficiency or revenue generation is crucial, and sustaining and expanding services is a goal, a moderate form of commercialization must be introduced. In other words cost-recovery, though not necessarily user charges, becomes the operative principle. The Drug Revolving Fund (DRF) scheme has been conceived along this principle.

Our investigations revealed that user charges generally do not exist in the health sector because many fear that user charges will scare away acceptors. Yet many rural people often prefer to patronize fee paying private health centers and clinics which they found to be more reliable in terms of services provided. Cost-recovery will create awareness among the people at the grassroots as they see the need for them to contribute to the improvement of health services. Moreover, paying for a service has its own distinctive advantage. More premium is placed on such services. Also, it tends to minimize the incidence of over-prescription (of drugs) by health workers since this will cost more to the consumer. On a more realistic note, and talking about sustainability, cost-recovery is inevitable given the present state of the nation's economy. Oil is a resource that is depletable and donor agencies are not going to be in existence in the health sector forever.

Barkin Ladi is a local government where cost-recovery has been practiced and has yielded very good results. The PHC co-ordinator confirmed that people are prepared to pay for such services as dressings, syringes etc., "because they see what they are used for." The DRF program in this LGA has been quite successful. The Barkin Ladi experience has shown that cost-recovery can be managed with proper coordination and community mobilization techniques like the education of mothers on clinic days.

Other services that the PHC department may want to exploit more seriously for cost recovery are birth and death registrations, dispensary and maternity fees, earnings from environmental sanitation, pest control/disinfection fees, laboratory test fees, etc.

- ii) Income received from hired equipment, letting or leasing of property belonging to the LGA. e.g. rent from local government housing units. This could be an important source of revenue in an urban/semi-urban local government authority.
- iii) Earnings from commercial undertakings. e.g. stallage, shops and shopping centers, hire of plant and equipments, motor park fees, etc.
- iv) local government fees and rates - incomes derived from licenses, permits, food control (food vendors licenses), economic charges etc. This is a very fertile area for most LGA revenue generation efforts. It is unfortunate that of the over 100 items listed in this category only about 3 are exploited for revenue purposes. The LGAs have been unable to develop effective mechanisms for collecting these revenues.

- v) Interest and dividends received on local government accounts.
- vi) Income from tax especially community tax/poll tax, cattle tax and property taxes. Ideally, this is where most LGA revenues are expected, but it is greatly underexploited. Less than 10% of estimated revenue from community taxes are collected in the LGAs visited. This leads to the issue of tax administration. It has been suggested over and over again that tax administration in the LGAs can only be improved if the community leaders are involved in tax collection. Community leaders will only be encouraged to participate in tax administration if they know for what the tax the community is paying is to be utilized. This touches the issue of reciprocity in community/local government relations and grassroot participation. Another issue under this heading is tax rate. Tax rates have remained at ridiculously low levels over the years. Our investigations revealed that over the past 15-20 years, this has remained at N7.50 per adult per year. For cattle tax, a tax rate of N2.50 per cattle head and 50k per goat head is levied in most parts of the North. These rates are out of touch with reality.

Tenement rates are rarely collected. Yet this could be a major source of revenue. The potential for collecting tenement rates from domestic and commercial owners of property as well as government grants in-lieu of rates is being exploited by very few LGAs in Nigeria.

Our discussion of the various sources suggest that there are at least five ways by which local governments can boost internally generated revenues. These are through the expansion of services, a mechanism of adequate pricing policy, expanding tax effort, financial investment, and community involvement/participation. These five areas need to be critically investigated for use in the sustainability of health services.

A third major source of revenue is **grants from the federal and state governments**. On the commencement of the PHC program, the federal government provided matching grants to model local governments who were able to satisfy certain criteria. Our investigations on the field also show that currently, the Federal Government is providing a matching grant of N200,000.00 through federal zonal PHC offices to states for supervision purposes. We recommend that most federal grants to LGAs should be selective, matching grants with objective of helping to raise revenue potential of the recipient LGA. Also, for the purpose of securing an increase in the level of a particular service, a selective grant might be superior to a general grant. For the purpose of increasing the local contribution to achieving the desired increase in a particular public service such as health-care delivery a selective matching grant is most appropriate. States are also required to make available 10% of their internally generated revenue to LGAs. Our investigations on the field show that such state grants have been few and very irregular. LGAs have received such grants from states only once or twice and definitely not in 1993 (except Yabo and Kaura Namoda LGAs).

The last source of support for LGAs health care programs is **donor agency funds**, popularly styled project grants. Not much can be said about this source because they are not normally included in the annual budgetary processes and records of the LGAs. Project grants are normally an arrangement between the LGAs and the agency concerned. Funds are released only when a work plan has been agreed upon between the donor agency and the LGA. A separate bank account is operated for such grants and the signatories to the account are usually the LGA chairman, treasurer and the PHC Co-ordinator.

## **E. Governance Issues in Local Government Finance and Budgeting**

In order to ensure sustainability of PHC delivery, there are certain areas of LGA financing and budgeting procedures that need to be critically examined. The discussion of these issues will be based purely on our observations on the field. These issues are clearly interwoven.

### ***1. Transparency***

Transparency as used here means putting all government transactions through a clear, comprehensible and public budget. Only in this way can a reasonable assessment be made of the claims by and on the government. The immediate consequence of a lack of transparency is the incessant resort to supplementary or extra budgetary accounts and series of virements. In all the LGAs visited, supplementary budgets were common. Specific examples of the lack of transparency exist. An example is the use of the item 'miscellaneous' in the budgets of LGAs as already highlighted above. The overhead expenditure items of most departments of the LGA are replete with these items. In a particular LGA, under the Preventive Department of Primary Health Care, miscellaneous expenses rose from N232,000.00 in 1989 to N1,050,000.00 in 1990. In another LG, out of a total expenditure on overhead and personal costs of N1,379,820.00, miscellaneous expenses was put at N650,000.00 (47%)! It is necessary that budget items be specified. to introduce more transparency into the budget making process and government generally.

### ***2. Accountability***

The issue of accountability touches on three areas. The first is the budgetary process. LGAs are not accountable to the communities they serve since these communities are not in anyway involved in determining LGA priorities. The lack of popular participation means LGA operators are not subject to the scrutiny of the communities they serve. Secondly, state inspection is almost nil. The LGA auditor introduced as part of the 1988 reforms in all states has been largely ineffective. Thirdly, LGA councils have also failed to serve as effective checks and balances on the LGA executive. Finally, the lack of qualified professional staff in the accounting departments of most LGAs render suspect whatever little supervision is claimed to be done.

Thus, LGAs are rather irresponsible in their spending patterns. Items to watch include travelling, entertainment and hospitality, stationery and printing. The overall allocation for entertainment and hospitality is close to 9.12% (on the average) of total outlays for personnel and overhead costs in the LGAs. In a particular LGA, 55% of the disbursement on overhead for the planning department is supposed to be used for stationery and printing. The issue is that those items have the tendency to be carried over and enlarged for subsequent years. It is not clear who, if anyone, is holding these personnel to account. For example, out of a total overhead cost of N53,084.00 in the Health and Social Welfare Department of a Local Government in 1989, N19,980.00 (37.6%) was actually spent on travel and transport. The result was that nothing was available for the maintenance of vehicles which is indispensable for supervision and evaluation.

### **3. *Timeliness***

As discussed above, LGA budgets start with the call circular issued by the Bureau of LGA, in deputy governor's offices in October for the forthcoming budget cycle - January to December. But it is common practice to find that in most LGAs, final approval for the budget by the legislature (council) comes several months late - well into the following year. In one LGA visited, the budget for 1993 was approved in July. This pattern makes it difficult to ensure consistency between budget and expenditure and avoid the all too frequent resort to supplementary budgets.

## **F. *Conclusions***

The issues raised in this chapter pose serious considerations for sustainability for primary health care in the LGAs. Briefly our main conclusions are that:

- Budgetary process in the LGAs is still mainly a line-item. This practice erodes a serious review of local programs as they relate to local problem and priorities. It also does not encourage popular participation and as such results in a lack of accountability.
- Budgets are delayed, use little professional (sectoral) input, frequently organized in ambiguous categories, and usually poorly proportioned to local program needs. This seriously impedes transparency and managerial effectiveness.
- The sizeable proportion of PHC budget devoted to recurrent expenditure does not make for effective health care delivery. This is more so given that the greater part of personnel expenditure goes into the payment of the salaries of non-professionals in the PHC Department whose role in PHC is not entirely



clear. Also, there is a need to review items of overhead costs to focus on expenditure items that bear direct relevance to health care delivery, particularly in supplies.

- Internal revenue mobilization efforts of most LGAs are grossly inadequate. There is a need to explore available sources of revenue in the various LGAs. For Primary Health Care, appropriate steps should be taken to educate people on the usefulness of user charges. User charges properly mobilized should provide enough resources to cover items such as maintenance of equipments, supplies, etc. Grants from higher governments and donor agencies can be structured to encourage internal revenue efforts.
- Transparency, accountability and timeliness are issues that must be seriously re-examined in LGA finances if the implementation of PHC is to be sustained.

## **VI. Management Issues in the Primary Health Care System: Supervision, Monitoring and Evaluation**

The LGA PHC system is very complex indeed. Territorially, the components of the system, arranged in increasing geographical areas, include: the family/household, the village/ward, district, LGA, the state, the federal zone and the federal territory. The delivery of the services of the LGA PHC systems is done through facilities that are arranged in an order of hierarchical levels, and include: volunteer health workers resident within the community of households of the village (rural) or the ward (urban), health clinics, primary health centers, and comprehensive health centers. The last are linked via referral with general hospitals and equivalent health care facilities.

In these facilities resources of many types are brought together to yield services. These include human (personnel), supplies, financial, and physical infrastructure. The primary health care services provided in the facilities include: registration, health education, growth monitoring and nutrition, illness diagnosis and treatment, immunization, family planning, pregnancy care, delivery and postnatal care, quality control, drug dispensing and dosage administration, special care for high risks, referral support, community outreach, and monitoring and evaluation of PHC services.

Guided by the principles of the primary health care approach, these different elements have to be organized in the LGA PHC system to ensure harmonious and efficient working relationships between and among its various parts. This includes minimizing conflict and duplication, providing incentives for effective utilization by targets, encouraging efficiency in facility operations, and insuring considerations of equity in the coverage of the populations in the geographical territory and its subunits. Thus the LGA PHC system presents a formidable organizational and management challenge, and implies an important need for adequate supervision, monitoring and evaluation to enhance its performance.

The information required for this purpose is generated by supervision, monitoring and evaluation. Over the past seven years awareness has grown that the best plans for LGA PHC system development will have minimal impact without adequate managerial processes to implement them. This part of the report presents issues brought out from our recent field observations on the supervision and monitoring and evaluation aspects of LGA-PHC. The chapter reviews the constraints within which the systems are operating and what may be needed to strengthen management of PHC in Nigeria.

## A. Supervision

As understood in practice in PHC in Nigeria, supervision activities normally consist of (i) physically going to the site of activity; (ii) going through the records kept by the PHC workers paying particular attention to the incidence of tracer diseases. In the cases of VHWs the supervisor goes also to check specifically: their box/kit, their records and drugs, the way they carry out procedures especially delivery of babies and care of the mother in labor, and to informally ask the village members about their impression of the VHWs. Supervision visits are expected to be done once a month, but are being carried out once in two months or less in most of the LGAs, in part because of difficulty with transportation. Supervision confronts a major problem because there is not enough equipment to sustain the required relationships (vehicles, motorcycles, bicycles, communication equipment, etc.) between health personnel in the headquarters and the field as they each carry out their responsibilities and tasks.

In fact, the whole supervision process appears to be falling very short. The team was told that supervision visits were being done but could not be shown copies of supervision reports. The team conducted some visits to PHC facilities: one each in urban and rural parts of each LGA to assess the physical facilities, operational effectiveness and management practices including supervision. In one LGA, the facility was already closed by 4 pm, no one was found in the premises, not even the guard. Household members in the vicinity of the facility confirmed that the facility was still providing service but closed from time to time during the official opening hours at the discretion of the health workers. The urban PHC facility was open but had no patients either being attended to or on admission. Interview with the community extension worker on duty indicated that supervision was poor. Records were purportedly kept but showed several gaps in time and in regard to proper treatment procedures. Clinic standing orders were not available for use and the records kept showed underutilization of services - less than 10 deliveries in one month. Underutilization was found at most facilities; often as few as two or three patients in a whole work day.

What is particularly disconcerting about these problems is not that there were problems in the field: implementation always falls short of the ideal. It is that supervisors were themselves often completely unaware of the problems. They were as embarrassed as we were concerned to find facilities in such disarray.

In many LGAs there is confusion about supervision and monitoring and evaluation activities. Indeed they are frequently used interchangeably when in fact the first, supervision deals with the one-on-one appraisal of personnel and facility performance, and the second, monitoring and evaluation deals with overall LGA performance on certain key health indicators.

To LGA personnel, "supervision" occurs in two ways. First, supervision is deemed to occur through the use of monitoring and evaluation forms which are ostensibly filled routinely by VHWs and facility-based worker and collated at the LGA headquarter level. From there returns are sent to states, zones and the Federal headquarters. Even were this in fact

"supervision" the reality is that many LGAs do not have these forms and this activity is not taking place. Where there are forms, returns are not sent because district supervisors cannot collect and/or submit the completed forms because of transportation problems.

The second method of "supervision" consists of visits to VHWs and facilities by designated supervisors (see Tables 5, 6, and 7).

**Table 5**  
**Levels of Supervision, Monitoring, and Evaluation**  
**in LGA PHC System**

<b>LEVEL OF SUPERVISION</b>	<b>PHC FACILITY</b>	<b>SUPERVISOR</b>
Household	-	District Health Supervisor
Health Ward	VHW Station Health Post	District Health Supervisor
Health District	Health Clinic Primary Health Center	District Health Supervisor Asst. PHC Coordinator
Local Government Area	Primary Health Center Comprehensive Health Center	Asst. PHC Coordinator LGA PHC Coordinator
State Zone (group of LGAs)	not applicable	Asst. State PHC Coordinator State Zonal PHC Officer
State	not applicable	State Deputy Director PHC State Director PHC State Coordinator PHC
Federal PHC Zones (group of States)	not applicable	National Zone PHC Coordinator
Federal	not applicable	NPHCDA Director (Operation) NPHCDA Director (Planning, Research, & Statistics) Executive Director NPHCDA

Source: Field work notes October/November 1993.

**Table 6**  
**Focus of Emphasis of Supervision in the LGA PHC System**

FOCUS	EMPHASIS
Personnel	Task performance
Facility	Organization of services (for meeting the needs of target population groups)
Health District	Coordination of services (within geographic target area)
LGA	Health Program Management <ul style="list-style-type: none"> <li>• Planning capacity</li> <li>• Administrative skills</li> <li>• Incentives for maintaining quality of services</li> <li>• Distribution of services in LGA territory</li> </ul>

Source: Field work notes October/November 1993.

**Table 7**  
**Supervision of VHWs in the LGA PHC System:**  
**Points of Emphasis**

Points of Emphasis in Supervision of VHWs
<ul style="list-style-type: none"> <li>• Physical presence</li> <li>• Record keeping</li> <li>• Procedures</li> <li>• Kit equipment</li> <li>• Drugs inventory</li> <li>• Frequency</li> </ul>

Source: Field work notes October/November 1993.

They are required to visit at regular intervals (once a month) and make direct observations as personnel carry out their tasks in the facilities and local areas. A majority of LGAs admitted that in fact supervisory visits had not been undertaken for up to six months and as noted above, even those which claimed to do supervision were generally unable to show the visiting team copies of such supervisory reports. We concluded that in all probability supervision work is not being done in most LGA-PHC systems. In any case, such reports, if they exist, are not used by management of the LGA-PHC to take corrective action. In some cases our visiting team was informed that such reports are merely filed away.

Supervision has also been severely constrained in LGA-PHC by the near total lack of guidelines and clinic protocols or standing orders. PHC personnel are required to use them to deliver services of appropriate quality. The standing orders and guidelines are also to provide the benchmarks to judge the competence of the PHC workers delivering care to PHC service users. Lacking such benchmarks, there are few citizens to judge performance.

Supervision is designed along one of two lines: geographical areas and PHC functional areas. In the area approach to supervision, a district health supervisor is given responsibility for an area and required to supervise the volunteer health workers, PHC personnel and the PHC facilities in that geographical area. The supervision visits are to be followed-up by detailed reports for discussion and corrective action. Barkin Ladi in Plateau State uses this model of supervision.

Where supervision is carried out along functional lines the assistant PHC coordinator for monitoring and evaluation plays a key role. However, he or she rarely has any contact with health personnel beyond their statistics, and also almost never has any clinical training. The other assistant PHC coordinators in charge of immunization and disease control, maternal and child health/family planning and nutrition, essential drugs, equipment and supply, and health education and women's activities, are required to visit health facilities and personnel across the LGA territory and supervise the PHC services for which they are responsible. Reports of their supervision activities are to be submitted to the LGA PHC coordinator. We found the latter approach to supervision led to fragmentation of effort, little attention to facility performance, and little sense of area-based needs and problems.

The widespread lack of understanding of the differences between supervision, and monitoring and evaluation is a major constraint hindering effective supervision in LGA PHC systems. Supervision is not done without direct observation of PHC personnel activities and PHC facility conditions. No matter how many monitoring and evaluation forms area duly completed, submitted and forwarded to the states, zones, and federal levels, this must be done to maintain quality performance and solve problems in the field.

## **B. Monitoring and Evaluation**

In one regard, monitoring and evaluation are better off than supervision: a significant amount of energy is going into M&E and a significant amount of data is being produced. However, there are some serious short-falls in the quality of data being generated as well as in the usefulness of the analysis done with the data.

In visiting the LGAs one cannot but be impressed by the volume of data being gathered. VHWs and TBAs keep simple record books; individual patient register cards are overflowing from boxes at health facilities; and copious data is entered into all sorts of record books. The assistant supervisor for monitoring and evaluation is busy collating and summarizing these data and, apparently, passing it upward to the states where further analysis

will reveal LGA strengths and weaknesses and guide further programs. Occasionally he or she shows off neat graphs or charts in his or her office. When asked who views them, they shrug and admit no one is particularly interested.

However, beneath the shine of this apparently impressive system, there are serious problems that question the usefulness of the data as well as the productivity of the substantial resources expended in generating it. These include: 1) The reliability and comprehensiveness of data gathered at all levels; 2) The reliability of base line data (i.e., community level data) used to calculate the various percents and ratios generated; 3) The reliability of data gathered at the state levels; and 4) The use made at any level of the data gathered, other than to pass to donors which desire evidence of system progress.

Each of the above-mentioned problems will be discussed in turn.

- 1) **Reliability and comprehensiveness of data gathered:** Virtually every respondent reported that there were serious short-falls in the data they received from the base of the system: the health delivery personnel. Many personnel simply had no forms, nor had they had any for sometime. Many supervisors reported that lacking transport they were unable to gather data from many care deliverers for lengthy periods of time. Records observed at health facilities were grossly incomplete, as asserted to the team by numerous health personnel. For example, several facilities lacked "patient registration" cards, but rather than turn away patients without cards, they simply never entered the case given in the record books (which required card information for each case recorded). Even the most optimistic local M&E personnel claimed no more than 70% of the actual data reached them. Others confessed they believed it was around 50%. Several believed that the TBA/VHW data was very prone to errors.
- 2) **Community Level Data as Baselines:** In general there is little accurate community level data to use as baselines to judge the measuring of patient data gathered at the grass-roots. One observer described M&E as "numerator" statistics: one might be able to claim some feel for absolute incidence of cases, but little for incidence vis-a-vis the population. This of course, reflects weakness in basic planning functions discussed in Chapter 4.
- 3) **Reliability of State Level Data:** The pyramiding of poor data up several levels does not improve the data, particularly when as much as 50% of LGAs report no or incomplete data in some states. Some state statistical personnel believed much of the data they did receive were bogus.
- 4) **Even assuming the above issues of reliability and completeness were resolved,** it is not clear what states and the federal government are doing with these data to return useful analysis to the LGAs. Data collected are so gross that they

cannot be used for any meaningful facility much less personnel assessment. In any case, there is so far initially no return of information to the LGAs, so there is not in any case much pay-off for their collection efforts.

These problems in monitoring and evaluation probably stem from several causes:

- M&E systems were designed to assess Nigeria's overall progress toward its PHC goals, not to analyze local facility performance;
- M&E has been strongly influenced by donor priorities in showing progress to project goals;
- M&E do not grow from any felt or articulated need at the LGA or state level, thus many of those responsible for gathering the data feel little priority in getting it done;
- Statistical skills are sparse in the field, so any analysis of the data is rare, either mathematical or substantive;
- General managerial weakness in LGA PHC have inhibited the "nuts and bolts" of data collection, training, distribution of forms, pick-up of forms, analysis and summary of them and the like.

The upshot is that Nigeria's PHC M&E system is not clearly of much value to anyone, particularly those delivering health care in the field.

Backing up supervision and monitoring and evaluation at the local level are the state government and the NPHCDA. While each has an important role to fill in supervision/M&E, each has so far not performed that role effectively.

Despite the guidelines provided in the Civil Service Reform and the local government reforms, some states have not yet organized their state ministries of health as recommended for enhanced performance of the PHC functions. An example is Plateau State where PHC is fragmented, so there is a Department of Family Health Services in the SMOH and a PHC department in the Deputy Governor's Office. Another example is Bauchi State where there is no directorate of PHC, but the officer designated as State PHC Coordinator reports to the Director of Medical Services under whose directorate, by implication, PHC operates. These arrangements do not place required authority in the hands of the state PHC coordinator to influence LGA PHC systems, and make supervision difficult if not simply unfeasible.

The National Primary Health Care Development Agency (NPHCDA) was inaugurated in November 1992 but its four zonal offices did not begin to function until the second half of 1993. The current effort to strengthen its staff and office infrastructure in the zonal offices is aimed at enhancing its performance in the area of supervision of PHC activities in the states



and in the LGAs. Under the new arrangement, the NPHCDA Zonal office will coordinate supervision activities in each of the states through its own staff - the state zonal officers. This is a departure from the previous dependence of the national PHC zonal coordinator on the state PHC coordinator/director of primary health care - an arrangement which did not work and where by supervision was not adequately carried out. In this regard the manpower required for supervision, when full staffing of the zonal offices is done, will need to be trained. Current skill capacity at federal level is still much lower than effective supervision of the LGA PHC System requires. Logistic support, especially transportation, is a high-priority need.

The federal government through the NPHCDA has made a grant of N200,000.00 available to each state to be matched by another N200,000.00 by the state. This matching grant fund is to be used for joint supervision of the LGA PHC system by the state and LGA.

The visiting team learned that only a few states have matched the federal grant, thus permitting supervision activities to begin. We understand that this federal initiative is being funded partially through a USAID grant.

That something can accomplished in each of these areas is suggested by the experience of Barkin Ladi LGA. There, aggressive use of a district-based supervision system plus development of several "rapid appraisal" techniques to measure community characteristics have strengthened PHC. By focussing responsibility for all health condition in a single area on a single person, the PHC director has focussed supervision of facilities and the links between them and the VHWs/TBAs as one person's responsibility. In turn, she has focused her attention on supporting and strengthening this person and her relationship with his him or her. Similarly, use of "mother's knowledge tests" and "hundred household" surveys have provided her with data useful to assess specific needs and conditions and in identifying facility and personnel-level performance data. The fact that the PHC director there follows these up with evaluation and corrective measures means personnel take it all seriously. Perhaps not surprisingly, the team found staff morale as well as site conditions there distinctly superior to any other LGA.

## VII. GRASSROOTS PARTICIPATION

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

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

In some cases, PHC personnel, whether by design or not, have integrated these advisory roles with a functional one, where a village health worker serves both as a "community" leader and as the chair of a village health committee. In most cases, however, (Plateau and Sokoto States), they are the secretaries of these committees.

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

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

the PHC program, facilitated house numbering and survey activities, found short-term workers for those activities, and encouraged residents to open their homes for health inspections. In some areas, they helped allocate and administer funds made available under Bamako Initiative revolving drug funds, including determining who were indigent in their respective communities and making free drugs available to them. In a few cases, they have begun building facilities or obtained seed money in the hope that the PHC department would take over the facility they began. All these are noteworthy accomplishments.

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

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

But perhaps the major defect of the present arrangement is that beneficiaries are not involved in program design or implementation. The forms and structures exist, but there are few incentives, if any, for LGA officials to involve genuinely those who benefit from these services. As a result, performance ebbs and resources are wasted.

For instance, on a site visit to a facility in one LGA, Sokoto State, we were informed that the village health committee met regularly. However, this did not provide an opportunity for these leaders to affect local government operations in any serious manner. The village head noted that he had paid seven visits to his LGA headquarters for the repair of the water point in his village in front of his house, without success. Similar efforts had been made to get more medications at a health post near to the village, also without success. As a result, the villagers no longer brought such information to the committee. Instead, the chief repaired the water pump himself (and locked it) and the villagers no longer even attempted to use the local health post--they simply walked an extra 10 kilometers to a clinic in town. Meanwhile, the post, now without patients to go with its empty shelves, stood empty except for the personnel still drawing salary there.

Similar evidence was found in two other LGAs. In one of the rural health facilities visited, the health personnel worked only irregularly. The community simply looked for alternative health facilities either in the private sector or in the town some 12 kilometers away from the village, rather than "wasting their time" reporting the erratic hours of these personnel to the health supervisors. It is therefore not surprising that the quality of service continues to suffer.

The consequence, thus, of this problem is that low grassroots participation weakens accountability and responsiveness of providers of health services, especially in the rural areas. This has serious implications for the legitimacy of the committee structures and the LGA. On the other hand, where the community is responsive and active in community services delivery, as in Barkin Ladi (Plateau), the community has served to strengthen the delivery of PHC services.

Moreover, we are of the opinion, based on the responses from our interviews, that grassroots participation may be enhanced by a more vigorous local government revenue generation effort. As suggested in Chapter 5 (Budgeting and Revenue), one of the reasons why many LGAs are reluctant to tap their potential revenue sources is that it may stimulate greater citizen awareness, demand for services, and accountable performance.

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

- workers in all institutional systems find their lives and jobs easier when they can define their work, limit their responsibilities, and limit external disturbances;
- the scale of vision of sub-tier committees may call for particular variations difficult to disaggregate out of a larger system established at a distant point (i.e., LGA, state, or federal levels);
- many components of key programs are determined by generally accepted professional/technical standards, and may not easily allow room for much popular input; training norms tend to emphasize this for health professionals;
- the rapid growth of the PHC system has meant that most energy has been focused on getting it "in place", not on fine-tuning it;
- resource shortages may make it impossible to respond to local input, particularly when much of it calls for distribution of resources in a zero-sum situation;
- local committees may be too unfamiliar with alternatives and options to be able to offer much programmatic input; they may also be unclear as to what their proper role is to be in PHC;

- committees may be hampered in some cases by their poor fit with functioning, traditional, local governance structures, the "fourth tier" of governance in Nigeria; and,
- in some areas, the multiplicity of committees may be more than the community can support.

Specific strategies for improving grassroots participation might include:

- strengthening health education units of LGAs. Some LGAs can benefit from pilot project funds;
- training LGA supervisory officials on the importance and relevance of grassroots participation for effective PHC delivery;
- tying a proportion of federal/donor funds to grassroots-linked programs and, most importantly, to locally generated revenues;
- clarifying the roles of the various committees as input mechanisms in joint sessions with key LGA personnel; and
- training both PHC officials and local community leaders along these lines:
- training in community mobilization might be given PHC leadership; and
- training in planning, programming, and budgeting, and in monitoring and evaluation, could cover methods of generating, using, and fiscally supporting community input.

To move beyond and fine-tune these recommendations, a program of operational research into the question of community input and strategies to stimulate it should be undertaken. Specific operational research activities could include the following:

- a comprehensive review of PHC programs and policies at the LGA level might be done to assess where and when there is "room" for public committee control over aspects of PHC;
- variation in the use of existing popular leadership/organizational structures may be explored, including the use of consensus of traditional leaders where they exist, existing organizations such as village development committees, modifying ward and district boundaries when appropriate to the local governance system and other local organizations;

- the impact of alternative zonal and federal guidelines regarding community programs, and on community-based monitoring systems; and,
- the relationship between internal revenue generation and popular participation.

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

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

In regard to democratic governance, the general issue of beneficiary participation is of great importance, as it is basic to the whole question of accountability and pluralism and has long-term implications for legitimacy and sustainability. As noted in Chapter 2, these characteristics must be strengthened, or organizational and management efforts and work toward transparency are not likely to yield a high-quality, efficient and sustainable program.

## VIII. INTERGOVERNMENTAL RELATIONS AND THE PRIMARY HEALTH CARE

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

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

### A. **Patterns of Intergovernmental Relations Problems in PHC**

During the course of our field work, we noted two different sets of problems. The first type were those associated with the decision to transfer PHC responsibilities to LGAs. The second relates to the linkage between SHC and PHC.

#### IGR Problems Associated with Devolution of PHC and LGAs

First, a number of states have been reluctant to devolve PHC to LGAs. While several states complied with the federal directive of a phased transfer of all PHC responsibilities to LGAs before June 30, 1990, some states did not. For instance, in Sokoto state, the transfer of PHC responsibilities to LGAs became effective (vide a SMOH circular No. MO/PHS/TH/10/16 of 26th January, 1993), only on February 1, 1993. Similarly Bauchi State

also did not devolve PHC responsibilities until the beginning of 1993. The hurry associated with these first delayed, then sudden transfer of responsibilities, equipment, drugs, and personnel led to fresh problems of their own.

Second, even in the states which transferred PHC to LGAs, local commitment to the program has often been inadequate to sustain its goals. For example, some LGAs were not able to pay the personnel transferred to them to operate PHC. This was usually due to lack of resources either in an absolute or relative sense. Such staff were forced to transfer to other services (state, federal, parastatal or private sector). Many of those who remain are not happy to be under LGA oversight because of the perceived high level of instability at this level of government.

Many PHC officials have complained that in the absence of state oversight LGA political executives lack commitment to PHC. They are more interested in programs which involve capital projects and contracts rather than PHC. Some observers argue the former type of projects provide them with tempting financial opportunities especially given the high level of turnover of political office-holders in Nigerian LGA. As if to confirm the fears of LGA political officials, they were all removed during the course of our field work in one fell swoop by the federal government four months ahead of proposed new elections to LGAs. With the events of November 18, 1993, these election have been suspended indefinitely.

A third problem associated with the transfer of PHC responsibilities to LGAs is the scarcity of medications and the difficulty in establishing an effective system to get them to the LGAs. Medications, especially EPI vaccines, are usually bought in bulk or received from donor agencies by state governments. However, these drugs have been in short supply and states have lacked the resources to purchase them. This severe shortage is regarded as mainly responsible for the sharp drop in EPI coverage (from 81% in 1990 to 40% or less in 1993). In addition, several LGAs lack the necessary infrastructure (most importantly electricity) to sustain cold chains. Several LGA generators, like other resources (e.g. vehicles and motorcycles) allocated for PHC, have been diverted to other uses by LGA political executives.

#### Intergovernmental Relations Problems Arising from Weak SHC/PHC Relationships

A second major set of problems is associated with the weak linkage between Secondary Health Care (SHC) and Primary Health Care (PHC), and between the institutions charged with integrating them.

On the basis of our field surveys we noted first, that state governments have weak capacities for effectively supervising local government PHC. They lack trained personnel and essential equipment such as vehicles and funds to carry out this assignment. Their authority to do so also includes, at least to many at the LGAs. This may explain some of the erosion of quality in PHC reported in Chapter 3. At one state department of PHC and



disease control we were informed that only donor funds were available for their activities. This was the pattern in most states visited. Some LGA personnel laughed disdainfully when asked when state personnel had last visited them! The technical backstopping and attention to standards provided by a supervisory, superior organization has for the most part been completely absent from LGA PHC.

A second outcome of the above situation is that the planning of SHC and PHC are not coordinated. Most state governments have not been able to convene and/or sustain the meetings of the state health council (the notable exception being Plateau State). These meetings are expected to facilitate the coordination of plans, programs and activities at the state level, as well as encourage better LGA-PHC performance in general.

Thirdly, many state officials complain that donors do not inform or involve them in dealing with the LGAs. This reflects and reinforces weak links between SHC and PHC. They argue that this further weakens their effectiveness in overseeing the implementation of projects which involve donor funds. The problem of course is how to prevent state involvement on these projects from degenerating into detailed control of all LGAs as in the past.

One agency whose creation ought have helped matters is the NPHCDA. It has organized itself fairly well to provide overall coverage with four coordinators in each its four zones. Unfortunately, the NPHCDA has its own teething problems of poor staffing and limited resources, and weak authority to do an effective job of supervision, coordination and norm-setting.

Fourthly, at the federal and state levels there is no clear allocation of responsibilities among the different agencies charged with PHC oversight. At the federal level, there is some confusion as to what the Ministry will be responsible for as against matters for which NPHCDA is responsible.

A 1992 publication (FMOH 1992:3) states that the responsibilities of the FMOH includes:

- Primary health care policy;
- Designing of health strategies, programs and interventions;
- Providing management guidelines for PHC program implementation;
- Basic PHC training: development of curricula, conduct of examinations, inspection of PHC training institutions, certification of PHC trainees, etc;
- Setting standards for PHC training and service delivery;
- Integrating data on PHC into the national health information system;
- Providing financial support to PHC implementation.

On the other hand, the functions of the NPHCDA according to the same document (FMOH 1992:4) are to:

- Review existing health policies, particularly as to their relevance to the development of PHC and to the integrated development of health services and health manpower, and propose changes when necessary;
- Preparing alternatives for decision makers at all levels based on scientific analysis, including proposals for health legislation;
- Conducting studies on health plans for PHC at various levels to see whether they are relevant to the national health policy, feasible and multi-sectoral;
- Promoting the monitoring of PHC plan implementation at various levels; and
- Stimulating the technical development of PHC on an equitable basis in all LGAs, for example technical support to implementation of selected PHC components as required. This assistance will be provided strategically to enhance orderly development. (FMOH 1992:4).

Similarly, at the level of states, there is also some confusion. The ministries of health are charged with the responsibility for assisting and supporting PHC. However, within the deputy governor's office in two of the four states visited are primary health care units or even departments! In one state the Director of PHC Department is already demanding that PHC activities in the Ministry of Health be merged with the Department of PHC in the Deputy Governor's Office. In another the PHC Division in the Deputy Governor's Unit has plans to recruit more staff to carry out activities already being carried out in the SMOH. Moreover, in none of the states is there really any attempt by these two departments to work closely with one another, with the possible exception of Sokoto State. For example, in Bauchi as in most other states, we were informed that the SMOH has no access to LGA budgets, yet these budgets were readily available in the Deputy Governor's office. A bound copy for 1992 was even made available to the team!

## **B. Suggested Actions**

The above review of IGR issues indicates several broad areas of needed policy changes and possible USAID assistance from the point of view of a Governance and Democratization initiative.

The policy issues include the following three crucial elements. First, an articulation of the PHC norms and minimum standards is needed, including a clear allocation of authority to take assertive responsibility for this to NPHCDA at the federal level, and SMOH at the LGA level. The deputy governor's offices should provide a PHC facilitator to address LGA-level issues as they relate to PHC.

Second, work should be begun by the FMOH or NPHCDA in collaboration with USAID to determine how much of the federal allocation to LGAs should go to PHC. This amount might be turned into a special or tied grant with oversight by representatives of all the three levels of government. And third, operational linkages between the SMOHs and the zonal offices need to be made to coordinate their support and supervisory activities, and maximize their scarce human and other resources.

Additional activities might build on CCCD and FHS assistance to federal and state governments in the past which has included such activities as: establishment of a viable PHC information system, assistance to participating universities (through research and training) and schools of health technology, and capacity-building at state and local levels for monitoring and evaluation. Although further exploration of the following ideas is necessary, they are offered as to possible activities in future projects as they affect the capacity of superior levels of government to assist the LGAs and hold them accountable. At the federal level, the newly created National Primary Health Care Development Agency could be assisted in its two-fold program of LGA management improvement and health care advocacy. These are tasks which the Primary Health Care Department of the Federal Ministry of Health performed credibly in the past. The new agency could specifically be supported in these roles:

- Having a zonal coordinator in each state with requisite personnel backup to help coordinate with SMOHs in view of the large number of LGAs within each federal zone.
- Pairing "willing" LGAs with universities for management/ health care training purposes;
- Assisting universities in implementing National Universities Commissions recommendations on the incorporation of PHC into their curriculum for training doctors;
- Collaborating with the Nigerian Medical Association in sustaining high-profile advocacy for PHC at a time when the Federal Ministry of Health may have a minister (political head) who may not be as interested in a PHC approach.

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

Information management capacity-- states should be able to assist LGAs improve upon their information gathering, storage, and management capacity, first in the health sector, then in other sectors such as finance and planning; an evaluation of the impact and effectiveness of present interventions in these areas will be an essential activity to consider in designing new initiatives or sustaining the present ones;

Supervision - LGA capacity in supervising their health personnel requires enhancement; states can assist here. However, states themselves need to improve the capacity to supervise LGAs through improved skilled staff, equipment and funds;

1. Attraction of skilled personnel -- Largely due to the instability of LGA policies, units, and finances, many skilled staff are reluctant to seek careers in LGAs. As a result, LGA personnel are managed at the state level by the Local Government Service Commission (LGSC). However, this poses problems of dual loyalty (to states and LGAs), or possibly of no loyalty to the LGA at all. While the problem of LGA stability will take time to settle, some progress could be made in consolidating LGA control over senior officers by devolving more managerial responsibilities from the LGSCs to the more able LGAs. Specifically, states could be assisted to encourage (the largest) LGAs to take on the problems of resource utilization (work appraisal, human resource auditing, deployment, training) while leaving the task of recruitment to the LGSCs;
2. Improvement of internal governance structures at LGA level -- All LGAs currently have a uniform internal governance structure (the strong mayor form). However, it might be expected that some states and LGAs may want to experiment with alternative management structures. States should explore how they can assist rather than block this process. This same logic also extends to possible modifications to the sub-LGA committee structure in the health sector.

Development of an appropriate framework for state-local **and inter-local cooperation** -- Continuous support should be given to the current initiative to assist states to hold and sustain the regular meetings of the state councils of health and strengthen supervision. It is understood (as shown in Chapter 6) that a grant of N200,000.00 per state is currently being offered by NPHCDA to which all three levels of government make a contribution.

An important initiative will be the need for training of senior staff at all the governmental levels for an increasing appreciation of the strengths and weaknesses of each level of government and the possible gains from a positive-sum (rather than zero-sum) interaction among various government agencies. This process could be helped by short-term training workshops as well as short-term staff rotation among the various governmental levels.

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

## IX. OVERVIEW OF LGA GOVERNANCE PROBLEMS AND PHC

The preceding eight chapters have attempted to present a broad overview of the governance problems of primary health care at the local government authorities. They have suggested that while a number of important gains have been made in the reform of local government structures and PHC delivery, there are serious obstacle in the way of Nigeria's public authorities providing basic health care to all her citizens by the year 2000, the goal of the PHC policy. These problems can be seen in a number of specific areas:

- Insufficient funds are budgeted for PHC;
- Little revenue is raised locally, either by taxes or user charges, for the LGA in general and PHC in particular;
- PHC is implemented without reference to long or medium term plans focused on the locality's health problems;
- LGA resources are allocated without benefit of an overall local development plan;
- LGA budgeting is opaque, often inefficient and poorly implemented;
- PHC does not always appear responsive to the wants of local citizens;
- PHC leadership at the LGAs appears poorly informed about conditions in the health facilities in the field;
- PHC LGA supervision and quality control appear weak;
- Inter-governmental linkages are weak with LGA, state, and federal levels largely disconnected one another;
- Data collected from the field is often erratic and unreliable;
- Many members of the public lack confidence in the reliability or quality of PHC facilities;
- Participative structures at the local level appear to be waning in popular support;
- PHC personnel morale appears to be low.

While other problems could be added to the list, it is a good starting point. The key question for any organizational analyst is "why?" Unless progress in understanding the "why" can be made there is little chance of overall improvement.

The team believes there are four overall problems that together have caused most of these. They lie in:

- weak accountability;
- poor incentive structures;
- lack of organizational/managerial skills; and
- low resource levels

Each will be discussed in turn.

## **A. Accountability**

As suggested in chapter two, accountability is critical to all aspect of any organization's performance. People and organizations can make errors. They can obtain poor information, misinterpret good information, work on erroneous theory, make poor choices when there is uncertainty, and the like. They can also confuse personal with organizational or public interest, be lazy, incompetent or even corrupt. Whatever the reason, errors are always with us. And it is the capacity of persons dealing with consequences of those errors to call others to account that make possible their correction. This is accountability.

Accountability is extremely weak in PHC and indeed, in the LGAs as a whole. Citizens cannot call PHC personnel to account for poor facility management and absence of essential drugs; superiors do not call PHC personnel to account for erratic hours, nor do PHC personnel feel able to call superiors to account for lack of technical support, supplies or supervision! LGA leaders cannot call states to account for failure to provide vaccines and states are unable to call the federal government to account for insufficient funds to purchase vaccines. Neither the federal or state governments can call the LGA officials to account for the failure to plan, or to budget in a clear and responsive (to local needs) way. Nor can anyone seem to hold them to account for misappropriation of PHC vehicles and generators, denial of imprest funds for PHC supervision, and the like.

Accountability is dreadfully weak in the current system: from LGA personnel to the public; among LGA personnel in their various professional roles; and between the LGA and superior levels of government(both directions!) This weakness, the team believe is the single greatest problem of governance at the LGA. Most of the problems discovered in the field can be traced to some extent to the pervasive absence of accountability in the current system.

## **B. Incentive Structures**

Related to accountability, though more specific, is the problem of weak incentive structures. Officials do not generally have incentives to do what can be seen as the "right thing" for PHC. For example, local officials have no incentive to raise funds locally. They receive a large federal allotment regardless of whether they raise any local funds. Local taxes and/or user fees are liable to mobilize local dwellers to pay more (and possibly critical) attention to local government and its services. Thus a little local revenue is raised, local citizens remain a pathetic, local programs remain under-funded and of poor quality. As a result local citizens continue to feel local government is irrelevant to them.

Similarly, there are no clear incentives for LGAs to commit more funds to PHC, particularly if they feel other activities will be more popular to the limited population actually attentive to LGA activities. Similar analyses could be made regarding PHC personnel listening to local committees, PHC leadership trying to upgrade local staff performance, and the like. The key question is where is the incentive: what extra resources, authority, influence, stature, public support, etc. will a person receive if he/she engages in a particular

action? This is particularly relevant if that action will challenge or demand something of others, not to mention require time/resources/energy of the person taking the initiative. If LGA personnel received one Naira for each Naira they raised locally much would probably change in the funding, public attentiveness and probable efficiency of LGA operations. If federal grants were tied to a minimum floor of PHC budget funding PHC would have more resources. If PHC officials depended on a reliable flow of user-fees and if that were a component of resources used to pay salaries of key supervisory personnel, quality control (to retain clients) would probably improve. Incentive systems are the life blood of all organizations.

Designing effective, policy-supportive incentive structures is a complex task. However, it is absolutely essential. Currently most bureaucracies are designed on a primitive, military-like reward and punish system based on top-down supervision. When in fact the cost of information, the limits of span of control, the abilities of humans to evade supervision, and the limits of human energy are realistically appraised, the limits of such systems can be appreciated. Organizations must go beyond them to build a self-maintaining system that lead members to "do the right thing" via built-in reward systems.

### **C. Organization and Management Skills**

Most PHC personnel are woefully undertrained in management and organization. Their professions are in the health areas and such O&M as they have had is usually brief, superficial, fragmentary, theoretical and lacks any follow-up. They are often working at one or two grades beyond their preparation and are swamped by tasks that exceed the physical resources they have as well. LGA senior bureaucratic personnel, while occasionally trained professionally in their areas of responsibility, are often not specifically trained for the demands or conditions particular to local government, and swamped by lack of support personnel. Furthermore, they rarely stay long enough in one post to master it before they are moved to another. LGA political personnel for the most part, have lacked professional O&M skills.

As a result, not surprisingly, technical and team-based functions such as planning, budgeting, management and supervision experience serious short falls throughout virtually all LGAs. Even where personnel choose to ignore negative or neutral incentive structures, their lack of skills or weakness in those skills by their peers tends to hurt their efforts. It probably does not help matters that a set of administrative routines or procedures for key local government functions either does not exist or was drawn-up far from the realities of local government.

#### **D. Resource Shortages**

While it has become a truism that one does not solve problems by "throwing money" at them, it is nonetheless still probably easier to solve them with funds than without! In Nigeria's battered economy, nearly all resources are scarce: drugs, petrol, vehicles, skilled personnel, etc. The team believes the foregoing three problems are the most critical. However, cash shortages are real and will continue to severely cramp progress in PHC. Intergovernmental relations, local supervision, local quality services are certainly hurt by resource shortages. Resource redundancy can occasionally compensate for problems such as those reviewed above. The irony of short resources is that it requires far better organizations to get things done, while the very resource shortages that require better organizations put those organization under even more pressure!

In the last chapter we will suggest a number of activities and policy issues which we believe will help address the governance problems we have raised.



## X. PROPOSED GOVERNANCE PROJECT ACTIVITIES

The purpose of this report and the field research on which it is based is to re-examine the conclusions reached and activities suggested by a smaller and single-region study done one year ago. It was designed to broaden the research from only the South West to include Nigeria's other three major regions: the North the Middle-Belt, and the South East. It was also designed to examine in detail the question of intergovernmental relations and their impact on LGA governance and PHC operation.

Finally, it was to revise, as needed, project activities recommended in the report of November 1992.

As chapter nine suggested, Nigeria's governance problems at the local government authorities and regarding primary health care, are complex and deal with tough causes such as accountability, incentive structures, organizational and managerial skills, and resource availability. Alone, USAID can clearly not address all these issues. However, there are a number of critical contributions it can make, particularly operating in a close partnership with three Nigeria institutions.

- the Federal Ministry of Health (Director of Planning & Research);
- the National Primary Health Care Development Agency (and its federal zonal offices); and,
- the Federal Ministry of State and Local Government Affairs.

A development assistance package likely to improve the LGA governance and PHC situation must also include three operational components, woven together to address the mix of organizational, policy and managerial issues this report has raised. These components are:

- policy research and policy dialogue with key Nigerian institutional decision makers;
- management and organizational training program which emphasizes training in applied, real-world problem-solving (in such areas as delimited in chapter nine) as well as in generic managerial and organizational skills; and
- field extension activities, where the same personnel involved in policy dialogue and research and training, follow-up with sustained contact with "alumni" working in the field: to assess training effectiveness, support alumni, and to learn from the real-world experiences of program alumni for revised training and further policy research.

To do this the team recommends that four centers of "Local Governance" be established at four Nigerian universities (two in the first year, one in year two, one in year three). These centers would take the lead in all three areas, developing a cadre of personnel from appropriate disciplines able to engage in: (1) policy research and dialogue (2) applied/problem-solving training, and (3) extension/field support. A major project output will be the critical mass of learning and skills found on local governance which this should create. Each of the three activities are discussed in more detail below:

#### **A. Policy Research, Dialogue and Development**

Many problems of governance are intensified by policies and procedures that weaken or blur accountability and create dis-incentives to efficient and effective operation. Additionally, existing policies and procedures often can be best understood as "inappropriate" administrative technologies. This is because they presume more time, skills, resources or organizational capacity than actually exist in the LGAs. Selected policy issues will be subjected to scrutiny by the "Local Governance" centers. This may entail field research to discover facts, quasi-experimental activities to test alternatives, review of literature to assess alternatives from other countries, experimental curriculum to assess alternative strategies in the field, interviewing trainers to learn of adaptations in the field, and the like. As circumstances and alternatives become clear, dialogue with appropriate Nigerian officials, cooperation with other government-focused research entities (i.e. Nigerian Commission on Inter-governmental Relations, other universities etc) will lead to specific proposal for policy and procedural changes. Extensive discussions already held with the leadership of the Federal Ministry of State and Local Government affairs and with appropriate personnel from the Chief of General Staff office have indicated that such research and dialogue would be very much welcomed by them.

The policy research component will have a "problem-solving" focus. Specifically, it will be charged with learning from the field what trainees, "alumni", and others are actually doing to function and succeed in spite of structural and procedural problems. This will both inform the dialogue and provide material for the curriculum to help structures function better in the world they currently work. In fact, in a few LGAs, personnel are raising local revenue, gathering useful local data, supervising personnel maintaining good facilities and making PHC work. How are they doing this? How can their success be translated into "lessons of experience" for others, elsewhere? The policy research function will thus be expected to function at several levels: learning from the field, translating that learning into curriculum, and dialoguing with Nigeria leadership.

Identifying the priority policy issues will be an early task for the "Local Governance" centers. While the issues will vary, all research should focus on the four general problems of: accountability, incentive structures, organizational and managerial viability, and resource flows. Also, all research should bear in mind the need to present tangible results at policy and operational levels.

Preliminary work by the team suggests several topics for consideration. These include:

- **Civic Participation:** What factors are associated with civic participation in health affairs at the local level? This would include participation by direct beneficiaries in health programs, by local organizations such as civic organizations, occupational associations, women's organizations, volunteer committees, traditional authorities, and others. What activities do they engage in, and with what results for health care? What socioeconomic, cultural, programmatic policy, health education, political leadership, and other factors relate to participation? (currently scheduled for May 1994).
- **Policy and Program Analysis of Health Sector:** What is being implemented in primary health care at the local level, with what problems and with what outcomes? How do local and superior levels of government communicate, solve shared problems, and develop new policies? What role is the PHCDA playing? What other state and federal policies are affecting local health policy implementation, and with what results?
- **LGA Budgetary, Accounting, and Auditing System:** What procedures are in place to manage spending according to the budget? What accounting and auditing systems are in place? How well do they operate? How do they affect health programs? How does this relate to federal and/or state directives? What conditions appear necessary for effective financial management?
- **Monitoring Supervision and Evaluation, and Management Information Systems at the LGA:** What systems are in place? What sort of information do they gather? How well are they used by management to facilitate better performance by delivery personnel? Does performance vary across the health sector? What varying mechanisms are used to gather, interpret, and act on information regarding performance? What impact are they having on LGA health management and why?
- **Local Revenue:** What do LGAs do to raise own-source revenue? What is associated with successful strategies? How are strategies related to regional and rural-urban variations? What leads some LGAs to raise revenue more aggressively than others? When is the public more willing to contribute revenue/taxes to LGAs and health programs in particular? What roles do PHC performance, federal and state policies, civic participation, and quality of local management play in local revenue? What is the impact of local revenue generation on civic participation and demand for accountable performance?

- **Local Initiative:** Which LGAs are characterized by greater and lower levels of local initiative? What do they accomplish? How can this be related to such factors as political leadership, professional (PHC) leadership, PHC program quality, civic participation, local socioeconomic and cultural conditions, traditional authorities, and donor activities? What role do their activities play in areas characterized by greater and lesser initiative? Is there any impact by federal and zonal policies and roles?
- **Inter-governmental Relations and Local Operations:** How does the configuration of rules, regulations, resources, and functions of the superior organizations (to the LGAs) affect LGAs in key areas as local revenue raising, monitoring and evaluation, management information systems, financial management, local participation, local initiatives, and general PHC performance? How much impact do these superior structures have? How do they create a structure of incentives and disincentives which affect local governance and health programs? How do they play a role in managing conflict among the various levels of government?
- **Federal Zonal and State Capacities:** What capacities exist at federal and state levels to set norms for supervision, monitoring and evaluation? At the state level? What constitutes the most effective institutional machinery to supervise PHC functions--from the state ministry of health or governor's offices or a combination of the two? What constitutes key resource requirements at this level how can they be best met?
- **Public Accountability:** How do PHC personnel utilize and not utilize directives from superior organizations? What information flows upward which superior organizations can use to appraise and hold accountable LGA performance? If there is variance among LGAs, why? To what extent does the local public affect program choice and management? Via what structures? When do local publics have more control over PHC programs?
- **Local Government Representative Institutions:** What is the status and functioning of key local government representative entities, including the committees and (when re-established) the LGA council? What functions are they performing? How do they work together and at cross-purposes? How do they relate to the PHC program? To what extent is the structure officially established in place and operating? With what impact on LGA programs and services?

## **B. Managerial and Organization Training**

Clearly a serious shortfall in the operation of local governance in Nigeria is the lack of training of LGA personnel in such key areas as planning, programming, and budgeting; supervision, and evaluation; management and management information systems; development of local revenue sources; encouraging grassroots participation; and developing a genuine role for community representatives.

A second and parallel shortfall is the absence of routines and systems which are appropriate to PHC tasks, and the resources and personnel abilities found in the LGAs. Such tasks as gathering baseline data, identifying problems, developing and choosing strategies, defining specific plans from those strategies, budgeting for those plans, developing specific work plans, and supervising the activities to implement the plans are generic to all complex organizations. However, the specific method of doing them must be tailored to the resources (financial, personnel, time) of any given organization, and to its priority needs: an "appropriate technology" of management must be developed for the organization concerned. So far, this has generally not happened in Nigeria's LGAs, regarding either PHC or LGA governance in general.

A third critical need is for LGA personnel to develop skills so they can identify and implement their own solutions to their administrative tasks and responsibilities. The last require the identification of analytical and strategic skills which can be imparted to trainees so they can better understand why problems exist and what their options might be in dealing with them. In short, they need to be trained to be problem solvers, and be familiarized with a range of options they might use to solve their own problems.

Current training activities tend not to cover the full scope of issues essential to LGA management. They also tend to be more theoretical than LGA-focussed, and they have little follow-up capacity. It is felt the training proposed here will usefully compliment existing programs.

A training program that would be explicitly applied, participative, and emphasize follow-up work by faculty and participants is recommended. Such a program would require participants, faculty, civil servants, and community leaders alike to share in the development of training curricula, work on solving, real-world problems, work together on actual LGA documents, and participate in field exercises. The program would emphasize real-world problem case studies generated by the participants, group-team activities to work through those problems, and the development of tangible outputs (analytical studies, proposed solutions to case-problems, plans, budgets, supervision protocols, workable management information systems) which reflect conditions in which trainees actually work, and which participants would field-test on their return to LGAs.

Training in these areas would last six to eight weeks, and would be followed-up by site visits by program faculty to assess and support participants' progress in developing and utilizing planning, budgeting, supervision, and management information systems.

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

- primary health care policy and strategies;
- identification and analysis of problems at the LGAs;
- programming solutions to problems at the LGAs;
- linkages between programs and budget at the LGAs;
- effective budgeting at the LGAs;
- effective personnel, program and facility supervision at the LGAs;
- determination of which data are useful for evaluation at the LGAs;
- data gathering and application techniques appropriate to the LGA environment such as rapid appraisal strategies);
- community mobilization and leadership;
- local revenue sources and systems, and program sustainability at the LGAs;
- the roles of other levels of government in PHC and the LGAs.

All topics would emphasize real-world problems, real-world problem - solving, and the importance of building administrative systems or arrangements that avoid or solve the four overreaching problem noted in chapter nine: lack of accountability, poor incentive systems, inadequate managerial talent and insufficient resource flows to sustain the activities projected. It is these four questions and the participants' own experience that should anchor the program in reality, and keep it relevant to their responsibilities.

### **C. Field Extension and Follow-up Activities**

Just as the policy research planned is incomplete without the training activities, the training activities are incomplete without a process to sustain and learn from the participants after they return to the field. Center faculty will develop and maintain an on-going relationship with their former participants. During these follow-up activities faculty would:

- provide personal support, encouragement and further guidance for alumni;
- learn how well training-based skills and strategies have functioned in the field and thereby strengthen the center's curriculum; and,
- help alumni solve specific problem in developing system and arrangements to perform their administrative responsibilities.

Extension and follow-up are critical to ensuring that a strong learning "loop" is built into the project. To begin with, "model" LGAs will be the foci of extension activities. As time passes, however, the centers will move more broadly to other LGAs in their areas, to encourage as much "spread" effect as possible. Finally, an annual one- or two-week

workshop will be organized at each center. This will bring together center faculty, program alumni, and a few key decision-makers to reflect on the year's successes and problems, and to revise the curriculum and work plan accordingly.

#### **D. The Centers**

It is anticipated that four or five six-eight-week training cycles be run each year. The other twenty weeks of faculty time would be allocated to intensive field support, applied policy research, development of curricula and model system, to conferences and to vacation.

As noted above, because Nigeria is a large and varied country, it is projected that four centers would be established to develop and implement this training. It is recommended that they be located at existing universities which have centers of local government and which are willing to make a genuine commitment to supporting high-quality, creative, interdisciplinary, and intensive training centers. It is also recommended that the classes be limited to no more than 30 persons per cycle. Two centers will be established in year one, and an additional one each in year two and year three, to spread the management burden and build from the lessons of experience.

Target populations are: LGA administrative professional personnel particularly the LGA treasurer, personnel manager and planner, and PHC coordinators and supervisors. A shorter two-week program of PHC sensitization and planning, budgeting, and management for LGA chairs, vice-chairs, and department supervisor would also be established pending reestablishment of this political level by the current or a future Nigerian government. With nearly 600 LGAs in Nigeria, this offers a potential population of some 12,000 persons for the two-month cycle, and some 1,800 persons for the two-week overview course. Both courses would run simultaneously to allow for interchange among the varying roles. Appropriate state and zonal personnel could also be included in either of the two programs, depending on their disposition. In addition, all the centers will collaborate in holding an annual workshop on strategies for improving intergovernmental relations in the Nigerian PHC. Such workshops will draw personnel from federal, state, and local governments. USAID would support such centers, including coverage of salaries and allowances for the program director, instructional personnel, and secretarial personnel. Moreover, USAID would support vehicle purchase and per-diem for fieldwork, computer resources as needed, per-diem and travel expenses for trainees, materials support, institutional overhead costs in return for office and instructional space, and publication costs for course-based materials.

Discussions in 1992 with the Director of the Federal Department of Public Health in FMOH indicated that such a program would be well-received, and not seen as redundant to existing training activities. In 1993, conversation with the Director of Operations of NPHCDA and several zonal PHCDA and SMOH personnel reconfirmed this viewpoint. In 1994, meetings at the Federal Ministry of Health and Federal Ministry of State and Local Government Affairs and Chief of General Staff office also confirmed very strong support of the project as outlined.

In further discussions with the Government of Nigeria on this idea, attention should be paid to encouraging a receptive environment for the innovations the program has in mind. These should include exploration of upgrading LGA planning and management routines and abilities, and possibly tightened federal and/or state planning/management requirements. A receptive environment might also include some program of challenge/incentive grants from USAID or the Government of Nigeria to LGAs which demonstrate real progress in implementing these measures. A system of "model LGAs" in the management area might be established in the first year or two of training to encourage implementation of new procedures. These should be linked to NCCCD's "focus" LGAs. Workshops and close liaison with state ministries of health and zonal offices can also be developed to encourage a supportive environment for project activities at both state and LGA levels.



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## Appendix A

### Interview Guide at the Local Government/Community Leaders

#### A. Interviewees

Chairman of Local Government Area

Secretary of Local Government Area

Supervisor of Health

Head, Personnel Management

Director of Primary Health Care

Facility Heads

Community Leaders

#### *I. Political/Managerial Leadership*

- (a) What are the procedures for approving Local Government budgets?
- (b) What are the merits/demerits of the change-over from state level to Council approval? (Speed, Effectiveness, Accountability, Transparency, Responsiveness)
- (c) What is the appropriate definition of the needs of the Local Government Area in terms of services?
- (d) What are the skills and training needed? Are these available?
- (e) What is the role of leaders in planning and budgeting (especially in terms of determining priorities)?
- (f) How does the Local Government Area source for alternative revenue sources (e.g., user-charges, new service, etc.)?
- (g) To what extent are Action Plans followed in Local Government Area? Do they have definite targets?
- (h) What is the nature of relationships between:
  - i. Executive and Legislative political actors
  - ii. Political actors and Senior Managers
  - iii. Departmental heads (health vs other departments)?

## **2. *Heads of Facilities***

- (a) What are the main problems (personnel, finance, equipment, supplies, etc.)?
- (b) What is the nature of funding from the Local Government?
- (c) What is their perception of adequacy in providing health care? (Examine program plans and assess how far targets are being met.)
- (d) Examine record keeping.
- (e) Assess financial relationship between facilities/health departments of local governments/community organizations/private sector facilities, etc.

## **3. *Community Leaders***

- (a) Find out role and impact of health facilities on community.
- (b) What is their perception of usefulness (efficacy of programs and facilities)?
- (c) What is their perception of priorities in Primary Health Care past and present (public education, nutrition, water/sanitation, MCH, FP, immunization, etc.)?
- (d) What is their perception of priorities across service requirements (e.g., roads, water, sanitation, schools, etc.)?
- (e) What is their degree of involvement in determining health service activities at formulation, implementation, and evaluation stages?

## **Appendix B**

### **List of Officials Interviewed**

#### **Ife Central Local Government Area:**

Mr. Remi Alli, Director of Finance  
(also, interviewed chairman, treasurer, vice-chairman and supervisor for health)

#### **Atakunmosa LGA:**

Mr. Segun Anjorin, Secretary  
Mrs. Adesina, PHC Coordinator, Atakunmosa  
Mr. Adewusi, Assistant PHC Coordinator

#### **Akinyele LGA:**

Mr. Ogunyele, Chairman  
Mrs. Omorilewa  
Mr. J.A. Adeniran  
Mr. R.A. Akintola  
Alhaji Bisi Yusuf, Head of Personnel  
Chief Goke Amuo Onidundu  
Alhaji Lanre Yusuf (DPMS)

#### **Zonal Coordinator (PHCDA Zone 'B' Office:**

Dr. Ogundeji, Zonal Office PHC Coordinator

#### **Barkin Ladi Local Government Area:**

Mrs. M. Gotip, Deputy PHC Coordinator  
Dr. Luka P. Lobadungze, Secretary

#### **Yaba Local Government Area:**

Alhaji Aminu I. Ginga, Chairman  
Muhmudi Yabo, Director PHC  
Garba Umar, Director of Finance and Supplies  
Abdullahi Hassan, PHC Coordinator  
Hauwa Abdullahi Kilgon, Office i/c Kilgon Dispensary  
Alhaj Muhammed Modi Yabo, Deputy PHC Coordinator, Yabo LGA, Sokoto State  
Alhaj Garbo Umar Yabo, Treasurer  
Mal. Umar Yabo, Senior Health Supervisor, Shagar Village

**NPHCDA Headquarters Lagos:**

Dr. A. Nasidi, Epidemiological Unit  
Dr. Mahdi, Director of Operations  
Dr. A.O. Sorungbe, Executive Director  
Dr. P. Okungbowa, Deputy Director

**NPHCDA Zone 'C' Office (Kaduna):**

Mr. Nuhu Shehu, Asst. Zonal NPHCDA Coordinator

**NPHCDA Zone 'D' Office (Bauchi):**

Dr. Hadeija, Zonal PHC Coordinator

**Plateau State Ministry of Health:**

Mrs. Sarata Bung, (DPHC)

**NCCCD Office, Jos:**

Dr. Bayo Parakoy, CCCD Epidemiologist  
Mr. Mike Mills, Peace Corps Volunteer

**Kaura Namuda Local Government:**

A.A. Laki Tambawal, Director of Health Services  
Yamkata Village Chief  
Bashir Ibrahim, Assistant Director for Monitoring and Evaluation  
Village Head of Yankabu

**Oyo State Ministry of Health**

Mr. Adigun, State PHC Coordinator  
Mr. Akinola, Deputy Director  
Dr. Adewole, Department Director

**Bauchi State Ministry of Health:**

Dr. Mania, Bauchi State Zonal PHC Coordinator

**Federal Ministry of Health**

Dr. Ashley-Deja, Ministry of Health  
Professor Julius Makanjuola, Director of Planning and Research

**Sokoto State Ministry of Health:**

Alhaji Mohammed Maru  
Mohammed Ibn Mahmoud, Monitoring and Evaluation Officer  
Stewart Baron, Peace Corps Volunteer

**Plateau State Bureau of Local Government:**

**Bauchi State Bureau of Local Government:**

Mr. D.D. Motomboni, Director, Deputy Governor's Office

**Sokoto State Bureau of Local Government:**

Alhaji Abdullahi B. Mohammed, Asst. Director, PHC, Deputy Governor's Office  
Alhaj Habiru, Department Governors Office  
Alhaji Halini Mohammed, Director General, Local Government Affairs

**Ahamadu Bello University:**

Dr. Omar Massoud  
Prof. Festus C. Nze  
Alhaji Ilu Habu  
Abubakar A.A.  
Dr. Stephen Bola Oni  
Mdl. Mohammed Kabir Isa  
Bello Ohiani  
Bashiru Jumence  
Usman I. Ahmed  
Ado Andeley  
P.C. Daudu

**Nigerian Community Development Banks Agency:**

Prof. A. Mabogunje, Director

**WHO/FMOH**

Dr. S.H. Brew-Graves



**ODA/British Higher Commission:**

Dr. Anne Bamishaiye

**USAID:**

Mr. Eugene Chiavaroli, AAO  
Mr. Taiwo Kehinde  
Mr. Rudolph Thomas  
Ms. Sandy Oikuti, NCCCD  
Dr. Stella Goings  
Dr. Barbara Maciak, NCCCD  
Mr. George Oligbo  
Mr. Felix Owangtang  
Mr. John McWilliams, FHS Project  
Dr. Jason Weisfeld, NCCD Project  
Dr. Doyin Fagbula, NCCCD Project  
Dr. H.O. Adasina, NCCD Project

**Price Waterhouse:**

Ms. Judith Burdin Asuni  
Mr. Achike Emejulu

**Ojo Health Department**

Mrs. C.O. Adejuwoa, Chief Extension Worker

**Pankshin Local Government Area:**

Mahamnadu Ade, PHC Director  
Mohammed Haruna, Deputy PHC Director  
Peter Biskida, Health Supervisor

**Ministry for State and Local Governments:**

Dr. George Irele, Director, Planning, Research and Statistics  
Abubakar Abubakar Anha II, Director General

**Obafemi Awolowo University:**

Dr. S. Bamidele Ayo, Head, Department of Public Administration  
Dr. A. Adedeji, Head Department of Local Government

**Office of the Vice Presidency/Chief of General Staff**

Oladosu O. Oyelakin, Director of State and Local Government Affairs

**Others:**

Dr. Linda Lacey, University of North Carolina

Dr. Ladipo Adamolekun, IBRD

Dr. Stan Foster, CDC, Atlanta

Dr. Susan Aradeon