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DECENTRALIZATION: FINANCE & MANAGEMENT PROJECT

Managed by
Associates in Rural Development, Inc.

In collaboration with
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USAID GOVERNANCE INITIATIVE IN NIGERIA
PHASE I REPORT: STRATEGIC ISSUES WORKSHOPS
(Ife and Zaria)

Decentralization: Finance and Management Project
Associates in Rural Development, Inc.

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PHASE I: OVERVIEW

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During March 1994 two strategic issues workshops were held on the theme of "Improving Governance in Nigeria's Primary Health Care Delivery System." Invited participants represented Federal and State Ministries of Health, university, local government administration, community health departments, local government officials, and primary health care administrators. The three major objectives of the workshops were to:

1) Evaluate the report of the research team (see "USAID Governance Initiative in Nigeria: A Strategic Assessment of Primary Health Care and Local Government," February, 1994) on its strategic assessment of governance issues in Nigerian local government generally and primary health care (PHC) specifically. The Orientation Report (OR) developed from this assessment is included in full in this report.

2) Discuss the issues, constraints, models of current success in the field, and potential strategies. This was accomplished in three discussion groups: Planning and Budgeting; Revenue Mobilization and Grassroots Participation; and Monitoring, Evaluation, and Supervision. Each of these groups summarized their key findings in a short list of strategies, which are included as they were written in the groups.

3) Communicate a set of resolutions related to strengthening PHC performance through training, policy dialogue, and extension activities. The resolutions outlined in this report are the result of a final workshop session to develop a written communique. The report also includes the overall objectives outlined by the project workshops, and the participant rosters. At the conclusion of this report, there is a brief summary of Phase I results and implications.

II. ORIENTATION REPORT AND GOVERNANCE LECTURE

ORIENTATION REPORT

for the

Workshop on Governance, Primary Health Care and Local Government Authorities in Nigeria

March, 1994

Sponsored by USAID; the NCCCD project; and The Departments of Local Government and Public Administration of Obafemi Awolowo University

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I. INTRODUCTION

The "Workshop on Governance, Primary Health Care and Local Government Authorities" grows from two field research efforts conducted in 1992 and 1993. Including five Nigerian social scientists and public health specialists and one American social scientist, the teams visited nine local government authorities (LGAs), five states, three zonal offices, and federal offices in Abuja and Lagos. Their mission was to assess the organization and management of primary health care (PHC) at the LGAs, evaluate whether improvements could be made in these areas, and make appropriate recommendations to the U.S. Agency for International Development (USAID) and the appropriate Nigerian authorities.

While the long-term focus of USAID has been on childhood diseases through the Combatting Childhood Communicable Diseases (CCCD) and the Nigeria Combatting Childhood Communicable Diseases (NCCCD) projects, USAID sees the success of these efforts as closely related to the broader agenda of PHC administrative capacity and LGA performance generally. Given this concern and the conclusions of the field research teams, USAID has committed itself to work in close partnership over a multi-year period with the appropriate Nigerian government agencies and levels to strengthen primary health care and local governance in general.

Two workshops are being convened in March, 1994, to support this effort. The purpose of these workshops is to develop further the understanding of project development personnel of the problems, resources and opportunities that exist at the LGAs and that affect primary health care. The information gathered will be used by the team to refine further the proposed extension services, training programs and policy agenda which the "LGA Governance" project will pursue.

To accomplish this goal, the project design team has invited a carefully selected group of persons well-informed about local government and primary health care in Nigeria. In selecting the invitees, the team has attempted to include primarily persons with practical, real-world experience in local government and primary health care, and in the other levels of Nigerian government that affect these key areas.

The agenda for the workshop will focus on three tasks:

- Reviewing the problems in governance and PHC identified by the field team: Is the team's analysis an accurate and complete one? Are there additional key problems the team has missed? Strengths (relevant to governance) it has missed?

- Analyzing the causes of these problems in the field: what are the key causes of these problems?

- Evaluating strategies to remedy these problems: What are some LGA and PHC personnel doing to overcome the operational problems the team identified? What training, extension and policy/procedural changes should be pursued in the forthcoming project to encourage and facilitate better LGA and PHC performance?

To support the rest of this agenda, this report will cover several areas:

- What is a "governance strategy" and why should one believe it will help local-level performance?

- What did the team find to be the overall status and circumstance of PHC at the LGAs?

- What did the team find to be the overall problem areas which explained problems in PHC?

It will also include a section of "discussion issues" covering each problem area:

- planning and work programming;

- local participation;

- local revenue;

- budgeting; and

- monitoring, evaluation, and supervision.

The "discussion issues" will include a review of possible causes of the problems and possible strategies to resolve them. While the team is offering them as a starting point, by no means are they to be seen as exhaustive! It is the team's firm belief that many solutions to problems it found at the LGAs are being discovered already by the very Nigerian personnel who already are working in the local government system and who know it best. Indeed, the purpose of convening the two workshops is to continue learning from the persons who have taught the team most of what it already has learned.

It is the field research/project design team's hope that each conference will generate a set of written findings on these three general questions, and regarding each of the five operational issues. These written findings will be the "raw" materials out of which a pilot training program will be developed, and an agenda of policy issues will be established. We look forward to your participation in this effort.

II. A GOVERNANCE STRATEGY

In attempting to strengthen PHC and LGA performance, USAID has followed what many have come to call a "governance" approach. Such an approach emphasizes good government performance (in this case efficient and effective delivery of health services) as the focus of concern, and emphasizes a multi-dimensional strategy to achieve this good performance, or "governance."

Specifically, a governance strategy emphasizes the need to address a number of aspects of governmental operations simultaneously in order to achieve improved performance. It would argue, for example that strengthening elections without looking as well at strengthening inter-governmental relations (and accountability) and bureaucratic cohesion, would be unlikely to provide the breadth and diversity of supervision public programs need in order to succeed. Similarly, it would argue that strengthening this supervision would not lead to improved performance without attention to effective organization and management: developing people and procedures to manage resources effectively, efficiently and according to law.

Currently, the general understanding of governance identifies five areas, each of which contributes to effective governmental performance:

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

In the team's survey of field conditions, it paid particular heed to these five dimensions of governance, and how they might help it understand PHC-LGA performance. In developing a preliminary agenda of project activities (training, extension and policy development and dialogue), it attempted to respond to the issues these raised.

In general, the team discovered severe deficiencies in accountability and organizational and managerial efficiency. It also found serious problems in a lack of transparency, and in underdevelopment of legitimacy, responsiveness and policy pluralism. The next section of this orientation paper will review the problems the team found in the field in the five key functional areas. The section that follows it will use the governance framework to organize the "issues" for review at the workshop.

III. CURRENT STATUS AND CIRCUMSTANCES OF PHC AT THE LOCAL GOVERNMENT AUTHORITIES

This section 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 section.

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, USAID's EPI sustainability study), achievements have been less than hoped. Indeed, a good case could be made that, given Nigeria's 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 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 82.7-109.89); child (1-4 years) mortality rates average 109.6 per 1000 (range 66.6-151.2). Thus 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 percent 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 percent (range 5.5-12.1) for the wasting that reflects acute malnutrition; 43.1 percent (range 35.6-51.9) for the stunting that reflects chronic malnutrition; and 35.7 percent (range 26.9-44.6) for the underweight that reflects thinness. According to a recent estimate, more than 31 percent 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 82.87 percent; and under-five mortality rate by 172.9 percent.

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. They are also 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, it 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 activities 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.

2. 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.

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, Kaura Namoda and Ojo, suggest that the goals are feasible and the policy is sound.

The rest of this section 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 a "very low." Within any given LGA, the commitment to PHC varies among the political (holders of elective positions of 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.

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 of 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.

Table I

Current Status of Nigerian PHC System with respect to PHC targets 2000 AD

PHC Component	Percent Target achieved at end of 1992
EPI Coverage	54.5 percent
Antenatal Care	48.4 percent
Nutritional Status: Pregnant women	34.4 percent
Nutritional Status: Children	39.7 percent
Attendance at Delivery	52.3 percent
Contraceptive Prevalence	38.0 percent
Access to Health Services	43.3 percent
Access to Potable Water	NA
Access to Latrine	NA
Availability of Essential Drugs	NA

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.

3. *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 are linked through:

- direct bilateral relations;
- the State Councils on Health.

The LGA-State-Federal relationship is through the Federal Zonal Health Offices.

The State-Federal relationship is 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. 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 percent 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.

4. Management Capability

Numerous problems exist in management of PHC at the LGAs. These include planning, programming, quality control, and problem identification and solving which 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 regarding 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; infestations of rodents and insects, etc.

There was evidence of poor (occasionally dangerous) medical practices at some 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.

5. *Participation of the Private Sector, Communities and Non-Government Organizations*

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 aspects of the better life for women program, 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 has not made comparable use of community organizations in setting local program priorities, trouble-shooting health problems, assuring facility quality control, etc.

Relations between PHC offices 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.

6. 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.

7. 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 esources 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 sections will turn.

IV. OVERVIEW: KEY OPERATIONAL PROBLEMS IN PHC

1. Planning and Work Programming

As the term is generally understood, there is essentially no planning occurring at the LGAs. Planning deals with the identification of problems, the setting of priorities, the allocation of resources, and the evaluation of results. It is closely related to work programming, which deals with the identification of a series of detailed personnel activities and expenditure of resources to achieve a pre-determined end or goal. This does not occur at the LGAs currently, with a few, minor exceptions.

Specific shortfalls identified in the field include:

- decay and disuse of the three-year rolling plan system as a clear guide to local capital investments;
- absence of any meaningful routine to identify, analyze and prioritize local capital projects;
- absence of any systematic or comprehensive method to identify local problems, set priorities and gather public input;
- absence of any significant problem-priority-program based input from the sector offices in setting local budgets;
- absence of any state-level mechanism to support or supervise compliance with the rolling plan;
- weakness in budget process (detailed below) which means it would be difficult to translate plans into budgetary blueprints or to evaluate their success;
- absence of clear professional role/responsibility at LGA for planning;
- weakness throughout LGA in gathering and evaluating all forms of data;
- little use made by PHC of "Baseline Surveys";
- little evidence of collection and/or use of local data to identify health care priorities or to organize work plans around them;
- few instances of programmatically oriented and detailed work plans in PHC;
- few resources (personnel, funds, vehicles) allocated to planning;

- no evident interest among political leadership in planning or other systematic assessments of local needs;

- poor discipline in budget process, including inaccuracy in estimates vs. needs, many variances and supplementals allocated during the year, late approval of budgets, and complaints of erratic and arbitrary release of funds for approved expenditures.

2. *Budgeting*

Certainly in some sense, budgeting does occur at the LGAs and in PHC. Estimates are presented, approved and expended. Records are kept and funds are accounted for. Still, there are serious problems in the LGA budgeting system that mean it is a less effective management and control document than it should and could be.

Budgets and budgeting are important because they are the working blue-print of an organization's activity. They translate priorities, plans and programs into specific activities. They are also important because they are a way to control what public organizations and personnel do: they regulate and limit just as they enable. Finally they are important as a visible statement (prospectively) and a record (retrospectively) of what a governmental entity has proposed and has actually done with its resources. Unfortunately, there are a number of ways budgeting at LGAs and regarding PHC specifically fall well short of these functions:

- budgets do not flow out of a broadly based (i.e., professional and public input) planning and priority setting process;

- budgets are made, for the most part, with little input from the professionals responsible for their sectors, with little input from the council members, or from the public;

- budgets appear to be largely additions to previous line-items rather than programmatically established;

- budgets are often wildly inaccurate vs. actual program needs, and therefore lead to repeated variances and supplementals during the budget year;

- budgets are frequently adopted well into the budget year;

- because of wildly variable revenue patterns (see "Local Revenue") budgets often do not reflect actual income;

- the process by which estimate requests become budget items is opaque and unclear;

- budgets do not appear related to any analytical process of establishing local problems, needs or priorities;

- budgets frequently reflect an inefficient expenditure pattern, where the balance among senior staff, junior staff, supplies and capital expenditures appears not to be analyzed according to any discernible criteria; and

- budgets frequently include large and ambiguous categories such as "miscellaneous," entertainment," and "travel."

3. *Monitoring and Evaluation and Supervision*

A number of serious problems plague monitoring and evaluation and supervision in PHC at the LGAs. In summary, the team's field analysis of monitoring and evaluation showed little evidence that reliable data was being systematically and comprehensively gathered at the LGAs regarding PHC, little evidence that any of this data was being "returned" to the LGAs in useful format from state or federal ministries, and little evidence that it was being used effectively at the local level to analyze, evaluate, and refine their PHC programs.

If anything, the situation was worse in supervision. Understood as the detailed observation of individuals and facilities as they undertake their functions, for the most part supervision simply does not occur or occurs so irregularly and cursorily as to be ineffective. In general we found ample evidence that most supervisors are generally ignorant of field conditions, of clinical performance, of supplies in facilities, of staffing of facilities, and the like. They served ineffectively both in their quality-control <u>and</u> backstopping/supporting roles. Performance suffered accordingly, as well as morale and discipline.

Specific problems noted in the field included:

- erratic collection of monitoring and evaluation data;

- questions as to the ability and follow-through of public-contact personnel who gather the bulk of the data;

- absence of forms to record data on;

- evidence that numerous facilities were collecting data on only a small proportion of cases;

- data not easily advisable into units useful for personnel or facility evaluation;

- little use by PHC or LGA leaders of what data is collected;

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- little quality control by state or federal authorities of monitoring and evaluation data;
- under-trained, frequently transferred and under-resourced monitoring and evaluation personnel;
- absence of transport for monitoring and evaluation functions;
- lack of information at PHC office regarding local facilities and personnel performance;
- erratic and too few supervisory visits to facilities and personnel;
- little direct observation of personnel doing their duties, particularly clinical care;
- absence of diagnostic and treatment protocols to guide and evaluate delivery personnel;
- reports of erratic and rare field support to village healer workers (VHWs) and traditional birth attendants (TBAs); incomplete medical kits for VHWs and TBAs;
- evidence of uncorrected poor medical practices in health facilities; similar problems with drug supplies, cleanliness, equipment , general staffing and open hours;
- fragmented responsibility for personnel and facility performance;
- little evidence that anyone is evaluating or responding to field performance levels;
- key breakdowns in: cold-chains, vehicles for supervision, supplies of vaccines; no plans to remedy these;
- little evidence of systematic programs of: problem identification, work plan supervision, remedial treatment, etc., and,
- facilities appear inefficiently utilized by public, with no apparent managerial program to remedy this.

4. Local Revenue

The fundamental problem facing LGAs in the area of local revenue is that they raise so very little of it. The vast majority of their funding comes from regular federal revenue transfers to the local governments, special grants from the federal government, and donor grants. The problems with these sources are three-fold:

- they are insufficient for LGA needs in general and PHC needs in particular;
- they are volatile, meaning that they can vary substantially from year to year and are out of any control of the LGA; and,
- they are external resources, and therefore may not engage the full attention of local dwellers, and may be seen as in some measure "found money" by officials.

The first two problems lead to revenue-starved and inadequate programs, and to programs unable to plan efficiently because of revenue uncertainty. The last may lead to public apathy, official carelessness and, perhaps, to public cynicism. Specific problems seen in the field include:

- absence of any research and experimentation on local revenue sources;
- avoidance by many LGAs of potentially rich revenue sources easily available to them;
- failure to pursue systematic cost-recovery programs in service areas where this is feasible;
- a generally passive attitude toward local problem solving, which tends to pass responsibility upward and excuse local failures because of central government "failures";
- little local public attention to the efficiency, appropriateness (to local needs) and honesty of local expenditures;
- passivity and low morale among sectoral personnel;
- dilapidated, under-staffed, under-supplied, disrepaired, incompletely built, often dirty health facilities;
- health systems unable to provide the most basic services to local residents; and,

- pressure from political leaders on what cost-recovery systems have been established in PHC.

5. *Participation*

In some respects participation is occurring in PHC at the LGAs. There is a model committee system that exists to some extent in all the LGAs. In its ideal it organizes all levels (village/ward; district; LGA), includes representatives of the public and PHC personnel, meets regularly, facilitates community organization by PHC personnel, provides community input from the grass-roots on up as to their problems and priorities, and provides input from the community as to personnel and facility performance. The latter two functions are to inform and guide PHC priority setting and management.

Unfortunately, there is some evidence that the reality has fallen well-short of the model. It is not at all clear that the committee system is as healthy at all levels and throughout the LGA; that the members of the committees feel their efforts are worthwhile; that the grass-roots and committee members believe their "input" really affects PHC policy and program in any way; that committees are able to discuss priority issues of local health care; that effective records are kept of committee meetings; that committees meet regularly, and the like. Top-down communication does seem to work fairly well via the committee structure, as does organization of communities for major events such as immunization days and building rudimentary structures for health posts. But a larger role does not appear exercised currently by the participatory structures. Specifically:

- many committees meet erratically and infrequently;
- shortage of transportation (vehicles and funds) mean PHC representatives often cannot attend committee meetings;
- committee members are beginning to complain about "too much talk and too little to show for it";
- local leaders complain that virtually every request they have made to PHC via the committee structure has been ignored;
- records of minutes of committee meetings are usually nowhere to be found at the PHC office;
- summaries or analyses of, and responses to committee requests or concerns cannot be found at the PHC office;
- PHC personnel cannot name a single idea they received from the committee that affected, altered, redirected, etc., their programs or practices;

- PHC personnel perceive the role of local committees as a way to mobilize the communities to implement programs the PHC has chosen, or to implement programs the local community wants but PHC does not see as a priority; and,

- even the general LGA committee appears to have no role in planning or budgeting in PHC.

V. DISCUSSION ISSUES

Each of the operational areas discussed in section IV are reviewed below for "discussion issues." These include:

- Why do these problems exist?
- What might be done to improve performance in these areas? Please do not consider these issues exhaustive! They are meant to start you thinking, to provide a beginning agenda for discussion, but not to limit your "brainstorming." What do you think causes these problems? What do YOU know about that has worked in resolving them? What strategies do YOU believe might work?

A. Planning and Work Programming

1. To what extent are the shortfalls found in LGA and PHC planning and work programming related to:

a. Incentive Structures:

What rewards and sanctions follow planning/programming performance:

- performance evaluation and promotion -- peers? supervisors?
- extra or more timely resources for LGA?
- extra or more timely resources for sectors?
- political rewards (i.e., public support, support by professionals, support by local organizations)?
- better/easier management of their resources?

Have there been disincentives to plan and work program:

- zero-sum impact on limited resources?
- budget cycle leaves too little time to plan and program?
- no one paid any attention to plan/program?
- resources programmed could not be shifted in emergencies?

- planning and programming stimulated local conflict that hurt those who did plan and program?

- plans and programs cost resources but could not be implemented because of organizational and managerial shortfall and erratic resource flows? and

- superior authorities' actions negated plans?

b. Accountability:

Who knows and cares if plans are made and work programs are prepared:

- superior levels of government -- general? sectoral?

- other LGA senior leadership?

- LGA chair?

- LGA council?

- local organizations, leaders?

- rank and file public service clients?

- subordinates within sector area?

What rewards and sanctins have they to respond to this? (see above, "Incentives")?

Who reviews and authorizes plans and programs? How do they get information regarding plans and programs?

- is there a set of review requirements?

- does the information systematically flow to whom it ought? have they the resources needed by LGA or PHC to leverage better work on plans and programs?

c. Organization and Management:

Have they the personnel, skills and time available to plan and program:

- LGA as a whole?

- sectoral offices in particular?

Are there specific shortfalls in:

- information gathering?
- information analysis and interpretation?
- program planning?
- program supervision?
- communication within and among sectoral units; and with LGA leadership?
- cost estimation? performance evaluation?
- plan draftsmanship
- financial controlling? audit?

Are there particular skill shortfalls at state or zonal levels that hurt planning and programming? (see above)

Do states and zones need more authority and/or a clearer role to support LGA and PHC plans and programs?

d. Resources:

What shortfalls in resources hurt planning and programming?

- time (i.e., arrangement of required tasks in yearly cycle)?
- staff (sufficient numbers of skills to plan)?
- funds (sufficient and reliable flows to implement plans)?
- supervision (sufficient numbers, funds and skills to assess implementation of work plans)?
- information: LGA, PHC, program and personal performance?

Where do these shortfalls lie:

- LGA generally?
- sector (i.e., PHC)?

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- zonal office?

- state (Bureau of Local Government, Ministry of Health)?

e. Institutional Framework:

How do state and zonal roles in LGA affect planning and programming? (authority? resources? actual role?)

How do LGA organization & operations affect planning and programming including: actual budget process, relationship (personal and official) among senior personnel, existence and position of specialized planning personnel, organization of PHC (i.e., district vs. LGA-wide supervision), role of PHC in budget process?

How do relations with public (rank and file, clients, leadership, organizations) affect planning & programming process, if at all!

2. What could be done to strengthen planning and work programming, at LGA overall and within PHC in particular?

a. What is being done already which succeeds in spite of current obstacles, i.e., what are the "lessons of experience" right now from those who are doing these functions?

b. To what extent might the following strategies strengthen planning and work programming at LGA and in PHC:

- requiring an LGA planning officer and staff, of equal rank to other senior staff?

- a stronger supervisory role for states and zones in outlining and reviewing local plans?

- establishing a public role in a "planning review committee" or "commission"?

- linking federal and state funds to approved plans and to approved work programs (in sectoral areas)?

- developing resources at the states and zones to assist LGAs in preparing plans and work programs?

- linking approved planning and work programming to personnel evaluations, salaries, promotions?

- linking improved planning and work programming to extra grants to a model" LGAs?

- strengthening training to LGA senior staff & sectoral senior staff in planning and work programming?

- altering timing and/or steps of budget cycle process to encourage planning (intrasectoral and LGA wide)?

- altering supervisory structure and processes within PHC to strengthen work programming?

- strengthening the local revenue base (to provide a more stable funds flow to implement plans)?

- strengthening state mandates for information gathering, analyzing and reporting (perhaps link to grant disbursement)?

- considering alternate structures/processes for approving actual expenditures (from approved estimates)?

c. Any other strategies?

d. How could these ideas be implemented?

B. Budgeting

1. To what extent are the budget generation and implementation problems related to:

a. <u>Incentive/Disincentive Structures:</u>

What rewards and sanctions are there for drafting a budget which is timely, accurate (regarding revenues and actual expenditures) and reflects local planning, including input from sector professionals:

- from state governments (sectoral and general)?

- from federal government (sectoral and general)?

- from local rank and file leaders, organizations (i.e., does budget performance affect amount and timeliness of subventions and grants, personnel career lines and rewards, local criticism, etc)?

What is the impact of non-conditionality of federal and state grants to LGAs?

What is the impact of the state civil service system on performance of senior professionals at LGAs?

What is the impact of low levels of participation at the LGAs?

What is the impact of instability of senior personnel (both political and professional) at the LGAs?

What is the impact of the weakness of states and zonal offices at the LGAs (regarding planning, budgeting, expenditures)

What is the impact of the weak cohesion of and small role in budgeting of LGA health (and other) professionals?

b. Accountability:

Who is paying attention to local budgeting/expenditure patterns?

- states?
- federal/zonal agencies?
- local clients/rank and file? - local professionals?
- state professional bodies or fora? - local leaders and organization?

What (if anything) are these entities and actors paying attention to? What resources have they to do this?

Is any superior agency systematically reviewing local planning, programming and budgeting, and the links among them?

What resources do potential supervising agencies control to sanction or reward budgetary performance?

Are budgets prepared in a transparent enough way to allow for external review?

Does information regarding budgeting flow where it is needed?

Do professionals have any bodies or fora to leverage budget decisions with information, criticism and pressure?

Does the public know enough about PHC (and LGA) operation in general to know when criticism of budgets is justified?

c. Organization and Management:

To that extent do the LGAs have professionals with the skills necessary to integrate planning and budgeting, to prepare accurate budgets, to analyze expenditure efficiency, and to control expenditures effectively?

- at leadership levels (political)?
- at professional levels?
- at supporting staff levels?
- at sectoral levels?

To what extent are there local persons outside LGA government (rank and file local leaders, local organizations) able to review and understand budgetary process?

To what extent do states and zones have personnel with budgetary skills needed to supervise and support LGA budgeting?

To what extent does the current budgetary system and process (schedule, participants, roles) support and hinder effective budgeting (accuracy, efficiency, time lines, relationship to planning)?

d. Resource Shortages:

To what extent are resource shortages at LGAs a cause of budgetary problems?

- staff (numbers; competence)?
- senior professionals (numbers; competence)?
- time given other duties?

To what extent do resource shortages at states and zonal offices affect their ability to support LGA budgeting?

- funds?
- staff numbers?

- staff training?
- equipment?

To what extent do short-falls and unreliability in revenue flows affect budgeting?

What other resource shortages affect the budgeting process?

e. Institutional Framework:

Is the LGA organized to encourage planning?

Is the LGA organized to encourage and respond to public input on planning and budgeting?

Is the LGA organized to stimulate effective background work by sectoral officers (problem identification, priority setting, planning, work programming) to support effective budgeting by them?

Is the LGA organized so sectoral input is a priority in developing the annual budget?

Is the LGA organized so the responsible officials have the time and staff to develop and supervise an effective budget?

Do states and zonal offices have enough authority to strengthen LGA budgeting?

2. How might problems in budgeting be resolved in the field?

a. What are LGAs and sectoral offices doing right now to develop more accurate, efficient and timely budgets, and to link them better to local problems and planning? What are the "lessons of experience" at this time in improving budgeting?

b. To what extent would the following strategies be likely to strengthen budgeting at the LGAs?

- strengthening a zonal review role vis PHC budgets?
- developing a state and/or zonal capacity to assist LGA's in budgeting?
- developing model guidelines for LGA/PHC budgeting (procedural and/or substantive)

- strengthening the LGA and sectoral planning and work programming processes (see "issues" section on "planning and work programming")?

- strengthening LGA-based revenues (see "revenues")?

- making federal revenue grants contingent on following model budget procedures?

- developing a program of special federal grants to "model" LGAs which pursue upgraded budgetary procedures?

- altering local budget process to strengthen input by sector professionals, public, and planners; by the public

- strengthening local budget staffs (numbers, training, funds)?

- strengthening linkage between budgetary performance and career rewards for senior professionals at LGAs?

- strengthening professional organizations, particularly among sector officers, at state levels?

- strengthening professional fora at state levels (such as "state councils on health")?

c. Other strategies?

d. How could these things be done?

C. Monitoring and Supervision

1. To what extent are the problems of monitoring and supervision related to:

a. <u>Incentive/Disincentive Structures:</u>

What rewards or sanctions are there for:

- local level workers to gather accurate and complete data?

- facility supervisors to gather and report accurate and complete data?

- PHC senior personnel to gather data from service-delivery personnel in a timely and accurate way?

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- PHC senior personnel to sanction service delivery personnel who do not gather accurate and complete data?

- PHC officer for monitoring and evaluation to pursue data? To double check data?

- PHC Officer for monitoring and evaluation to analyze data gathered locally? To report analysis?

- PHC supervisory personnel to perform site visits and supervise care delivery?

- PHC supervisory personnel to attempt to upgrade field performance?

- LGA senior personnel to depend on LGA health sector performance?

- LGAs to report monitoring and evaluation data prescribed by Ministry of Health?

What resources have supervisory personnel to reward or sanction subordinates for performance:

- LGA personnel vis PHC personnel?

- PHC personnel; from PHC coordinator to bottom of system?

- what personnel, supply, budgetary, program latitude have PHC senior staff to respond to supervisory information?

- what resources have states and zonal offices to reward and sanction LGAs and PHC for monitoring and supervisory performance?

- what rewards are there for state and zonal personnel which improve monitoring and supervision at LGAs?

- what information returns to LGAs which is useful to them from the monitoring and evaluation data which they gather?

b. <u>Accountability:</u>

Who knows if monitoring data being reported upward is complete and accurate? (can anyone?)

What authority and resources have they:

- to sanction and reward performance?
- to assist and strengthen weak performers?
- to modify resource flows to respond to monitoring and evaluation performance?

To what extent is the public able to deprive PHC of resources when it is dissatisfied with field performance? What other (if any) sanctions has it? Has it any rewards it can give?

To what extent can the PHC coordinator and other supervisors sanction or reward personnel for performance?

What factors impede the PHC coordinator and other supervisors from knowing of field performance:

- time; other duties?
- travel resources?
- professional competence?
- morale?

To what extent do state and zonal officials receive information regarding PHC field performance? What resources have they to sanction/reward variable performance? Authority? Funds?

To what extent are there local organizations or leaders able to articulate grievances and concerns vis PHC performance?

To what extent are M&E plans made in response to LGA concerns for information?

Is any LGA PHC officer clearly responsible for performance by specific personnel, sites or in overall (sub) LGA areas?

c. Organization and Management:

To what extent do traditional birth attendants (TBAs), village health workers (VHWs), health facility personnel, etc., have the training to gather accurate information?

To what extent do the PHC monitoring and evaluation officers have training to gather, evaluate/collate, analyze (for local use) and pass upward the data gathered by service delivery personnel?

To what extent do state and federal officials have the training to return useful information to LGAs?

Is the current data-gathering organization a workable one? Why or why not?

Do the LGAs have sufficient organizational capacity to support the gathering, collating and analysis of monitoring and evaluation data?

Is LGA PHC organized in a way which encourages clear allocation of responsibility for personnel performance, facility performance, and area problem-solving?

Do PHC personnel have the medical, organizational and managerial skills to assess effectively personnel, site and area performance? To identify problems, develop strategies to solve problems, to implement the strategies?

Do state and zonal officers have the organizational and management skills to evaluate and strengthen LGA PHC organizational and managerial performance?

Do local organizations have the capacity to analyze and criticize LGA PHC performance? To articulate alternatives?

d. Resource Shortages:

To what extent are the various levels of government short the following resources which impede monitoring and evaluation and supervision (PHC office, LGA in general, states, zonal offices, federal offices):

- skilled personnel?
- budget support?
- transport?
- time (given other duties)?
- authority?
- clear understanding of task and purpose?

e. Institutional Framework:

To what extent is monitoring and evaluation and supervision hindered by:

- supervisory structure at LGAs?
- distance between LGAs and states/zonal offices? weakness (authority & resource) of states & zones?
- absence of any role for LGA personnel in developing national monitoring and evaluation goals, responsibilities and procedures?
- weakness of local organizations, leadership?
- weak role by public in PHC management?
- weak private sector alternatives to compete with PHC facilities?
- absence of clear linkages between funding, personnel and other resource flows, and PHC performance?
- weakness of professional (health) organizations and fora?

f. Other:

Inappropriate information is mandated by federal/state requirements

2. What could be done to ease these problems:

a. What is being done right now at the LGAs to strengthen monitoring and evaluation and supervision in spite of these problems? What are the current "lessons of experience" from the field? What can we learn from them?

b. To what extent would the following strategies be likely to strengthen monitoring and evaluation and supervisors at LGAs and in PHC:

- linking regular federal and state revenue grants to improved monitoring and evaluation performance?
- providing special "challenge" or incentive grants to improved monitoring and evaluation systems and performance?
- allowing LGAs to help design data instruments and set data priorities?

- establishing a state or zonal office to analyze monitoring and evaluation results for LGAs and to transmit information to them?
- strengthening monitoring and evaluation office via direct revenue grants from Federal Ministry of Health to those offices?
- expanding training of monitoring and evaluation personnel?
- assigning transport (motorcycles) directly to monitoring and evaluation and supervisory personnel?
- developing a state or zonal support capacity for monitoring and evaluation at LGAs?
- mandating an area/generalist-based supervisory structure for LGAs?
- mandating a certain portion of the PHC budget to support transport costs for PHC supervision; linking to federal revenue transfers?
- clarifying supervisory responsibilities of PHC coordinator?
- emphasizing evidence of supervision and follow-up in career development of PHC senior personnel?
- requiring clinical qualifications for supervisory personnel?
- improving pay of supervisory staff?
- requiring personnel audits of PHC; develop a model staff configuration?
- linking PHC budget more closely to user-fees and cost recovery?
- strengthening a formal role for local committees in personnel and facility evaluation?
- developing model information-gathering strategies (such as "100 household surveys" and "mothers' knowledge tests") to evaluate facility and personnel performance?
- strengthening training in supervision, personnel development and facility management?
- demoting or removing from PHC staff non-performing supervisors?

- strengthening state and zonal staffs, and deploy them to the field much more to work with LGA-PHC personnel in supervision?

- strengthening state role in evaluating supervisory performance by LGA-PHC senior personnel?

- expanding the status, authority and pay of LGA district supervisors"?

- ensuring each district supervisor has his/her own transportation (motorcycles) and imprest funds (direct federal grants) plus mandate supervision to receive federal budget allocations?

- insulating PHC-generated revenues from transfer to other LGA budgets?

- expanding role of supervisory evaluations in career development of all PHC personnel?

c. Other suggestions?

d. How to implement these?

D. Local Revenue

1. Why is so little local revenue raised, either by LGA in general or PHC in particular:

a. To what extent do local dwellers and officials have incentives/ disincentives to raise local revenue?

What is the impact of size of federal subvention?

What is impact of non-conditionality of federal subvention?

To what extent does rank and file public have confidence in: policy choices, management skills and honesty of LGA governments?

How does the instability of local office-holders (elective and appointed) affect developing a local revenue base?

What rank and file demands are there for expanded local services; to what extent do local rank and file understand a link between local revenues and local services?

b. Accountability:

How accountable do local rate/fee/tax payers believe LGA officials are? How does this affect local revenues?

To what extent do superior levels of government supervise and make demands on local officials vis local revenues and expenditures? What local organized interests/groups are willing to raise local taxes/fees to get better services?

What media exist to make various LGAs and their residents aware of services/ revenues in other LGAs?

What are the key resources for winning elections? how does this affect public control over officeholders?

What organizations do the rank and file have confidence in? what connection have these to local officeholders?

c. Organizational and Managerial Shortfalls:

Do local officials and professionals have working knowledge of alternative tax and fee strategies?

Do they know how to organize and operate revenue systems?

Do local organizations have the skills to lobby LGAs for expanded services?

How skilled and organized are professionals in advocating for their program areas?

How effective are LGA officials in budgeting and expenditure control?

d. Resource Shortages:

Are there resources available to capture via taxes/fees?

Do the organizational and managerial skills exist to manage local revenue systems?

Are services locally good enough to draw fees?

e. Institutional Framework:

What legal scope have LGAs to raise revenues (taxes and fees)?

Do LGAs have the personnel structure to manage expanded local revenues?

Is there a communication structure through which LGA personnel can build support for expanded local revenue? Legitimize such actions?

Are there market surrogates to help establish a reasonable fee schedule? To help keep prices and services appropriate?

2. What could be done to expand local revenue in spite of these problems?

   a. What is being done? What are the "lessons of experience" in areas where revenues have been enhanced, either via user fees/cost recovery or by taxes?

   b. What other strategies might be pursued:

- reducing federal grants in general?
- making federal grants conditional on local revenue raising devolving authority over and responsibility for some services closer to users?
- instituting more user-fees for cost-recoverable services; dedicating revenue to those services?
- conducting research on alternate revenue bases & sources?
- involving R&F more in planning, priority setting and budgeting?
- involving leadership of local organizations more in planning, priority setting and budgeting?
- providing greater civic and public education on services and local government?
- strengthening role of professionals in budgetary process ?
- providing training in revenue alternatives, options, systems, etc. for local officials and professionals?
- strengthening role of federal/state governments in setting local revenue/ expenditure levels?
- revising local elections systems for more frequent elections, more constituencies, greater use of "natural communities" in representation, stronger role for councils (legislative bodies)
- training for leaders of local organizations supportive of greater service levels

4/c

- developing a central resource to help localities evaluate local resource/ revenue capacity?

- tying sector budgets to service-fees/cost recovery?

- expanding scope of LGA tax authority?

- "challenge"-type grants to LGAs and to other local organizations conditional on delivering services and raising revenues (taxes, user-fees, donations)?

- working with local communication networks (religious organizations, market associations, benevolent organizations) to raise awareness of local services?

- providing training in planning and budgeting for local officials?

- strengthening financial control and auditing capacity at LGA and State levels?

c. Other strategies?

d. How could these changes be accomplished?

E. Participation

1. What has led to low levels of local participation in PHC:

a. To what extent do residents/PHC personnel have an incentive or disincentive to participate in health advisory committees? Other roles in LGA/PHC:

- Meeting convenience?

- Travel cost?

- Lost income?

What benefits do they receive:

- bicycles?

- food?

- fare?

- status?

Can they see results for their efforts:

- in facilities?
- in supplies?
- in personnel (are procedures and performance responsive to specific problems)?

Do PHC personnel respond by developing new programs of PHC at LGA or by changing priority setting in PHC at LGA?

Do they believe there is any integrity to LGA process?

Do their constituencies take their role seriously?

b. To what extent are residents able to hold PHC personnel accountable for programs and performance:

- Can they affect in any way the selection, posting, promotion of PHC personnel?

How open is LGA decision making:

- information?
- process?
- accessibility?
- receptivity?

Can they affect in any way the resources allocated to PHC:

- LGA budget?
- institute user fees and other cost recovery mechanisms?
- local taxes (i.e., have they the capacity to increase or decrease budgetary flows)?
- have they the knowledge to understand PHC: operations, goals, limits, purpose, etc.?

- how are residents able to hold representatives on committees accountable? (removal? pressure?)
- how are elections, nomination connected/disconnected to grass roots (what are key resources to win?)

c. To what extent are local residents hindered in participation by lack of skills to analyze, understand and interact with PHC, and LGA affairs generally:

- Knowledge of PHC and their rights?

- Knowledge of PHC and their role in it?

- Knowledge of PHC and the resources they must contribute to make it operate?

- Knowledge of their LGAs PHC system and its operation:

  -- LGA needs and characteristics?
  -- local resources, limits?
  -- local decision making processes?

- Lack of public organization cooperation and communication skills by PHC personnel?

d. Lack of institutional base and framework and participation:

- Lack of organizations and structures to integrate, aggregate and articulate their perspectives?

- Lack of leadership able to integrate, aggregate and articulate their perspectives?

- Absence of organizations and structures to influence decision-making at LGA level (personnel, programs, facilities, revenue)?

- Absence of organizations and structures to bring together PHC service delivery personnel and local residents, and where each has incentive to listen to the other?

- Is the committee system (as constituted) an affective or appropriate structure for participation and communication?

e. <u>Resource Shortages:</u>

Extent to which LGA constraints mean PHC personnel are utterly unable to respond to local wants?

Extent to which PHC programs are in chaos because of erratic & unreliable resource flows?

How does shortage of public health information & civic education affect accountability?

Extent to which local residents/leaders have time to devote to PHC decision making & administration?

Extent of information available locally regarding public health and PHC performance: to leaders, to R&F?

f. Other:

To what extent is PHC directed by norms, standards and requirements that may be inconsistent with local rank and file desires and hinder participation:

- technical requirements of medical/PH care?
- state and federal mandates regarding priorities?
- medical judgement regarding cost/effectiveness of various priorities?
- donor priorities, demands, preemption?

2. What could be done or is being done to strengthen participation in the face of these problems:

a. What are "lessons of experience" in field where sustained, serious public participation has occurred and made a difference in PHC?

b. What other strategies might be pursued?

- public education regarding PHC?
- education of PHC personnel regarding community organization, community cooperation, communication, etc.?
- what existing social organizations could be brought into PHC decision-making; LGA decision-making?
- how could personnel decisions more systematically utilize public input (at local level? regarding state personnel commission)?

- how could PHC internal management get closer to people (i.e., greater use of district supervisors; locating more senior personnel outside LGA seat; more use of user fees and cost recovery; more use of local representatives in planning and priority setting for PHC)?

- more tangible incentives for service on committees?

- give committees (LGA level) a clearer role in budgeting, staffing, planning (i.e., give it statutory powers under state guidelines)?

- revision of local election system (i.e., more representatives, more constituencies? more corporate body representation? stronger council)?

- revision of local revenue system (i.e., require lots more revenue to be raised locally) (federal/state grants on matching basis)?

- revamp committee system (i.e., selection of members, numbers on committee, number of committees, authority and role of committees, direct election of members of intermediary and LGA committee?

- enlarged role for LGA-wide PHC committee in PHC planning, budgeting, personnel selection and management; use local committees more regarding local facilities)?

Revise local planning and budgeting system:

- expanded role for professionals from the sector departments?

- expanded role for committees?

- clearer requirements to be met before state and federal matching funds are granted?

- tougher auditing?

- public influence enhanced through expanded use of local revenues?

- what additional role could states and zones play to enhance participation?

- rearrange PHC responsibility: some upward to states, some downward to districts and villages?

c. What else could be done?

d. How could these things be done?

VI. CONCLUSIONS

The preceding document is intended to serve as a starting-point to learn from the Nigerians actually working in the LGA and PHC systems. It is based on several months of field research on these systems conducted by a team of American and Nigerian social scientists and public health personnel. It has attempted to focus on key areas of LGA-PHC operations, and assess their impact on the PHC system.

Five problem areas were identified:

- planning and work programming;
- local participation;
- local revenue;
- budgeting; and
- monitoring, evaluation and supervision.

Using what has been called the "governance" framework, the team attempted to analyze the sources of these problems. Based on research on organizations over the past several decades, this framework emphasizes the need for complementary strengths in several aspects of organizations if they are to be likely to operate well. These include:

- accountability;
- transparency;
- organizational and managerial effectiveness;
- participation and legitimacy; and
- policy pluralism.

The "governance" framework also emphasizes the need to build incentives into organizations that will underscore and strengthen each of these dimensions.

Section four of this document reports the current circumstances and conditions of LGA-PHC in Nigeria, presenting the information along the categories emphasized in the governance framework. Section five offers a set of discussion questions which attempt to explore what might be done to improve LGA-PHC operations. As noted in the introduction to this report, we offer these to stimulate thinking and discussions by those Nigerians with operational experience in the LGA-PHC systems.

Good Governance, Primary Health Care and Local Government Authorities

A lecture presented by Professor James Wunsch,
Creighton University
March, 1994

Governance

In recent years the concept of "governance" has gained increasing attention: among academic and scholarly analysts of development, among bilateral donor organizations, and even among international and multi-lateral organizations. They have used the concept both to make sense of some of the disappointments experienced by developing nations in the past, as well as to help plan and design new efforts which might have a greater chance of success.

The concept "governance" has come into use to help capture several major lessons learned over the last several decades:

- there is no single or simple institutional "recipe" for good government;
- there is no single characteristic or feature of government which, once achieved, will guarantee good performance; and
- good governmental performance is associated with several operational features, all of which must be achieved to reach the goal of effective and efficient operations.

During the last thirty to forty years, many strategies have been pursued in the search for effective and efficient government. These have included attempts at mass democracy, single-party systems, military government, guided democracy, strong-man rule, and the like. Development organizations have, in turn, emphasized such diverse strategies as building basic infrastructure, reaching the rural poor, strengthening private markets, building institutions, developing management and, most recently, democracy. Yet, for all the effort and treasure expended on these diverse strategies, none has brought the desired goal: efficient, effective government and human development.

"Governance" has been "coined" to capture three basic ideas:

1) Governmental performance is the ultimate criteria of evaluation of any political-administrative arrangement. At the end of the day, can a particular government deliver those goods, services and social values which its citizens desire, and do so in a way which they believe to be legitimate?

2) Comparative analysis of government operations, including decision-making and administration, suggest that this effective performance and legitimacy require that any government embody five principles in its operation. These include:

   - accountability;
   - managerial and organizational efficiency;

- transparency or openness in decision making;
- responsiveness to the public; and
- pluralism in policy options.

3) Lastly, the concept of "governance" is intended to capture the importance of institutionalizing procedures that ensure officials and citizens alike operate consistently with the give organizational principles. Institutionalization requires that rules (laws, correct decisions, constitutional provisions, generally accepted norms) govern and guide governmental operations.

Organizations and Governance

At the heart of the "governance" concept are the five operational features which analysts believe are critically related to effective and efficient governmental performance. Each will be reviewed in some detail:

Accountability: Accountability is present when citizens and officials can hold one another to account for the discharge of their responsibilities to one another. Among other things, this means that persons have something close to symmetrical power relations with one another and that they know what their mutual responsibilities to one another are. One reason why elections and independent courts are often emphasized in discussions of sound administration is because they are ways by which governmental power is balanced by public means of accountability.

In complex organizations, accountability needs to run in three directions: top-down, bottom-up; and laterally. Each of these are worth reviewing:

Top-down: For there to exist accountability from the top-downward, citizens and officials need to be able to ensure their superiors fulfill their responsibilities and obligations to them. These include the full and due enforcement of laws, honest and faithful handling of resources, fulfillment of obligations to deliver resources required by approved programs, and the like. Top-down accountability is usually exercised through elections, legal suits, administrative appeals and actions, provisions to discharge incompetent or faithless civil servants, and the like.

Lateral: Because most of a government's business, be it policy-making or administration of programs, occurs behind closed doors, and because of government's control of most of the information needed to assess performance, a second sort of accountability is needed to supplement "top-down." This is "lateral," the form of accountability where civil servants, political leaders and citizens observe one-another and demand ethical, efficient and effective performance. Do their peers follow professional norms? Are they discharging their

duties fairly and honestly? Are they obeying law? Mechanisms to assure lateral accountability, among other things, include social pressure and high morale, procedures to protect "whistle-blowers" and provide for fair and impartial investigation of complaints, and professional norms articulated by professional associations and organizations.

Bottom-up: While it would seem fairly straight-forward that superiors must be able to hold their subordinates accountable for their performance, in fact it is not. The sheer size and scope of many organizations often make it difficult for superiors to keep track of service-delivery and middle- management personnel, while the ambiguity of measures of performance make evaluating organizational performance difficult. Information is lost going upward; authority "leaks" away going downward. Strong rules protecting civil service tenure, external pressure and the like also work to weaken chains of command. All these factors complicate the ability of superiors to demand good performance from subordinates, and hold them accountable when they fall short.

Overview: Accountability may be the most important of the five organizational requirements, because it is necessary to catch and correct shortfalls in the other four areas. Accountability requires multiple mechanisms: elections, independent courts of law, administrative tribunals, professional organizations, public knowledge, professional peers, inspectors-general, standard bureaucratic chains of command, and perhaps mechanisms by which citizens-consumers-clients can take their support/patronage elsewhere if all else fails. Together they can provide the multiple and diverse methods of holding office holders and officials to account. A general rule of thumb regarding accountability: the more power anyone has the more essential there be multiple mechanisms of accountability.

Organizational and Managerial Efficiency: Organizations and their personnel need to be able to reliably, efficiently and effectively transform resources into goods and services. To do this, among other things, they must be able systematically and accurately to determine needs, define problems, define solutions, plan programs, allocate resources, implement plans, evaluate performances, learn from their environments, and readjust programs.

Complex organizations attempting to achieve complex goals are particularly dependent on organizational and managerial efficiency. Their mission requires substantial division of responsibilities and labor; extensive technical specialization; geographic dispersion, coordination with other, independent organizations; adaptation to changing conditions; coordination over long periods of time; and efficient raising, allocation and management of costly and often perishable resources.

At least three dimensions must be considered in dealing with organizational and managerial effectiveness and efficiency: personnel skills; organizational procedures and routines; and basic organizational design. Personnel skills include standard management and executive skills as well as specific task-related skills. Personnel need those skills, judgement and intelligence necessary to do their jobs.

Organizational procedures and routines refer to the standard operating procedures which characterize organizations and their routine functions: how budgets are made, performance is assessed, personnel are selected and promoted, resources are allocated, and the like. Procedures need to fit the organizational imperatives and constraints: resources, environment, task, goals and the like.

Organizational design refers to the basic structure of the organization. For example, is it implementing a known technology, in a stable environment, with easily measurable results? If so, a traditional hierarchical structure may work well. However, if an organization is working with a problem which is incompletely understood, in a changing and unpredictable environment and with ambiguous results, than a more open, experimental structure may be optimal. Indeed, perhaps many, small, independent and quasi-competitive organizations would provide a better structure. Our understanding of the link between task and design needs to be further developed.

Organizational and managerial efficiency is far more complex than generic "management training" programs can hope to address. A more comprehensive and custom-designed analysis must be performed to assess what any given organization must do to improve its operations.

Transparency or Openness in Decision-Making: Transparency refers to the extent to which citizens and officials have the information to critically appraise governmental action. It requires information be available on what decisions have been made, who made them, how they were made, what actions followed them, and what the outcomes of all these actions were. Transparency is important, among other reasons, because accountability and organizational and managerial efficiency depend on it. Unless citizens, peers and superiors can see what was done, etc., they can not know who to hold accountable; unless organizations and managers can assess what was done and with what consequences, they cannot determine how to improve organizational performance.

In local governments, a number of activities are critical to transparency:

- a clear budgetary process;
- accurate budgets;
- an open planning process;
- open discussion of priorities and their selection;
- reliable, accessible and comprehensible expenditure records;
- public criteria for, and announcement of managerial decisions;

- public measures of performance; and

- openness as to when, how and by whom decisions were made.

Providing transparency is always challenging. Many decisions of government are technical; decision making itself is often confused; and decision makers often seek protection in secrecy. While perfect transparency is probably never achieved, without some level of transparency accountability is impossible; because no one (public or officials) can know who is responsible for governmental actions. Similarly, without some level of transparency, improving organizational and managerial efficiency is nearly impossible; no one can determine what caused sub-optimal performance.

Responsiveness to the Public: An efficient and effective governmental organization which is not responsive to the public will not provide good governance. For a time, under leadership exceptional both in knowledge and ethics, it may provide what the public wants and needs. But such leaders are unusual in any society, and when they pass from the scene the organization is likely to stray eventually from the public's agenda and pursue its own.

Responsiveness to the public can be achieved in a variety of ways: elections, a public role in planning and priority setting, dialogue with organizations representing the general public or specific communities within it, and the like. Responsiveness to citizens/clients/ consumers is a key aspect of accountability. It is also necessary to alert organizations to shortfalls in their organizational and managerial effectiveness, and provide guidance for adjustment. In a world where democracy is the basic criteria of governmental legitimacy (even though it is at times more often invoked than observed), responsiveness is a necessary prerequisite for legitimacy.

Responsiveness does not necessarily imply a perfect correlation between public wants and governmental actions. Particularly in such technically complex areas as public and primary health care, mutual education and dialogue are essential to facilitate good policy choices. But there must be communication and, ultimately, convergence between public wants and governmental actions or legitimacy and then performance will erode.

Policy Pluralism: Environments, technologies, public needs, resources available are always in flux. The problem of today differs from that of yesterday, and the tools at hand do as well. Organizations attempt to develop routines, procedures and policies to convert resources into solutions: efficiently and effectively. But with so much change, organizations must be open to and presented with a constant flow of new strategies, options and tactics. This could be called "policy pluralism," and it is an essential ingredient to keep organizations responsive to public needs and wants and to maintain their organizational and managerial efficiency. Organizations cut off from this are at best inefficient; often they become completely stagnant.

Using the Governance Framework

The ideas of "governance" are not new. What is new is the emphasis the framework places on their complimentarity and interdependence. It emphasizes the need for balance among them, and the need to achieve each via multiple methods. Accountability, as here discussed for example reaches in three directions and includes multiple institutions and processes: elections, courts, administrative procedures, professional organizations, peer pressure, etc.

The need for balance among the various dimensions can be seen by considering the results of imbalance. For example accountability without organizational and managerial efficiency would lead to frustration: people would call for improved performance, but organizations would be unable to provide it to them. Or, accountability without transparency would lead to confusion. People would demand improved performance, but not know who was responsible for sub-optimal performance and thus who to hold to account. Organizational and managerial efficiency without transparency or accountability would tend to lead to irresponsible technocratic government, with neither moorings in public priorities nor the ability to redirect itself if it failed to provide for public needs.

The "governance" framework is useful in the applied world of organizations and their problems because it offers a comprehensive analytical or diagnostic check-list. When the manager or analyst discovers operational problems in organizations he is charged with, governance offers a set of questions to help identify the problem or problems which need to be remedied.

In the research conducted by the joint American-Nigerian team on primary health care (PHC) at the local government authorities (LGAs), numerous operational problems were identified. On further analysis, the team framework identified possible causes of many of these problems. Once possible causes are identified the governance framework can be used as an analytical framework in each LGA to see if it points toward strategies to 'unlock" the problems. For example, consider the problem of grounded vehicles. Several dimensions of "governance" are potential explanations for and point to strategies to deal with this problem.

Certainly organizational and managerial effectiveness might be involved. Is preventive maintenance being done when needed; are repairs contracted out or performed in-house promptly, and followed up as required; are frequently needed replacement parts stockpiled or easily locally available; is money budgeted for these tasks and for fuel and lubricants; are budgeted funds available in a timely and reliable manner when they are needed; are contractors and suppliers paid in a timely and reliable manner? Are these activities done routinely and dependably, or must each be done on an ad hoc and individual basis? While organizational and managerial short-falls are often associated with deficiencies in skills or management routines, a frequent experience in developing areas (and elsewhere) is that trained and up-graded personnel do not significantly strengthen performance. One reason for

this is the rewards and sanctions they do and do not face for their performance. These are associated with such issues as accountability, transparencY and responsiveness to the public. Thus these issues should also be considered.

Frequently, those persons responsible for the readiness of vehicles in four key areas (fuel/lubricants; repairs; funds; competing uses) are not in any way responsible to the personnel who are to use--and depend on--the vehicles in their duties. Accountability is to someone who faces no adverse consequences from a vehicle-related PHC performance shortfall, so neither that person nor those responsible for the vehicles suffer nor can be called to account for the consequence of their inaction. The same questions can be asked of the public and LGA leadership as a whole: is the leadership really accountable to those it is to serve?

Transparency can also be a problem, when the funds budgeted for vehicles and their operation and/or their actual availability are unclear. Similarly unclear procedures for maintenance and hidden processes by which vehicles are reallocated to more questionable, personal use make effective management difficult. Transparency can be involved when PHC as a whole is performing poorly. Concerned citizens find it difficult to know who to blame because of an opaque administrative process: is it the PHC's fault because of poor management; the LGA system's fault because the wrong persons are responsible for key support activities; LGA leaders' fault because they are not allocating resources needed to support key programs; or the fault of national leaders because of a shortfall in their support for LGAs? Opaque decision and administrative processes make it difficult to determine who or what is the problem.

Even if a community can determine with confidence that, perhaps, LGA leadership is misallocating resources from PHC, if there are no systems or expectation of public responsiveness, the public will be unable to take action to convey their displeasure; encourage leaders to change policies, procedures or performance, or to replace the leaders.

Even in as mundane and routine an area as vehicle operations, policy pluralism is important. Solutions to one LGA's problems may lie in strategies developed in another LGA. What processes (such as state councils on health) exist to cross-fertilize learning and experimentation among the many Nigerians working in PHC? In LGA administration as a whole?

This single example has attempted to illustrate how "governance" can serve as an analytical framework to help participants in the LGA. PHC systems assess and analyze the nature of their operational problems, and develop a broader repertoire of managerial, organizational and policy-relevant strategies to deal with these problems. In evaluating PHC-LGA the research team found many of the operational problems appeared related to several or all of the key dimensions of governance.

Using an analytical framework, such as that suggested by the governance approach, helps the analyst to think through potential problems and identify the critical ones. There are rarely simple solutions to these tough operational problems. But using a systematic framework to pose questions helps develop reform strategies, be they reforms in training, procedures, responsibilities, authority overall structures, or several areas combined.

Governance and PHC-LGAs in Nigeria

Overall, the research team found grounds for concern in all areas of governance in the LGA-PHC system. As the Orientation Report discussed in detail, there are numerous operational problems that impede effective PHC at the LCAs. In terms of governance patterns, the following problems were observed:

Accountability: This is weak in all three directions: lateral, top-down, and bottom-up. Among professionals, morale is low, peer expectations appeared low, and operational standards were uneven. At the grass-roots there was little belief that they were able to influence PHC decisions or actions in any significant way. Similarly, PHC personnel appeared to accept with resignation poor support (funds, expertise, supplies, backing) from their superiors. The same applied to the professionals and the political leaders. From the top little administrative control appeared operable. Zones and states had little authority over LGAs; PHC professionals were often more than out of touch with field personnel; and there rarely appeared any organizational coherence around any programs.

Transparency: This area was also in serious problems. Budgets were late, inaccurate, often ignored in practice, and rarely if ever followed by systematic work plans. Expenditures were unclear, with large amounts budgeted in ambiguous categories. Auditing was nearly absent. How budgetary decisions were made was obscure even to professionals in the LGA system. There were no measures of program achievements, no use of base-line studies to set goals, no systematic programs no planning and vacuous and vague work plans. The system was highly opaque in virtually every way.

Organizational and Managerial Efficiency and Effectiveness: This area was also a trouble spot, with serious shortfalls in all areas: identifying priorities, setting goals, developing programs, organizing operations, managing resources, managing facilities, allocating funds among facilities-personnel-supplies, providing effective supervision to the field, assessing performance and revising activities accordingly.

Responsiveness: In general, there is little public input for PHC to respond to. What there was, because of the weakness of the LGA-PHC committee system, was often fragmented, not well informed, and not clearly representative of general public feeling. The LGAs as a whole, because of the underdevelopment of the election process, and PC in particular, because of the incomplete development and utilization of the committee process, were not particularly responsive to public wants.

Policy Pluralism: In its youth, PHC is still attempting to implement effectively the national PHC policy and strategy. It has not begun to generate alternative strategies and tactics. This is partly understandable, but nonetheless, a disadvantage in that the learning and refining process characteristic of all new programs is slowed.

Overview and Conclusions

Analytical frameworks such as the "governance" model are useful if they help people discover why operational shortfalls exist in particular organizations or programs. They should provide a "check list of possible trouble areas to help inform and guide interventions to improve organizational performance.

In the case of the LGA-PHC system of Nigeria, numerous operational problems exist. "Governance" can be used to help determine the causes and suggest actions to remedy these problems. Nigeria's PHC program is a revolutionary effort to bring services to its rural population. It is hardly surprising there are numerous challenges to making this a success. It is to build on this start that this paper and workshop are designed.

III. WORKSHOP OBJECTIVES

WORKSHOP ON IMPROVING GOVERNANCE IN NIGERIA'S PRIMARY HEALTH CARE DELIVERY SYSTEM

WORKSHOP OBJECTIVES

- To review and analyze the findings of the USAID Governance Initiatives In Nigeria: A Strategic Assessment of Primary Health Care and Local Government.
- To develop a greater understanding of the problems, resources, and opportunities that exist at the LGAs.
- To provide current information of signs of positive LGA PHC development; "what is already working well?"
- To offer and evaluate strategies to remedy the current operational problems of LGA PHC.
- To identify what training, extension, and policy/procedural changes should be pursued in the forthcoming project.
- To discuss the problem areas of planning and work programming, local participation, budgeting, local revenue, and monitoring, evaluation and supervision.
- To generate a set of written findings and resolutions.
- Overall, to work together and learn together in order to strengthen the efforts of LGA PHC throughout Nigeria.

IV. ILE IFE REPORT

- PROGRAM
- STRATEGIES
- COMMUNIQUE AND RESOLUTIONS
- PARTICIPANT ROSTER

PROGRAM FOR
WORKSHOP ON IMPROVING GOVERNANCE IN NIGERIA'S PRIMARY HEALTH CARE DELIVERY SYSTEM (1)

Venue: **Conference Centre, Obafemi Awolowo University**

Date: **March 7 - 11 1994**

Monday, 7th March 1994 (Opening Session)

10:00 - 10:45 a.m.	Welcome Address by the Dean, Faculty of Administration and Ag. Provost, College of Administration, Law and Social Sciences, O.A.U. Ile-Ife, Professor Oladimeji Aborisade. Keynote Speech--Representative of the Director, USAID Affairs Office, Lagos. Keynote Speech--Federal Minister of Health and Human Services.
10:45 - 11:00 a.m.	Tea/Coffee Break.

1st Plenary Session

11:00 - 1:00 p.m.

- Chair: Dr. Shehu Madhi, NPHCDA Lagos
- Workshop Modality - Dr. John Erero
- Presentation by Professor James Wunsch (Governance & Nigeria's PHC System).
- Lead Discussant: Dr. B. Adeyefa PHC Coordinator, Osun State Ministry of Health, Osogbo.
- General Discussion

1:00 - 2.30 p.m. - LUNCH

2nd Plenary Session

3.00 - 5.00 p.m.	- Chair: Dr. H.O. Adesina NCCCD, Ibadan.
	- Presentation by Professor Dele Olowu (LGA-PHC System, achievements, challenges and opportunities)
	- Lead Discussant: Prof. K. Alausa, Faculty of Medicine, Ogun State University, Ago-Iwoye.
	- General Discussion.
7:00 p.m.	- Cocktail - OAU Conference Centre.

Tuesday 8th March 1994

9:00 - 9:30 a.m.	Workshop Modality: Gary Forbes
9:30 - 11:00 a.m.	Session One: Conditions and Obstacles
11:00 - 11:30 a.m.	(Tea/Coffee Break)
11:30 - 1:30 p.m.	Session Two: Issues Paper
1:30 - 3:00 p.m.	LUNCH
3:00 - 5:00 p.m.	Session Three: Models of Success

Group I: Planning and Budgeting

Chair: Prof. J. Makanjuola, Director, Planning, Research and Statistics, Federal Ministry of Health, Lagos.

Rapporteur: Dr. Lanre Nassar

Group 2: Revenue Mobilization & Grassroots Participation

Chair: Mr. 0.0. Oyelakin, office of the CGS, Abuja

Rapporteur: Dr. Kunle Awotokun

Group 3: Monitoring and Supervision

Chair: Dr. Ogundeji, NPHCDA 'Zone B' Ibadan.

Rapporteur: Mr. David Adeyemo

Wednesday 9th March 1994

9:00 - 9:45 a.m	Panel Discussion Chair: Dr. (Mrs) Fagbule NCCCD, Lagos.
9:45 - 11:00 a.m	Session one: Strategies
11:00 - 11:30 a.m	(Tea/Coffee Break)
11:30 - 1:30 p.m.	Session Two: Strategies
1:30 - 3:00 p.m	LUNCH
3:00 - 5:00 p.m.	Session Three: Implementation

Thursday, 10th.March 1994

3rd Plenary Session	(Group Presentations)
9:00 - 10:00 a.m.	Chair: Dr. G.I. Ile, Federal Ministry of States and Local Government Affairs, Abuja.
	- Presentation by Group I (Planning and Budgeting)
	- General Discussion
10:00 - 10:30	- Coffee Break
10:30 -11:30	- Chair: Dr. S.B. Ayo, HOD Public Administration, Ile-Ife.
	- Presentation by Group II (Revenue Mobilization & Grassroots Participation)
	- General Discussion

11:30 p.m - 12:30	-	Chair: Dr. M.O. Oduwole, MOH, Lagos.
	-	Presentation by Group III (Monitoring and Supervision)
	-	General Discussion
12:30 - 2:30 p.m.	-	LUNCH
2:30 - 5:00 p.m.	-	Field Trip

Friday, 11th March 1994

4th Plenary Session

9:00 - 10:00 a.m.	-	Evaluation of Field Trip
	-	Chair: Mrs. Lola Payne, MotherCare, Lagos
10:00 - 12:30 p.m. Activities, & Training.	-	Adoption of Action Plan on Policy Issues, Extension
	-	Chair: Professor James Wunsch
	-	Facilitators: Project Personnel, Chairs & Rapporteurs of Working Groups
1:30 - 2:30 p.m.	-	LUNCH/Departure of Participants.

STRATEGIES FOR PLANNING AND BUDGETING

Future Strategies for Strengthening LGA PHC:

1. There is the need to set up well equipped planning offices to be manned by qualified officers.

2. There is the need for intensive training programmes with inputs from local government service commission on planning and budgeting.

3. Establish Accountant-General's office for the LG level whose functions will include planning, budgeting, and reviews. And to feed the Federal Government on the planning needs of the local government.

4. Review the existing line item budgetary method. There is a need to tie budgets to programs.

5. Review the existing budget format, and make it more flexible to accommodate changing expenditure and revenue sub-heads.

6. The need to have call circulars much earlier than October.

7. The need to strengthen the local revenue base to provide more funds flow to implement plans.

8. The need to develop model guidelines for LGA/PHC budgeting.

9. The need for sector professionals, partners etc., to be properly trained in the art of budgeting.

10. The need to have closer collaboration between local government and federal government through the LGA-based Accountant-General particularly in the area of accountability.

11. The need to reflect the contribution of the donor agencies in the budgets to keep us aware of our counterpart funding and to prepare us for sustainability.

STRATEGIES FOR REVENUE MOBILIZATION AND GRASSROOTS PARTICIPATION

Future Strategies for Strengthening LGA PHC:

1. Improve quality of service through utilization of trained manpower by training the skilled and unskilled labour; training the people to maintain the equipment used for PHC.

2. Involve community leaders, politicians, local organizations, and NGO's in revenue generation that would involve levies and donations by the members of the community.

3. Local government should invest in drug stores and side laboratories to be manned by pharmacy technicians and technologists respectively.

4. In order to encourage local revenue generation by LGAs there should be some index on their efficiency, federal revenue allocation to LGA's should be partially based on meeting their revenue generation targets.

5. Efforts should be made to train LGA and PHC officials in budgeting and planning.

6. Expand the scope of revenue base of LGs by increasing their sources of revenue.

7. Every LGA PHC department should organise training for local government officials/leadership at least twice in a year.

8. The LGA PHC should assist the communities to provide incentives to LG PHC management committee members, e.g. refreshments.

9. Functional village, district and local government PHC management committees should be established and properly maintained in all LGAS.

10. Organization of drama group in each LGA, provision of health education materials, e.g., flannel-graphics and other possible visual aids. Use of public outreach for community leaders, churches, mosques, school children, market places etc. could encourage increased community participation.

11. Resolutions of each health committee meetings should be written down in minutes and passed on to policy makers who in turn should take them seriously and strongly consider their implementation.

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STRATEGIES FOR MONITORING, EVALUATION AND SUPERVISION

Strategies for strengthening LGA PHC:

1. Expansion of the existing M/E unit, e.g transportation.

2. FMOH should provide funds for the expansion and strengthening of M/E offices with a view to establishing a uniform standard.

3. Increase federal revenue allocation to be tied to PHC revenues.

4. Mobilizing community for participation in PHC.

5. Training of the appropriate personnel for specific functions in the PHC system, e.g., supervision.

6. Regular review meeting on PHC programs at each level of government, i.e., federal, state and LGA.

7. To inculcate greater discipline to the operations of PHC system at LGA level.

8. In the implementation of the PHC program, all tiers of government should be more "inward looking" now as regards resource generation and utilization.

9. Emphasize the need to make the two-way referral system more effective.

10. Make maintenance a high priority in LGA.

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COMMUNIQUE

WORKSHOP ON IMPROVING GOVERNANCE IN NIGERIA'S PRIMARY HEALTH CARE DELIVERY SYSTEM

A Workshop on 'Improving Governance in Nigeria's Primary Health Care Delivery System' vas held at the Conference Centre, Obafemi Awolowo University, Ile-Ife, between 7th and llth March 1994. Keynote addresses were delivered by the Honourable Minister of Health, and a epresentative of the Director of the USAID Lagos Office. In attendance were officials of the Federal Ministry of Health, the National Primary Health Care Development Agency, state and ocal government officials from Oyo, Osun, Enugu and Anambra states and selected experts from wo universities. The Workshop was hosted by members of the Departments of Public Administration and Local Government Studies of Obafemi Awolowo University, IleIfe. The Vorkshop was sponsored by USAID.

The principal objective of this workshop was to increase understanding of project-related ersonnel of the problems, resources and opportunities that exist at the LGAs and that affect rimary health care. The Workshop proposed the following resolutions for improving overnance of Nigeria's primary health care delivery system under three headings:

RESOLUTIONS ON POLICY ISSUES

1. Encourage local generation of revenues.

2. Explore the possibility of establishing Accountant General position for the LGA's whose responsibilities would include formulating policies on planning, budgeting and review.

3. Encourage self-sustaining and self-reliance in financing PHC programmes at local government level to avoid dependence on donor agencies.

4. Policy conflicts between state and local governments in revenue mobilization should be clarified and resolved.

5. Research into possibility of introducing innovative budgetary techniques.

6. Strengthen the compliance of monitoring and evaluation and improve the quality of the data and the completion of the forms.

7. Strengthen mechanisms of financial accountability at all levels of government.

8. Develop LGA PHC budget that are tied to programs.

Training

1. Every LGA PHC Department organise advocacy training workshops for key officials of the LGA at least 2 times a year on the PHC program.

2. Intensive training programs on planning, budgeting and financial management.

3. Training extended to LGA personnel in administration and management.

4. Training in planning projects, record-keeping, problem identification and program prioritizing extended to CDAISL LGA'S, and PHC committees.

5. Strengthen the training in health education at the community level.

6. Training in basic data collection techniques, storage, analysis and presentation of data using simple techniques.

7. Training in the maintenance of equipment and infrastructure.

Extension Activities

1. Functional village/District/LGA PHC management system should be established and maintained in all LGAS.

2. Monitoring of PHC activities should be strengthened.

3. The two way referral system needs to strengthened.

4. Community leaders, politicians, local organizations and NGOs should be involved in revenue generation that would involve levies, cash, in-kind donations by community.

5. The State Council on Health should be made functional in all states of the federation programs.

6. Create more opportunities for states and LGA PHC to share models of success, and carry out joint problem-solving through workshops seminars.

WORKSHOP PARTICIPANTS

	Name		Status		Organization
1.	Dr. M. O. Oduwole	1.	PHC Director	1.	Lagos SMOH
2.	Dr. H.O. Adesina	2.	Rep. NCCCD	2.	Ibadan
3.	Dr. I.O. Abayomi	3.	HOD Community Health	3.	OAU, Ile-Ife
4.	Mrs. A.A. Alao	4.	PHC Coordinator	4.	Egbeda LGA
5.	Dr. Gary Forbes	5.	Consultant	5.	USAID
6.	Dr. Jim Wunsch	6.	Project Director	6.	USAID
7.	Mr. G.A. Awotidebe	7.	PHC Coordinator	7.	Ife Central LGA
8.	Mrs. C.M. Adesina	8.	PHC Coordinator	8.	Atakumosa LGA
9.	Professor Dele Olowu	9.	Project Director	9.	OAU, Ile-Ife
10.	Dr. M.L. Nassar	10.	Rapporteur	10.	OAU, Ile-Ife
11.	Dr. Awotokun A.M.	11.	Rapporteur	11.	OAU, Ile-Ife
12.	Mr. David Adeyemo	12.	Rapporteur	12.	OAU, Ile-Ife
13.	Dr. B.O. Adedeji	13.	HOD	13.	OAU, Ile-Ife
14.	Dr. M.O. Ogundeji	14.	FMH, Zonal Office	14.	
15.	Mrs. Ladipo Adebisi	15.	Deputy PHC Director	15.	SMH, Ibadan
16.	Dr. Casimir Orjioke	16.	PHC Director	16.	SMH, Enugu
17.	Dr. A.E. Oleksy-Ojikutu	17.	USAID	17.	USAID, Lagos
18.	Dr. E.O. Ndukwe	18.	Medical Officer PHC	18.	Nsukka LGA
19.	Dr. B. Adeyefa	19.	PHC Director	19.	SMH, Osogbo
20.	Mrs. Lola Payne	20.	MotherCare	20.	USAID, Lagos
21.	Dr. M. Lecky	21.	Participant	21.	FMOH, Lagos
22.	David B. Green	22.	Participant	22.	USAID/ARD
23.	Dr. John Erero	23.	Workshop Coordinator	23.	OAU, Ile-Ife

V. ZARIA REPORT

- PROGRAM
- STRATEGIES
- COMMUNIQUE AND RESOLUTIONS
- PARTICIPANT ROSTER

PROGRAMME FOR

WORKSHOP ON IMPROVING GOVERNANCE IN NIGERIA'S PRIMARY HEALTH CARE DELIVERY SYSTEM (2)

Venue: Conference Centre, Kongo Campus, Ahmadu Bello University Zaria.

Date: March 15-19, 1994

Tuesday, 15th March 1994 (Opening Session)

10:00-10:45 a.m Welcome Address by the Director, Institute of Administration Ahmadu Bello University, Zaria.

Keynote Speech - Representative of the Director, USAID Affairs Office Lagos.

Keynote Speech - Representative of the Fed. Min. of States and Local Government Affairs.

10:45 - 11:00 a.m. Tea/Coffee Break

1st Plenary Session

11:00 - 1:00 p.m.

Workshop Modality Dr. John Erero/Gary Forbes

- Chair: Dr. E.S. Essien, Dept. of Community Medicine, ABU, Zaria.
- Presentation by Professor James Wunsch (Governance & Nigeria's PHC System).
- Lead Discussant: Dr. Barbara Maciak NCCCD Kaduna.

	-	General Discussion
1:00 - 3:00 p.m.	-	LUNCH

2nd Plenary Session

3:00 - 5:00 p.m.	-	Chair: Professor E. Ikoiwak HOD, Dept. of Local Govt. Studies, A.B.U. Zaria.
		Presentation : Professor Dele Olowu (LGA-PHC System; achievements, challenges and opportunities).
		Lead Discussant: Alhaji Mohammed Sule Maru; Director of PHC, Ministry of Health Sokoto.
		General Discussion
7:00 p.m.		Cocktail - Kongo Conference Centre.

Wednesday, 16th March 1994 (Group Work)

	GROUP WORK:
9:00 - 9:30	Workshop Modality: Gary Forbes
9:30 - 11:00 a.m.	Session One: Conditions and Obstacles
11:00 - 11:30 a.m	(Tea/Coffee Break)
11:30 - 1:30 p.m	Session Two: Issues Paper
1:30 - 2:30 p.m	LUNCH
2:30 - 4:30 p.m	Session Three: Models of Success
4:00 - 4:30 p.m	Tea/Coffee Break

4:30 - 6:00 p.m. Session Four: Strategies

Group I: Planning and Budgeting

Chair: Coordinator, (Asst. Zonal Coordinator NPHCDA 'Zone C' Kaduna).

Rapporteur: Dr. Omar Massoud (Dept. of Local Govt. Studies ABU, Zaria).

Group 2: Revenue Mobilization & Grassroots Participation

Chair: Mrs Monica Gotip (PHC Coordinator, Barkin Ladi LG. Plateau State).

Rapporteur: Professor F.C. Nze (Dept. of Local Govt. Studies).

Group 3: Monitoring and Supervision

Chair: Dr. C.T. Ityonzughul, Director of PHC, MOH, Enucju State

Rapporteur: Professor E. Ikoiwak (Dept. of Local Govt. Studies, ABU, Zaria)

Thursday, 17th March 1994 (Group Work Contd)

9:00 - 10:00 a.m. - Session Five - Strategies

10:00 - 10:30 a.m. - (Tea/Coffee Break)

10:30 - 12:00 Noon - Group Reports
Chair: A. Ikotun (ASCON, Badagry). Presentation by Three Work Groups on Future Strategies

12:00 - 1:30 p.m. - Lunch

1:30 - 4:00 p.m. - Field Trip

Friday, 18th March 1994

9:00 - 10:00 a.m	-	Evaluation of Field Trip Chair: Dr. J.Y. Jiya (Director of PHC, MOH, Niger State).
	-	Adoption of Communique, Action Plan on Policy Issues, Extension Activities & Training/Evaluation of Workshop. Chair: Professor Dele Olowu Facilitators, Project Personnel & Rapporteurs of Working Groups.
12:00 noon		Lunch/Departure

Strategies for Strengthening LGA PHC Planning and Budgeting:

1) Training and Retraining of personnel.

2) Need for the establishment of a data bank and encourage its utilization. Establishment of well equipped planning units.

3) Reorganization of monitoring and evaluation units into full fledged PRS units.

4) Adoption of Programme budgeting as opposed to traditional budgeting system.

5) Effective Community Mobilization through village, districts heads division committees.

6) Inter-sectoral collaboration and coordination.

7) Ensuring budgeting transparency through publicity.

8) Enforcing budgeting discipline through auditing monitoring and evaluation.

9) 60-40 percent ratio of emoluments services- i.e. 60 percent to emoluments and 40 percent for services.

10) Making sure that budgets are synchronized with baseline plans and rolling plans.

11) Policy advice/Guidelines from State and Federal Governments.

12) Ministry of Health should oversee PHC activities in Local Government instead of the office of the' Deputy Governor. (PCY)

Strategies for Strengthening LGA PHC Revenue Mobilization and Grassroots Participation

1. Local governments should be allowed to execute programmes based on the priorities established by them.

2. The implementation of PHC programmes should be decentralized to the district level to make for programme effectiveness.

3. Fees and rates charged and the by-laws authorizing them should be reviewed to reflect the changing economic circumstances in which local government now operate.

4. PHC competitions should be instituted. And prizes awarded to Local governments which excel in any given area of PHC activity.

5. PHC review meetings should be held regularly.

6. To improve participation the strengthening of state and local government PHC personnel is called for.

7. Appointment of PHC coordinators should be based on competence and not on seniority.

8. There should be timely data collection and mini surveys at local government area, district and village levels to enhance planning and plan implementation

9. Community education programmes on hygiene and environmental issues should be instituted.

10. Vehicles should be provided for PHC operations at all levels and adequate funds and assignments made for their maintenance.

Strategies for Strengthening
LGA PHC Monitoring, Evaluation and Supervision

1. Provide, in the short term, financial incentives for rural postings and practice.

2. In the long term, provide the basic infrastructure necessities of life as provided for in Nigeria's national policy.

3. Train and retrain with particular emphasis on on-the-job training.

4. Initial placement should be commensurate with qualifications, experience, and skill.

5. Excellence should be recognized and rewarded either in cash or in kind as a motivating factor.

6. Structures and equipment should be regularly maintained. Equipment acquired or received should come with appropriate technology complete with spare parts.

7. PHC facilities should be nationally cited in order to enhance patient utilization.

8. Procure drugs in accordance with essential drug policy, procure drugs from reputable pharmaceutical bodies; procure drugs with reasonable life span; procure drugs close to existing consumption rate. Have proper storage and distribution.

9. Federal government should endeavour to allocate the recommended 5 percent gross allocation to health; state 10 percent and LGAs 20 percent. State should take advantage of World Bank and African Development Bank loans for facilities and health projects, e.g., The Health System Funds.

10. More funds should be put into M & E efforts.

11. Staff should be motivated in order to encourage probity and accountability at all levels of government.

12. Local Government should emulate the Federal example by sensitizing, mobilizing and supporting PHC as a development strategy.

13. States and Local Governments should be encouraged to use computers for analysis and storage of information.

COMMUNIQUE

WORKSHOP ON IMPROVING GOVERNANCE IN NIGERIA'S PRIMARY HEALTH CARE DELIVERY SYSTEM

A Workshop on 'Improving Governance in Nigeria's Primary Health Care Delivery System' was held at Kongo Conference Hotel between 15th and 19th March 1994. In attendance were officials of the Federal Ministry of State and Local Government, the National Primary Health Care Development Agency, State and Local Government officials from Kaduna, Sokoto, Niger, Plateau and Benue States and experts from universities, the Administrative Staff College of Nigeria and a few non-governmental organizations. The workshop was hosted by the Department of Local Government Studies, Ahmadu Bello University, Zaria in collaboration with experts from the Departments of Public Administration and Local Government of Obafemi Awolowo University, Ile-Ife. The workshop was sponsored by the USAID.

The principal objective of this workshop (as well as an earlier one held at Obafemi Awolowo University, Ile-Ife from March 8-11, 1994) was to increase understanding of PHC personnel of the problems, resources and opportunities that exist at the LGAs and that affect primary health care.

The workshop proposed the following resolutions for improving governance of Nigeria's primary health care delivery system under three headings: policy, training, and extension.

RESOLUTIONS ON POLICY ISSUES

1 Improve linkages between LGA Councils and PHC, between LGA Departments and between LGA PHC and State Ministry of Health and Federal Ministry of Health.

2. Site PHC facilities where maximum use by patients can be assured.

3. State Ministries of Health to collaborate with and to oversee local PHC programmes.

4. State Councils of Health should be made functional and should operate in consonance with National Policy on Health.

5. Review LGA tax rates and bye-laws to increase revenue generation.

6. States and LGAs to explore ways of greater coordination in sharing revenues. Furthermore should be made mandatory for state governments to pay the 10 per cent revenue generated internally to LGAS.

7. LGAs to explore possibilities of commercial ventures for revenue generation.

8. Appoint PHC coordinators solely on basis of competency and experience.

9. Publicise all LGA plans, budgets and financial reports, where possible in local languages.

10. Provide short and long-term incentives to motivate PHC workers to work in disadvantaged or remote areas of LGAS.

11. Review and enforce and streamline Environmental Protection Laws in LGAs in line with National Environmental Protection Agency Act.

12. Review and update PHC base-data and situation-analysis in all LGAs especially in view of the creation of new LGAs in the country.

13. Involve and encourage non-governmental organisations (NGOS) in PHC activities.

14. Make it mandatory for companies sited in LGAs to assist PHC activities in the LGAS.

RESOLUTIONS ON TRAINING

1 Training should focus on skills of community education in hygiene and environmental issues.

2a. Utilise existing training insitutions to develop management and supervisory skills at all levels; and

2b. Initiate evaluation of training efforts of existing institutions engaged in Local Government training.

3. Develop skills in the areas of data and information processing, storage and retrieval and utilization.

4. Develop models of LGA PHC budgets and annual financial reports and train LGA leaders to implement.

5. Involve non-PHC staff like Finance Directors, Personnel Directors, Chairmen and Council members in training by devising orientation workshops and seminars for them.

6. Develop training programmes to upgrade competences of Local Government and PHC staff in Project and Programme planning.

7. Train PHC Coordinators, Assistant Coordinators and Supervisors on how to write job descriptions and monitor performance.

8. Train PHC Coordinators and their Assistants in the techniques of staff motivation and human relations.

RESOLUTIONS ON EXTENSION ACTIVITIES

1. Involvement of community in PHC Programmes.

2. Need for Community Education on PHC activities.

3. Conduct evaluation and operations research in respect of service extension.

4. Extend training to the job site.

5. Provide recognition and rewards to motivate LGA staff.

6. Community end-users should be recognised and rewarded for active participation in PHC programmes.

7. Strengthen M & E units to generate relevant field information to aid decision-making at LGA, State Ministry of Health and Federal levels.

8 Hold Conferences and workshops of PHC staff, to review programmes and services at State and Local Government levels. Such workshops should be cost-effective.

9. Give extensive publicity to PHC activities through Newsletter.

WORKSHOP PARTICIPANTS

	Name	Address
1.	Alhaji M.D. Ijakoro	Suleja Local Govt. c/o HOD/PHC, Medical Health Dept., Suleja.
2.	Dr. D.B. Parakoyi	CCCD Project Office Room 263, SMH HQ, P.M.B. 2014, Jos, Plateau State.
3.	Alh. Dauda Umar	Zaria Local Government, Zaria.
4.	Steven Anzaku	SMOH Uqtrs, P.M.B. 2014, Jos., Plateau State.
5.	Mrs. Monica Gotip	P.M.B. 2003 Barkin-Ladi LGA, Plateau State.
6.	Mr. A. Ikotun	Dept. of Local Govt. Studies, ASCON, P.M.B. 10040, Topo, Badagry.
7.	Dr. E.S. Essien	Dept. of Community Medicine, Faculty of Medicine, A.B.U., Zaria.
8.	Mr. Alex M. Sharta	NAVDO, 27, Berkley Street, Onikan, Lagos.
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10.	Dr. Haruna Dlakwa	Dept. of Pol. Science & Admin., University of Maiduguri, P.M.B. 1069, Maiduguri.

11.	Alh. Nuhu Shehu	NPHCDA, PHC Zone 'C' Kaduna, P.M.B. 2010, Kaduna.
12.	Salihu Abdullahi	HOD/PHC Dept, Lapai, Niger State.
13.	Alh. M. Daudu Gawu	HOD/PHC, Gurara Local Govt, Gawu-Babangida, Niger State.
14.	Mrs. Deborah E. Chagu	Makurdi Local Government Snr Staff Quarters, Ankpa Ward, Makurdi. OR Makurdi LG Secretariat, Health and Social Welfare Dept., Makurdi.
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23.	Sule M. Isafe	Kaura Namoda Local Government, Sokoto State.
24.	Abubakar Z. Tambuwal	Kaura Namoda Local Government, Sokoto State.
25.	Idinsu Musa	Zaria Local Government, Kaduna State.
26.	Dr. Omar Massoud	Dept. of Local Govt. Studies, ABU, Zaria.
27.	Professor E. Ikoiwak	Department of Local Govt. Studies, ABU, Zaria.
28.	Michael Mills	Peace Corps Volunteer, PHC Dept. P.M.B. 1, Pankshin, Plateau State.
29.	Professor F.C. Nze	Department of Local Govt. Studies, ABU, Zaria.
30.	Dr. C.T. Ityonzughul	PHC Director, Ministry of Health, Makurdi, Benue State.
31.	Dr. Gary Forbes	ARD/USAID.
32.	Professor Dele Olowu	OAU Ile-Ife.
33.	Dr. John Erero	OAU, Ile-Ife.
34.	Dr. Jim Wunsch	Project Director.

VI. RESULTS AND IMPLICATIONS

SUMMARY REFLECTIONS ON WORKSHOPS

Event:

Two week-long strategic issues workshops were held in early March 1994, one in Ile-Ife and another in Zaria. Nearly fifty participants attended. Each workshop consisted of presentations on the topic of "Strengthening Governance in Nigeria's Primary Health Care Delivery System." There was also a series of group workshops, where attendees discussed the PHC system. These resulted in written and verbal reports to the assembled group, with the key results documented.

Highlights:

* Representatives from fifteen local governments were present at the workshops.

* Other attendees included representatives from the Federal Ministry of Health (including the zonal offices), the State Ministry of Health (several state PHC directors were in atttendance), the NCCCD program, USAID, university Teaching Hospitals, and University faculty from the Departments of Local Government, Administration, and Community Health.

* There was strong commitment for the USAID-sponsored NCCCD project. This was really the foundation of the support for the workshops -- it encouraged the turnout, and enabled the general optimism and good faith the attendees had in attending the workshops. In other words, the Governance Workshops were built on the positive track record of the NCCCD project, and participants viewed the workshops as a logical progression of program implementation.

* At the opening session of the Ile-Ife Workshop, the Federal Minister of Health came from Lagos to deliver a welcoming speech.

* The field trips to PHC rural clinic sites during both workshops was a highlight to many participants. It brought a sense of in-the-field reality and importance to the otherwise "conference" dynamics of speeches and a more passive-style participation.

* Evaluation forms completed by all participants resulted in a 4.8 on a 5.0 scale for both workshops.

Accomplishments:

* Actually being able to hold two workshops in separate regions of the country. This not only doubled the participation and expanded the geographic representation, but it also provided a higher quality of findings from which to chart the next phases.

* The workshop format and level of dialogue was very impressive to Nigerian PHC officials at all levels, and gained a significant degree of initial credibility at this early stage of the Governance project.

* A clear and strong articulation of the overall Governance Strategy by both Dr. Olowu and Dr. Wunsch was well-received by the participants, and provided the theoretical foundation for the sessions that followed.

* The consensus process of developing the written communique for each workshop, and its distribution to participants and other interested parties.

* The written materials, particularly the Orientation Report, also the Issues Paper and other planning formats, were very effective in making the workshops smooth-running and focused on the critical PHC issues. Without them the workshop would have tended to go off track, with discussion leading into all kinds of peripheral topics.

* The workshop format, especially the three break-out groups that worked on PHC issues and obstacles, models of success currently in place, and strategies for the future. This is where the best participant feedback and overall input into the planning process took place.

* There was a clear set of procedures with designated products to achieve for each workshop activity.

* The role of the rapporteurs proved to be not only effective, but absolutely necessary to accomplish the high quality of work in such a short period of time. They did not dominate the workshops with their individual opionions and ideas, but rather facilitated discussion and assisted in producing quality product from each group.

* The creation of a support team of clerical support, computer expertise, drivers, runners, etc. was instrumental in achieving the "relatively" smooth operation of the workshops.

Lessons Learned:

The sheer geographic size of Nigeria, along with the given infrastructure difficulties (e.g., fuel shortage, cumbersome banking procedures, etc.) require careful and proactive planning of project activities to ensure ongoing success.

An attempt needs to be made to involve more independent and non-governmental parties in the project.

Practitioners at all levels in the PHC system were in almost total agreement with the assessment laid out in the various research documents, and are ready and willing to move on to implementation strategies. The most excited dialogue in the workshops happened when discussing possible actions that need to be taken to strengthen the system.

A training strategy is only one piece of an overall strategic approach. As delineated in the Governance Report, two other strategies include policy dialogue and field extension and follow-up activities. Without a multi-strategy approach, the project will not be able to affect significant change. Classroom based training, no matter how practical and interactive, still may not affect the way PHC carries out its functions. Trainees may have new ideas, new attitudes and maybe even new skills, but the transfer of learning, where on-the-job behaviors are actually changed, is very difficult. An approach that might offer additional advantage is to design brief, onsite, targeted, problem-solving training events with key PHC practitioners. These training "interventions" could be designed to create change efforts that would be built on PHC staff involvement that would ensure ongoing responsibility and commitment.

The Trainers' Team was originally planned to include local government and administration faculty from several universities. This was felt to be somewhat limiting related to practical experience. Therefore it was decided to consider bringing others on board, including ASCON faculty, University health educators, NCCCD medical staff, and Nigerian-based consultants.

Because of the political unpredictability at the LGA level, it was decided to focus the initial training pilot sessions at PHC practitioners, and not concentrate on the LGA chairmen and council members. Later efforts could be attempted to deliver training to the LGA officials.