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**Primary Health Care and Local Government in Nigeria:
An Agenda of Key Policy Issues**

James S. Wunsch
Creighton University
and
Associates in Rural Development, Inc.
Co-Director DFM/PHC-LGA Project, Nigeria

and

Dele Olowu
Obafemi Awolowo University
Co-Director, DFM/PHC-LGA Project, Nigeria

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PREFACE

This report is one of several prepared as a result of an ongoing program studying the issues of democratic governance as they relate to delivery of public health services. It was prepared through the Decentralization: Finance and Management (DFM) Project, with the support of USAID in Lagos, Nigeria. The DFM Project is managed by Associates in Rural Development, Inc.

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I. INTRODUCTION

The purpose of this paper is to review and make suggestions on the key policy issues facing the government of Nigeria in regard to improving the "governance" of its Primary Health Care (PHC) system. In doing this, the paper will briefly review the background and performance of the system, analyze the causes of problems in the system, and discuss nine key policy areas which have affected PHC operations.

In 1988, the Federal Military Government of Nigeria, accelerated its program of decentralization of authority and responsibilities to its local government authorities (originally begun in 1976). These included:

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

- Adoption of a presidential or strong-mayor system universally in all local governments. In effect, this meant the complete separation of executive and legislative branches (1991).

In 1988 the Ministry of Health promulgated a new national health care policy. The new policy was to refocus national health resources from an urban, curative and medical orientation to a rural, preventive and public health-learn strategy. Primary health care was to be organized and managed at the local level, with the state and national governments providing secondary and tertiary health care as well as technical assistance to the local levels. In 1986, on a pilot basis, fifty-two local government authorities (LGAs) were selected as models to begin developing a Primary Health Care (PHC) system at the local level. Each was given a grant of 0.5 million naira and technical and material assistance to reorient and develop a local system.

Under the PHC system, states were to be responsible for overall supervision and coordination of PHC and the federal government was to be responsible for policy questions. Four large zones were created as an intermediary level to facilitate federal-state relations. The federal government directed all states to completely devolve all PHC responsibilities to the LGAs by June 30, 1992.

II. DECENTRALIZATION AND PRIMARY HEALTH CARE IN NIGERIA

The PHC system in Nigeria is interesting because it represents a field experiment which radically altered a major human service administrative system. Among other things it tests a number of arguments often associated with decentralization. Certainly senior Nigerian personnel who supported and helped facilitate the policy reform expected improved performance would result, at the very least in regard to access by poor and rural people to health care. More broadly speaking, the LGA decentralization, it was hoped, would improve efficiency and effectiveness at the local level by shortening long and circuitous administrative channels and encouraging greater flexibility and responsiveness to particular local conditions and needs. It was also hoped it would strengthen local-level participation in local affairs and stimulate more local revenue.

As a reform, the changes had real substance. Personnel, resources, authority were all transferred to the LGAs, and the states (whether by default or design) were put on a serious "diet" as resources were reallocated to the LGAs. LGAs received the authority to raise taxes and levy fees for service, to let contracts, to hire and fire personnel, and to establish and manage their own budgets. They also had local elections, electing an executive (LGA Chair) and legislative body (LGA Council). The reform seemed rather clearly to be an instance of devolution rather than merely deconcentration.

On its face, much progress appeared to have been made in PHC by 1992. Personnel were deployed, buildings were built, programs were begun. And, in strictly medical/technical terms, much was in place (training, donor activity, supplies, epidemiological data analysis, help in vaccination campaigns) to support the program. Nonetheless, there was concern among the donors and key Nigerian health personnel as to whether or not PHC as an organization and the LGAs as the key supporting organizations were operating effectively in developing, managing and revising PHC programs and operations.

In response to this concern USAID, with the support and encouragement of the federal Ministry of Health and working closely with other major health-related donors, launched a team of researchers in October of 1992 to do a preliminary reconnaissance of administration, organization and management of PHC at the LGAs. During this time and during follow-on research from October 1993-April, 1994, the team used the "democratic-governance" framework of USAID (which closely parallels those of the IBRD and the UNDP) to assess and evaluate the non-medical technical organizational-administrative-operational effectiveness of PHC at the LGAs.

III. GOVERNANCE AND PHC AT THE LGAs

In recent years, the concept "governance" has come into use to help capture several major lessons learned over the last several decades in the comparative study of government, public administration and public policy:

- 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;
- Good governmental performance is associated with several operational features, all of which must be achieved to reach the goal of effective and efficient operations.

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

At the heart of the "governance" concept are the five operational principles which analysts believe are critically related to effective and efficient governmental performance. The team's research strategy was guided by this agenda of concerns as it explored the first task it faced: accurately describing and evaluating the current condition and circumstances of PHC at the LGAs.

This report will first review the highlights of this picture, then turn to analytical and policy prescriptive sections: (1) what caused these problems; (2) what policy issues are related to these causes; (3) what policy changes might improve performance on these "democratic-governance" concerns?

During the research only a limited number of LGA's were visited (eleven). However, these were generally regarded as among the best managed and operating LGAs. From the research a number of operational problems were discovered, ones serious enough to justify questioning the very effectiveness of the most basic of PHC operations.¹ These included:

- Planning, programming, quality control, problem identification and solving and the like were haphazardly done by most LGA PHC staffs. Conscious and systematic programs to perform these functions were virtually nonexistent.
- Management awareness of field conditions and needs was quite low in most LGA PHC programs. This was particularly clear in the areas of personnel management and facility supervision.
- Training programs were intermittent, non-systematic, often too brief to achieve desired goals, and lacking in follow-up.
- Field supervision was generally sporadic, and lacked any overall plan. Often it was virtually nonexistent. Vehicles were frequently out of service because of breakdown or lack of funds for fuel.
- Facilities were frequently inappropriately located and designed, given available infrastructure, underserved areas, and existing facilities.
- No cost-effectiveness or utilization studies could be found through which LGA-PHC personnel had assessed their programs.
- Guidelines for supervision had been developed by the federal Ministry of Health, but were not in use in most LGAs.
- Resources did not appear rationally balanced among supply, salary, and capital budgets, so personnel facilities lacked supplies and sometimes facilities lacked personnel; other facilities appeared over-staffed.
- Poor "housekeeping" existed at most health facilities, including erratic opening and closing hours; poor record-keeping; unreliable staffing (particularly by

¹For the detailed conclusions resulting from this research activity, see Ikhide, Olowu, Owolabi, and Wunsch, 1994, "USAID Governance Initiative in Nigeria: A Strategic Assessment of Primary Health Care and Local Government," Burlington, VT, Associates in Rural Development, Inc.

upper ranks); epidemiological data in disarray; lack of cleanliness; dilapidated, broken, and poorly maintained equipment; absence of basic medications; infestation of rodents and insects; lack of knowledge of the local community, etc.

- There was evidence of poor (occasionally dangerous) medical practices at health facilities.
- Budgets poorly reflected actual expenditures of PHC, and had to be frequently revised; there were often no funds for key supplies or basic medications, and salaries were often paid late.
- There was little evidence of state or federal support of or awareness of PHC operations at the LGAs. There was little contact between state and federal personnel, and LGA personnel.
- LGA-PHC personnel had made no or very little use of community organizations in setting local program priorities, trouble-shooting health problems, assuring facility quality control, etc.
- Relations between PHC office and community committees appeared haphazard and disorganized, including absence of minutes, reports or other records of the committees' activities.
- There was evidence of declining confidence by members of local health committees that their deliberations and recommendations were taken seriously.
- Many local residents regarded the PHC system as unreliable, ineffective and unresponsive to their needs.

The governance approach is useful as a "checklist" to assure the analyst has comprehensively reviewed the variety of problems potentially erosive of governmental performance. It furthermore helps to draw the analyst's attention toward potentially key patterns in empirical information. Of course, in different government programs different problems will be manifested, so each analysis must be "customized."

The team believes it is a misuse of the framework to use it to short-cut the analytical process and simply conclude that any operational deficiencies found would be explained by (and therefore remedied by improvements in) short-falls among the five "governance" variables. Instead the team believes each problem area must be analyzed independently. While the governance concerns provide a suggestive agenda of possible "culprits," the final analysis of causes of any governmental shortfall must go well beyond identifying the governance categories to understand the circumstances and processes that caused the

problems. Nonetheless, the governance model is quite useful. As the report shows in section V, below, two aspects emphasized by the governance model are key to understanding the Nigerian PHC system: "accountability" and "organizational efficiency and effectiveness." Another concern, "reward structures" closely parallels the governance model vis accountability. The last factor, "organizational misfit to resources," is another concern entirely.

The remainder of this report will review the causes of this disappointing performance and its implications for Nigerian policy. It will analyze the causes at two levels: first, the factors which have caused these shortfalls in performance; and second the strategic and institutional nature of these problems and how they have interacted to create stubborn obstacles to improving PHC. Then it will review a number of Nigerian policies which appear to have negatively affected PHC and suggest possible changes in these policies.

IV. THE LGA-PHC CONTEXT

Underlying the governance problems reviewed above are a number of factors which help explain them. These can be categorized, loosely, as problems in the natural, political and policy environments of PHC, and problems in the organization and design of the PHC-LGA system. Each worked to hinder effective and efficient PHC operation.

A. Environmental Problems

1. *Resources:* Resources for PHC have been inadequate to the task and unreliable for most of the period the primary health care policy has been in effect. Personnel, for example, are generally working at tasks well beyond their training. It is a rare LGA which has a person trained at the R.N. level. Virtually none have physicians in the system. Service delivery personnel generally have only a few weeks of health training, and with that are diagnosing and prescribing powerful antibiotics, tranquilizers and the like. Trained medical personnel are usually swallowed up in administration in state capitals, far from any clinical setting. Funds are equally short. Primary health care must compete with several other programs for a limited federal grant: primary education, public works, agriculture, administration and miscellaneous. In any case, the grants are too little to cover all the needs. And PHC is generally fourth or fifth in aggregate funds allocated by the LGA governments. Because no effective local tax base or user-charges system has been developed, local revenues do not exist to buffer these uncertainties or inadequacies. Finally, rapid inflation, sudden federally mandated salary adjustments, and funds reallocated into other areas mean PHC's funds are not only inadequate, they are erratic. A budget is not really a budget in the sense that a manager can rely on the funds. As Caiden and Wildavsky suggested, the budget is only the first stage in an often opaque and uncertain process to determine who gets actually to spend funds.

2. *Natural Environment:* As Pressman and Wildavsky so clearly demonstrated in their study of Oakland, California, nearly thirty years ago, complex projects and programs are difficult to make work even in a relatively rich and organizationally redundant environment as has the United States. However, when the opposite is true, management is perhaps nearly impossible. In a situation such as rural Nigeria the wear-and-tear on personnel and equipment is high, and the systems are anything but redundant. If a vehicle breaks-down, the necessary spare part is rarely handy; even rarer is a spare vehicle. When the telephone is not working, there is usually no second one nearby to use, nor any alternative short of a personal messenger. When the generator breaks down, the vaccines needing refrigeration spoil. And there are no extras. When key personnel are ill or injured, or a family emergency takes them away, the system stops or does without. There simply is no redundancy, and as Landau helped to show us, its absence is terribly erosive of organizational performance.

3. **Public Environment:** For the most part there is virtually no active or informed constituency in the public for primary health care at the local level. Indeed, there is probably no public constituency which is organized and informed of primary health care throughout Nigeria, with the potential exception of some PHC workers. For the most part, people at the grass-roots were not informed about primary health care policies or decision-making, and knew nothing of LGA planning and budgeting as it affects PHC. If they were active at all, it was largely reactively, as individuals, and at the service delivery level. Community awareness of PHC and organization to influence it was minimal to non-existent. Finally, there were no active health-related professional associations to act as surrogates for local communities. The LGA, village and ward health committees met erratically, were poorly organized, and ineffective in influencing health policy or administration. For the most part, LGA-wide political or social organizations did not exist, though there was organization at the historical and traditional community levels, below the LGA.

4. **National Policy and Institutional Environment:** LGA-PHC has been affected by the national policy environment in several ways. First is the instability caused by the repeated creation of new states and LGAs from old ones, which diluted personnel and budgets to establish new administrations, buildings, motor-pools and the like. This process also has destabilized organizations as personnel lacked opportunities to build relationships with their civil service and political colleagues.

Second is the economic and budgetary uncertainty as the federal government moved from one strategy and policy to another. This applies both to the macro-economic level and to the ministry level. Supplies, budgets, prices, and program priorities have all been subject to rapid change. Third is the reorganization of state, regional and federal health institutions and the failure clearly to define the authority and responsibilities of state, zonal and federal officers vis-a-vis the LGAs in general and PHC in particular. This has involved creation of a new federal primary health care agency and ambiguity as to its responsibilities vis-a-vis the federal Ministry of Health, and of four national zonal or divisional headquarters (one of which was still not even 50% staffed in March of 1994, several years after its establishment). It also has involved a continued--but unclear and generally unbudgeted--role for Nigeria's thirty states. Actually, even within the states there was confusion, as both the state bureaus of local government and the state ministries of health claimed authority over LGA-PHC. Of course, neither has had the resources to do much of anything at the LGAs, so the significance of the tussle is unclear, except to create more confusion. In all this confusion and change, LGAs have been unclear which of their superior organizations they were responsible to if any, and for what. Interestingly enough, the same applied to the superior organizations!

Third, the national decrees establishing the local government system established only a single institutional form for all local government in Nigeria, regardless of urban size, cultural differences, geographic differences and the like. Furthermore there have been

no mechanisms institutionalized to allow for learning and change in response to experience with the system as established. Legislatures have been short-lived and had no or ambiguous authority to act to change the system; courts have been weak and not involved in local government institutional change; and no real professional bodies exist to gather, analyze and address learning at the local level to appropriate authorities. Thus, the system, rigid and inflexible to begin with, has lacked "feedback loops" to benefit and grow from experience.

5. *Local Political Environment:* Nigeria has pursued a democratization reform gradually since the late 1980s. This included one round of local and state elections after many years of moribund local and state politics. Because, perhaps, of the recency of the reintroduction of local elections and local governance, there was in 1993 (when this research was done) little evidence of an active local political process or debate. Those politicians defeated in local elections tended not to carry on a policy or program-related debate, but to pursue the victors through the courts (criminal allegations) or via interference from the governors' offices. Additionally, most people we spoke to (on all political sides) believed the PHC leadership had frequently used its offices to advance its personal fortunes. Thus there was much turnover in LGA leadership, but little discussion of policy. In November of 1993, the federal government dismissed all elected officials, so now there is no institutionalized local political process. Finally, the "informal" local leaders, ones representing historic and often natural local communities, have no institutionalized role whatsoever in the LGA system. Thus the links which usually exist between citizen and community leader and thus undergird those community leaders as they take on political roles, are lost at the LGA level of governance.

B. Organization and Design Problems

A number of organization and design problems can be seen also to have weakened PHC-LGA. These include distance from the top to bottom of the system, dissension within the local government's PHC staff, the speed with which the system was established and expanded, weak leadership from all levels, organizational confusion at state and federal levels (discussed above), the system of funding for PHC (and LGAs in general), and the role played by the donor organizations. Each will be briefly reviewed.

1. ***Central Weakness vis a vis Responsibilities:*** Given Nigeria's size, the weakness in road networks, the often fallible telephone system, and the frequent fuel shortages, decentralization was probably a good strategy. Unfortunately, many key functions were maintained by the center, and their delay (often failure) has been a problem. The centers (federal, zonal, states) retained key functions in purchasing and distributing vaccines, in gathering and analyzing data, in selecting and posting senior personnel, in training, and in quality control. While these are functions that the center(s) may well have needed to do, they were functions at which it (they) more often than not, have

failed. LGAs have been left paralyzed or to function as best they can on their own, often without key equipment, supplies, personnel, or technical assistance, and with no authority or resources to obtain them on their own. Indeed, even at the LGA itself, fuel, vehicle and weather problems have meant that PHC field personnel often have gone weeks without contact from their LGA supervisors. Indeed, "distance" problems have been reinforced by an inappropriate emphasis on public health data collection, and little emphasis on hands-on supervision of actual service delivery. Finally, the last has certainly been hindered by a LGA-PHC "model" supervision system that fragmented supervisory responsibility across the several LGA "assistant PHCs", created no or a very weak area-oriented performance evaluation system, and left most service delivery personnel without a clear-cut, single superior. In short, none of the "centers" fulfilled their responsibilities, and the whole system suffered from it.

2. ***Dissension:*** Much conflict in LGA PHC has developed over the supervisory role of non-clinically trained but health-related personnel, primarily sanitation workers. A recent court decision overturned a requirement that the LGA primary health care coordinator be clinically trained, and required that the senior PHC officer be promoted to coordinator. Whether or not this has damaged PHC operations is beyond the scope of this research, but it certainly has led to much conflict within some LGA PHC systems.

3. ***Top Down and Rapid Construction:*** From 1988 to today, Nigeria has turned from an urban, medically oriented and curative system to a rural, public health oriented and preventive one. This has required a massive change in philosophy, doctrine, operations, funds; much new construction; a massive expansion and relocation of personnel; and development of whole new systems of data gathering, budgeting, purchasing, personnel development, supervision and the like, to sustain and maintain it. Simply put, there has been substantial dislocation, as personnel take on jobs they are not yet prepared for, others jockey for position, some resist the change, and administrative procedures are found wanting. The speed with which the LGA system was established also hurt, as in a matter of a few years and with little opportunity for evolutionary and gradual learning, a single model was established, model procedures were promulgated, and a large cadre of inexperienced personnel were assigned to the many LGAs. While procedural and organizational learning and adaptation no doubt has occurred, there have been no systematic mechanisms to review and spread the word on their success, nor to allow LGAs to institutionalize their learning. In Nigeria, all institution-building is top-down, allowing for little input and no initiative from the grass-roots or by their local political leaders in the process of institutional revision.

4. ***Leadership:*** Leadership has been weak, for the most part, at all levels. While there were senior personnel we interviewed who had defined their roles and functions fairly clearly and were pursuing them, the vast majority of senior personnel either had little concept of what they might do to strengthen the system, or were constrained

and discouraged by their lack of resources. At all levels, PHC, state, region, federal, we found a strong sense of discouragement and passivity.

5. **Funding:** Virtually all local government in Nigeria is funded by federal revenue grants. These consist of a single large local government disbursement as well as special grants during the budget year to respond to emergencies or new federal priorities. Effectively between 90-96% of all LGA revenue comes from this source. LGAs have the authority to levy numerous local taxes: on markets, local enterprises, local dwellings, licenses, and fees for service. While some taxes are levied, they are at absurdly low rates and ignore most of the more promising sources. Why, is a matter of some debate, but seems likely to be related to some (or all!) of the following possibilities:

- local leaders are close to many of the small-scale business-persons who would be the most cost-effective sources of tax;
- local revenues sources are relatively cost-ineffective, or at least cumbersome to collect;
- there is no federal or state revenue reward or penalty associated with raising or failing to raise local revenue;
- user-fees/charges are politically unpopular and viewed with suspicion by local dwellers who have seen local funds disappear suspiciously in the past.

As a result of these, and perhaps other factors, LGAs raise virtually none of their own funds, with not particularly surprising consequences (to be discussed below) for spending patterns and for local inattention to LGA affairs. As noted above, this pattern of little local revenue does nothing to strengthen organizations already starved for funds.

6. **Donors:** To single out the donors for criticism may seem far-fetched or at least ungrateful. The donors are the one source of extra revenues, reliable supplies, vehicles, special programs, and the like, that LGAs can tap into. Unfortunately, while they certainly do some good via their programs, they also tend to preempt the political pressures the better-led LGAs might otherwise bring to improve a foundering system (as the donors tend to "colonize" the best LGAs), and preempt priority setting by all Nigerian health organizations: since the donors have the only slack resources, their priorities tend inevitably to become Nigeria's. Finally, the donors often poorly coordinate their activities among one another vis a vis a single LGA, adding administrative burdens to it, while they rarely coordinate at all with state health programs. Thus the donors are a mixed blessing.

V. STRATEGIC PROBLEMS AND OPERATIONAL ISSUES FOR PHC

The eleven circumstances or factors discussed above interact to create several key, general strategic obstacles to improving PHC performance. These include:

- weak accountability;
- poor reward systems;
- weak personnel and low organizational capacity; and
- poor fit between organizations and task.

The following sections will briefly review each of these patterns and show how the factors discussed in section IV created and sustain them.

A. Accountability

It can probably be safely assumed that any large, spatially dispersed, multi-tasked, human-services organization will perform unevenly, particularly during its early years. Accountability (i.e., the ability of clients and others concerned to make effective claims on it when its performance is not satisfactory) is critical to catch and correct the inevitable problems and errors.

If accountability is conceptualized as flowing in three directions (upward to organizational and political superiors; laterally to professional peers; downward to clients and citizens) then the extent of non-accountability of PHC in Nigeria can be seen: at none of these levels was it operable. In large measure this was because of the patterns discussed in section IV, above.

1. "Downward" accountability was weak because of:
 - a) the absence of local organization, awareness and sophistication regarding PHC, including the virtual absence of LGA-wide organizations;
 - b) the absence of a viable and active political process at the LGAs;
 - c) the absence of local funds going into PHC, either as general or service-related revenues;
 - d) the absence of a culture of client-responsiveness among PHC personnel;
 - e) the absence of any institutionalized role for the "informal" political leaders and institutions (historical and traditional) involved and active in local governance.

2. "Lateral" accountability was weak for several reasons:
 - a) the rapid expansion of the system plus often superficial training led to many marginally trained and marginally professionally socialized personnel;
 - b) frequent (at times constant) shortfalls in supplies, equipment and salaries eroded morale among personnel;
 - c) weak supervision from above and weak demands from below allowed a gradual slide in performance to go unchallenged.

3. "Upward" accountability was also weak for several reasons:
 - a) weak and undefined roles for superior levels of government left LGA PHC programs largely on their own;
 - b) a cumbersome and inappropriate LGA PHC supervisory structure fragmented responsibility for personnel as individuals, and as members of area-based teams;
 - c) repeated shortfalls in fuel and equipment prevented even minimal contact between delivery personnel and supervisors;
 - d) some supervisors lacked the clinical knowledge to effectively supervise their personnel.

B. Reward Structures

In a variety of ways, the circumstances discussed above (section IV) created reward structures which worked to discourage actions which might have resolved some of the LGA-PHC problems, and rewarded actions which made some of them worse. This can be seen regarding funding, supervision, service delivery, local grass-roots participation, professionalism and political leadership.

1. ***Fund raising and revenues:*** Nigeria's method of disbursing revenues does nothing to encourage raising local revenue. Each LGA receives a grant tied to a formula based on population, area, and need. This grant does not vary, regardless of local effort (or lack of effort) in raising funds. Additionally there are no policies to encourage or facilitate development of revolving funds for medications or supplies, and user-charges to reinvest in facility upkeep, personnel, or other operating costs (vehicles, fuel, training, etc). Indeed, there are no established systems by which such funds can be routinely sequestered from regular LGA operating accounts (though a few aggressive LGA PHCs have established these on an ad hoc basis with supportive

LGA chairmen). Nor is there any policy or financial support from the federal government to establish such systems. Thus, although the experiences of a few LGAs demonstrate that revenues can be raised locally and significantly improve PHC performance, (i.e., Drug Revolving Funds), there are no institutionalized systems or rewards to encourage this. Instead the LGA's path of least resistance is to spend until the federal grant is exhausted, and then do no more. The fact that the federal grant is effectively a "common pool" resource to locals does not encourage close surveillance of how the money is actually spent.

2. **Supervision:** Supervision is difficult, poorly organized, time-consuming, not clearly rewarded, and not clearly cost-effective given the resources and constraints supervisors face. It is difficult and time consuming because of the difficulty of travel (poor roads, long distances, unreliable vehicles), the administrative chores that await still at headquarters, the fragmented personnel responsibility divided among the assistant PHC coordinators, and the large number of personnel to supervise. Secondly, the reward structure does not appear to differentiate between those who supervise and those who do not: evaluation systems are rudimentary at all levels, promotion is closely tied to seniority, and the salary structure has been ravaged by inflation. Finally, the system is so starved for effective medical-clinical personnel and the service delivery persons are generally so undertrained that it is not clear to many supervisors what they might accomplish in the field in any case. Very often PHC exhibits what Jon Moris called the "hub-in-wheel" administrative syndrome, where the senior person (here the PHC coordinator) is competent, but the next level of personnel is vastly less so. Here, the senior person tends to take on so much that he/she is overloaded, and the organization suffers from chronic backlog and/or stasis when that person is away, ill, or leaves. This also impedes development of strong and institutionalized supervisory linkages downward through the PHC system.

3. **Service Delivery and Professionalism:** With supervision very weak, with local organization and awareness of PHC quite weak, with funds independent of service delivery (and inadequate as well), with salaries inadequate and tied primarily to seniority, with no functioning professional associations of PHC personnel it is not clear how superior service delivery or professionalism is encouraged. Record keeping is rudimentary, and the only contact by field personnel with PHC supervisory staff is usually with the statistics officer. The latter is clinically untrained, and only gathers aggregate data on incidence of various diseases. While some personnel, it is hoped, will be motivated by intrinsic rewards, the extrinsic rewards are unclear. Furthermore, the inelasticity of budgets and cash flow mean that the more cases a facility serves, the more supplies it will exhaust, and the less prepared it will be for more cases. Also, our research suggested several supervisors were simply not competent to evaluate clinical performance, so it is not clear if some personnel in the organizations would even recognize superior service delivery. Finally, the supervisory structure above the LGAs does not appear to work any better than that of the LGAs. Thus,

there appears to be no effective reward structure for the PHC coordinator either.

4. ***Grass-Roots Participation:*** In the current system, there are few if any rewards for grass-roots participation. Local and "informal" leaders receive nothing to cover travel costs or opportunity costs to attend meetings, and report they mostly "talk, talk, talk," and accomplish nothing. LGA-PHC personnel rarely can recall an instance where they changed personnel, priorities, programs or anything else in response to grass-roots input. For them, the grass-roots organizations are mechanisms to mobilize the public to do things PHC decides on. Since there are no slack resources to use to respond to community wants, since there is no way to expand resource base by expanding programs, (i.e., via use of cost recovery) a mobilized, proactive community is just another claimant on already exhausted resources. In summary, it is not clear who if anyone is rewarded for community organization. In general, a passive and obedient community makes health workers' lives easier.

Leaders and institutions which actually have the trust of the grass-roots, usually the "informal" sector, and often linked to historical and traditional communities, play virtually no role in PHC or LGA governance in general. This further weakens participation and thereby reward structures linked to performance.

5. ***Political Leadership:*** If we understand political leadership here to refer to LGA chairmen taking an assertive role in expanding the capacity and improving and performance of LGA-PHC, one can see several problems for this in the reward structure. To begin with, since the key shortfall is financial and there is little more Nigerian revenue to get from outside the LGA, if the chair does not capture significant donor revenues (which bring their own problems), he must raise the funds locally. This would mean a choice between taxes or user fees, an unpopular pair of choices. Second, there are usually few if any mobilized groups or constituencies to support his efforts. Third, LGA personnel instability has been very high since 1988, so a potential leader has an uncertain time frame in which to work. Fourth, there are numerous other, often better organized claimants for LGA resources: teachers, merchants and drivers using dilapidated roads, contractors interested in construction projects, and the like. Finally, only one cycle of elections occurred before the elected LGA personnel were dismissed, thus no pattern of electoral reward for producing health services was ever demonstrated.

C. Weak Personnel and Organizational Capabilities

At both the LGA in general and at PHC in particular, personnel and organizations fall well short of the tasks they are allocated. They have little systematic knowledge of the resources and problems faced by their LGAs. They are unable to develop realistic and specific plans to address local problems. They cannot convert plans into programs nor, for the most part, programs into detailed work plans. Their budgeting is ineffective and they do

little if any appraisal of program performance. They are ineffective in balancing expenditures among personnel, supplies and capital investments, do not supervise personnel or facilities well, and either do not attempt or fail at quality control. There are few if any management information systems in place, and no evidence of their use in managing local programs. Established budgeting, expenditure, property control, personnel or auditing systems are poorly understood and largely ignored. Standard operating procedures bear little resemblance to legal prescription. In summary, local governance in general and PHC in particular are not operating effectively or efficiently. The speed of LGA and PHC establishment; the inexperience of the cadres; the lack of feedback and learning systems, the rigidity and lack of real-world foundation for the prescribed LGA structures and procedures; the harshness of the Nigerian natural environment; the resource shortages; and the overwhelming challenges to the LGAs probably all explain these problems.

D. Misfit Between Organization and Resources

This analysis would be incomplete without recognizing as a last problem the resource shortfalls the LGA-PHC system has faced. While these shortfalls created separate problems of accountability and reward, it is still unclear how PHC might succeed even were these latter problems resolved. It has had insufficient trained personnel to staff its facilities, to supervise its staff, to lead it, or to link it to the state and national ministries; it has had insufficient funds to build, equip and maintain the facilities it needed to cover its areas; and it has lacked funds to purchase the supplies, sustain the salaries and pay the overhead costs of the PHC system. Certainly altering the reward structure could encourage more local fund raising and cost-recovery, but it is not clear if even this could have covered all the costs of the nation-wide system chosen in 1988. It appears likely that some aspects of PHC need fundamental reconsideration: reduction in scope of coverage, increase in private-sector responsibility and use of its resources, restructuring the national finance system, adding requirements for local taxation and cost recovery, or a mix of these strategies and perhaps other alternatives as well. Short of such fundamental change, the resource shortfalls alone will probably mean the task will continue to exceed the organizational capacity.

E. Implications for Good Governance

Among other rationale, theorists of decentralization as an administrative reform strategy have argued that locating control of organizations closer to those served by those organizations will lead to: greater local, public involvement in programs; improved organizational responsiveness to local priorities and needs; speedier decisions; more innovation and learning by the system as a whole; improved organizational performance (as clients-consumers are closer to the organization's leadership); and more willingness to fund locally desired projects and programs. These are all key components of a good "governance" system. It is not at all clear from our research that these consequences occurred in Nigeria's PHC decentralization. However, this should not necessarily lead the policy-makers to reject decentralization reforms as a tool of improving governance, but perhaps to attempt to learn

more about what is required for them to succeed. To this goal, several areas appear critical in understanding PHC's governance problems:

- a viable local political process must exist, including informed and active constituents who are interested and place a value on the service concerned, and stable local political competition which develops a cadre of local political leadership;
- significant local funding must be required (taxes, cost recovery) in order to insulate the program from externally based disruptions, to lead citizens and officials to take seriously the funds they spend, and to encourage citizens and officials to set some of their own priorities (because they can fund them);
- local control over some program choices and organizational features must exist to encourage citizens and officials to invest time and resources in assessing and directing programs and to allow for local flexibility;
- local organizations should be designed to meet more clearly supervisory tasks and responsibilities, and to be flexible enough to take into account the varied natural demographic, social and cultural environments in which they operate;
- mandated responsibilities must be reasonably proportioned to resources;
- local organizations must be clearly "nested" in a stable broader organizational context which has defined responsibilities in enforcing mandates, quality control and bureaucratic operations at the local-level, and which encourage learning from field experience, and adaptation and change in response to that learning (i.e., clearer inter-governmental systems including feedback loops and mechanisms for organizational change);
- the personnel systems must provide appropriate tools and remuneration for the tasks at hand.

These suggestions, in turn, imply attention to several policy issues for the government of Nigeria. It is to these that this report now turns.

VI. PHC, GOOD GOVERNANCE, AND RELATED POLICY ISSUES

This report's analysis began with a review of observable problems in PHC operations in the field. Then it explored what circumstances seemed to underlie and cause these problems. Finally it suggested that the impact of these problems on PHC could be summarized by several factors: accountability, reward structures, low organizational and managerial capacity, and resource-organization misfit. Now the report will turn to nine policy areas which, once addressed, might help resolve these problems. It is important to emphasize here that these are policy issues regarding the organization of PHC and local governance in general, and require far more than the upgrading of existing personnel (i.e., via training) if their concerns are to be met.

A. Funding

The current system has provided inadequate resources for PHC. While the federal disbursements are substantial, they are inadequate for several reasons: (1) they must be divided among several program areas where demand is virtually inexhaustible; (2) the instability of the Nigerian economy means that the purchasing power of the grant is not reliable nor do supplemental allocations respond to changed circumstances in a predictable and dependable way; (3) they are simply too small for the scale of activities envisioned in the PHC policy. The federal allocation, furthermore, has been inadequate because it is quite likely it has worked to suppress raising local revenues for health programs. Specifically, with substantial money flowing into the system without local effort it has proven politically difficult to get local leaders and populations to exert themselves, either by taxes or systems of cost recovery. Additionally it is arguable that in the current system the Naira which come from the center are not seen as "local" funds and therefore are spent with reduced attention to efficiency, effectiveness, or honesty.

While these are problems which plague all LGA sectors, education and primary health care seem particularly hard hit. This may be because these sectors require large allocations and serve generally poor and politically un-connected people. Also, as many respondents suggested, as salary-intensive sectors they provide less opportunity for lucrative contracts than public works-related activities, such as transport. Indeed, in response to these problems and pressure from the well-organized teachers unions, the federal government recently (1993) re-federalized all local education activities.

Several changes in policy might be considered to remedy these problems. These include: (1) requirements for expanded local cost recovery in PHC operations; (2) requirements to expand the proportion of LGA budgets raised from local taxes and fees; (3) requirements for local matching funds to receive federal grants; (4) requirements of base percentages of the federal disbursement to be spent on PHC by the LGAs.

- (1) **Local Cost Recovery:** While many PHC activities (sanitation, survey work) incur costs which are not recoverable by the very nature of the activity, and some are recoverable but because of the need for and value of maximum coverage (childhood immunizations, education) may not be good candidates for recovery, cost recovery in many services is feasible and justifiable. These include fees for visits to clinics for personal care and costs for medications and supplies (bandages, etc.). Even vaccinations could be included on an ability-to-pay basis.

While there are no national requirements for cost recovery, several LGAs have undertaken it with excellent results (i.e., Drug Revolving Funds). Rather than depleting stocks which cannot be replaced until a new budget year (if then) and leaving facilities and local residents without services, cost recovery in these areas has meant supplies, morale and public confidence were far better. Facilities in areas with effective cost recovery were cleaner, better equipped and better staffed. To pursue cost recovery successfully, PHC/LGAs must solve problems of pricing (subsidized prices lead to supply flow out-the-door and into the market for resale and may not allow for replacement of expended medications and supplies), identification of and provision for indigents, and of security of PHC resources (from LGA pressures to co-mingle PHC funds with LGA accounts, and spend them on non-PHC activities).

Currently, while there are no national prohibitions to cost recovery efforts, it is not particularly encouraged either. There are no national rewards for it, no national effort to support it, and no federally or state-based pilot efforts. The "Bamako Initiative" programs, quite limited in scale and scope, are the only externally supported efforts in this area. The fact that several LGAs have undertaken "Drug Revolving Funds" programs in spite of this weak support shows this avenue has promise.

- (2) **Requirements for Expanded LGA Taxes/Fees:** The LGA will never become a responsible political entity nor one able to address local needs until it raises a significant amount of its own revenue. Given current budgets and needs, we would suggest this should be phased in over several years, perhaps 10-20% of the LGA budget in year one, leading to a full 50% or more over 5-6 years. Local residents will be unlikely to pay the LGA much attention until it is spending their money; dependence on federal funds alone will leave LGAs well short of the resources necessary to develop local areas and programs, and will make LGAs vulnerable to externally based disruptions.

LGAs are authorized to raise revenue from numerous sources. These include:

- (1) Proceeds from public utilities or services provided by the local government (e.g., water supply, motor parks, butcher facilities, transportation, market fees, other user fees);
- (2) Income received from hired equipment, leasing of LGA property;
- (3) Earnings from commercial undertakings;
- (4) Local government fees and rates (e.g., such activities as licenses and permits to sell food, operate vehicles, operate retail stalls, etc.);
- (5) Interest and dividends from government accounts;
- (6) Local personal and property rates (taxes): community tax, poll tax, property and tenement rates, livestock (per-head) taxes. As noted earlier in this report, these sources have been largely untapped.

The key question then becomes how to persuade LGAs to do this. Simple "requirements" are likely to be ignored and probably unenforceable. This fact brings us to policy issue #3.

- (3) ***Local Matching Requirements for Federal Grants:*** Probably the only way to induce increased local fund raising is via an incentive system tied to the federal grants. This could be arranged a number of ways: 1:1 matching of the entire federal allocation; a non-contingent federal base grant, then supplementary moneys released on a matching basis; different matching ratios keyed to an LGA development/wealth index, etc. The goal could be reached in a variety of ways, as long as the principle of incentive/matching funds was observed. To work, this would probably have to be done with the entire LGA budget; were it only required of PHC, LGAs would be tempted to simply cut funds allocated to PHC.
- (4) ***Required Base Percentage of LGA Budget Allocated to PHC:*** PHC, while offering many benefits to local development, and helping strengthen the human resource base for Nigeria's overall development, competes with several programs which are supported by economically stronger constituencies: i.e. public works, transportation and agriculture. In the past, education had a special position with a mandatory floor allocation as a percentage of the overall LGA budget. Another strategy to strengthen the resource flow to PHC would be to introduce such a floor (perhaps 10-20%) for PHC. Research by the NPHCDA could establish the cost of a base PHC program, and adjust LGA

budgets accordingly. As above, this would probably not be enforceable as a simple regulation, unless it was somehow linked to the disbursement of the overall federal allocation to LGAs.

This suggestion raises the issue of "recentralization" of control in PHC. This report most emphatically rejects this, at least as a general approach to PHCs problems. However, this position still leaves much room for refining the collaborative and supportive roles of the various levels of government. Regarding this issue it is important to note that all mature federal systems are characterized by a mix of governmental roles in the various sectors. Some decisions are left to localities, others are controlled by regional bodies, and some by national bodies. Some have referred to the principle of "subsidiarity" to help determine what level should be in charge of which task: the lowest level which can effectively discharge a particular function should do it.

However, sometimes if the most local level is to operate effectively, frameworks need to be set by superior levels: frameworks of due process, peace and tranquility, standard accounting practices, clear property rights, scientifically based procedures, trained personnel, and the like. The experience of Nigeria suggests that local financial contributions need to be nested in such a framework, one that encourages local responsibility and financial effort to sustain local services. This does not negate the goal of decentralization: it is a prerequisite to achieving it. Experience in a given country and a given sector is probably the best teacher of what sort of frameworks are needed to encourage effective operations, and which functions should be lodged at which levels.

- (5) **General Needs:** For policies such as these to work a center with strengthened resources is needed. For example, localities would probably need help establishing local cost-recovery and taxation systems. The center would need greater capacity for technical assistance to assess budgetary and expenditure performance, and to assure commitments were being kept. The extent to which the federal government could do this (vis nearly 600 LGAs!) is not clear. Nor, however, is the current capacity and dependability of the states. Not incidentally, the states need to develop and raise more revenue from their own sources in order to fulfill their responsibilities as well. A strengthened role for the public might also be required. That issue will be discussed, below.

B. LGA and PHC Management and Budgeting Processes and Requirements

Throughout the LGAs, including the PHC departments, the team found ineffective to entirely absent systems and procedures in the areas of planning, programming, budgeting and evaluation. These caused critical problems for the governance concerns of efficiency,

accountability and transparency. These deficiencies need to be addressed at several levels, and with a variety of strategies. These include:

PHC Planning, Programming and Budgeting: Only one of the eleven LGAs we visited had developed a comprehensive health program based on research into local health needs and resources. None of the other LGAs had a systematic method to assess local health conditions, needs and resources. Nor had any developed an overall health plan or program. Several could articulate loose priorities, but they were not translated in any significant way into local programs (i.e., facility development or upgrading; personnel deployment or development, etc.). And PHC budgeting was, again except in one case, primarily a rolled-over line-item budget with a few wish lists appended.

It is unlikely LGA PHC programs will meet the expectations held by those who devolved responsibilities to them (i.e., more effective, efficient, flexible; locally oriented and responsive; able to raise local resources) until they begin learning more of their localities, take a proactive stance to setting and asserting local priorities, and develop goals and programs in which their personnel can feel ownership and which grow out of local needs. LGA level PHC personnel should be trained in these skills and should help NPHCDA develop model procedures and requirements to perform these activities on a regular, perhaps biannual, sequence. NPHCDA or the state MoHs should require submission of these plans, vet them, and tie grants to LGAs to their successful completion. Needless to say, NPHCDA or the states need to be upgraded so they can perform these functions. However, these activities will not change much at the LGAs unless the LGA's planning and budgeting process is also strengthened in general.

LGA Planning and Budgeting Process: There are many problems with the LGA planning and budgeting process. To begin with, there is no systematic and orderly process by which local needs are assessed, priorities are set, and general strategic decisions are made. Furthermore, budgeting is usually inaccurate, nearly always opaque, and generally appears to be arbitrary. It is not linked in any visible way to local needs nor does it grow out of much, if any, dialogue with the local professional personnel from the various departments much less with the public. As a result, budgets do not reflect any overall local development strategy, nor do they reflect the sectoral professionals' sense of local needs or ideas on how to address those needs.

The tendency of budgets also to be volatile during the operating year weakens the ability of sector professionals to plan and manage well even within the parameters the LGA does draw for them. Finally, LGA budgets appear to be apportioned among capital development, supplies, facility maintenance and personnel without any sense of balance among these components. Thus new facilities are built where unneeded, existing facilities erode because they are not maintained, workers sit idle for lack of supplies and equipment, and clients stop coming to facilities for lack of medications. In summary, a strengthened PHC planning-budgeting system will not lead to

improvement without a parallel strengthened LGA planning-budgeting system. These problems suggest several policy changes might be considered for LGA planning and budgeting:

- the states, working through the bureaus of local government, might return to an expanded role in reviewing LGA compliance with specified steps and procedures in the planning-budgeting process;
- the states working through the bureaus of local government, could establish (or join in consortia with other states to establish) training programs in planning and budgeting, along with field-extension personnel to support LGA personnel;
- LGA personnel might be required to establish:
 - (1) biannual local development need surveys and development plans;
 - (2) a role for local notables (voluntary association leaders, traditional leaders, benevolent association leaders, church leaders, etc.) in the planning process;
 - (3) a budgetary process which includes a defined role for sector professionals as well as requires specific budget proposals from them;
- states might review LGA actions for compliance with model procedures in these areas (perhaps guided by state targets and guidelines) which LGA leaders could be required to respond to as they prepare the final budget;
- LGA personnel might be required to prepare budgets in tighter time lines, with grant penalties if they fail to meet them;
- states/federal governments might establish base percentages which must be allocated to key sectors such as health, as well as models of resource apportionment within the various sectors (the latter subject to modification with good reason);
- auditing by state officers should be strengthened;
- federal grants might be held until LGA compliance is certified.

Federal Grant Process: LGA budgeting is hampered by uncertainty as to the size and timing of federal disbursements. LGA budgeting would benefit by clarifying these earlier, by dispensing as much as possible with supplementary and special grants, by

tightening requirements regarding local budgetary processes (as discussed above) and by tightening requirements for local matching funds to receive federal funds.

Strengthen the Resources and Roles of the Local Government Training Centers: Ife, Nsukka and Zaria each have and operate local government training centers. These, perhaps with donor support, can play an enormous role in supporting training, developing new procedures and routines tailored to local government, and supporting policy dialogue.

C. Linkage Among Government Levels

The current system has fallen short in virtually every aspect of inter-governmental linkage. Neither the federal nor the state governments have provided either technical assistance or quality control for the LGAs. The federal government has been ineffective in leading and supporting the states; it is itself divided by the confusion and competition between the federal MOH and the NPHCDA over which is responsible for what. At the states, the ministries of health and bureaus of local government are unclear as to which is responsible for what at the state levels, and occasionally are competing for "turf" at the LGAs. Finally, the LGA itself is unclear to whom (if anyone) it is accountable and for what. As discussed above, this situation has seriously eroded accountability and weakened organization and management of PHC. In so far as the various levels of government are important components of the reward structure, it has weakened it as well. Several policy questions should be addressed to begin resolving these weaknesses:

- (1) ***Clarified Responsibility Between the Federal Ministry of Health and the National Primary Health Care Development Agency:*** At a very general level, MOH and NPHCDA have defined roles: MOH is responsible for policy and general guidelines; NPHCDA is responsible for supervising their implementation. Yet in practice the leadership of neither institution is satisfied with the arrangement, and accuses the other of interfering in its activities. As well as wasted resources, this may in part explain the weak support the entire PHC system has had from the center and the general confusion as to the roles each lower level of government is to play.
- (2) ***Clarified Responsibilities and Authority for Quality Control at State and Federal Levels:*** It would be a mistake to return to a single, top-down administrative structure to cover as large, diverse and populous a country as Nigeria. Nor would it be wise, however, to expect local entities in a human services area as technically complex and with as many externalities as PHC to operate in isolation from one another and from a center. An effective but limited center is needed to assure scientifically established technical procedures and routines are done properly. It is needed to see that programs which require national implementation (such as contagious disease control) are performed. It is also needed to assure that public health measures with broad community

benefit are done at all! At this time, this function is rarely carried out in Nigeria's PHC system. A key policy issue is clarifying and facilitating what responsibilities and authority the states and national offices have regarding PHC at the LGAs. For example, it was clear from the team's research that quality control had deteriorated markedly at the LGAs, no doubt for a variety of reasons. Among those reasons was the absence of contact with externally based technical specialists, and the belief of many LGA personnel that the states had no authority over their programs.

As well as clarifying what technical assistance and quality control functions might be done by states (personnel observation and evaluation; program evaluation; in-service and extra-mural training; facility appraisal; community health audits, etc.), the personnel, logistical and financial prerequisites for these functions to be performed by the states also need to be analyzed and provided. Finally, someone must have authority to follow-up on weak areas at the LGAs. This might include authority to sanction, suspend or dismiss personnel; to require remedial training; to reduce in grade; to suspend funds; to redirect budgets, etc. It also should include access to resources to deploy to assist struggling or backward LGA-PHC programs. Given the distance between Lagos or even the four zones and the LGAs, this should probably be the state MoHs. A parallel and complementary policy issue is clarifying exactly what role the zonal offices ought to play, vis-a-vis the states and the LGAs. At present this is unclear and in fact varies from one zone to another.

- (3) ***Clarified Responsibility Between the State-Level Ministries of Health and Bureaus of Local Government:*** At present all states have a ministry of health and a bureau of local government. In many cases each is competing for a role at the local level. The absurdity which this can reach can be seen in several states where the bureau of local government is recruiting medical personnel to create a PHC office within it to compete for LGA turf with the MoH, which itself already has PHC personnel! In fact, each can play an important role. The state ministries of health have, as a rule, far greater familiarity with health issues, policies, personnel and administration; the bureaus of local government have greater knowledge of and authority over general LGA administration. Rather than competing to take over areas where the SMOH's have a presumable relative advantage, BLG's could contribute by focusing more on upgrading overall LGA administration, and facilitating SMOH contact with and access to LGA personnel. In any case, these two organizations have different strengths, and ought to work in support of, rather than in competition with each other. A related issue is clarifying the overall authority the BLG's have vis-a-vis the LGAs. While it would be a serious and retrogressive step to have the BLGs "take over" the LGAs, they could play a positive role assessing LGA compliance with clarified common procedures and policies, and providing technical assistance and quality control.

- (4) ***Clarified Role for the Federal Ministry of State and Local Government:*** Under a decentralized-devolved system such as Nigeria's the federal ministry of local government appears as a bit of an anachronism. No longer does it routinely intervene in LGA personnel, programmatic or fiscal affairs. Thus the question is raised: should it exist at all? If so, what role should it play?

It would be a mistake, the authors of this report believe, to abolish it. It would be a more serious mistake to restore it to its old role, dominating the LGAs. However, LGAs and states need a good deal of technical assistance in upgrading their abilities to do their jobs. Technical assistance in local taxation and financial management, personnel development, program planning and evaluation, etc., are all needed. Critically needed is research on policy questions such as those discussed in this report. Finally, in so far as federal demands regarding local revenue and local matching funds grow, a central capacity to evaluate compliance will also be needed. Thus, the federal ministry is important, though exactly what its responsibilities should be calls for further thought. Should it be found inadequate to the task, these functions might be lodged in the office of the Vice President or the Chief of General Staff.

- (5) ***Expand Resources for States:*** State governments lack sufficient resources at present to take on these substantial inter-governmental responsibilities. As federal grants will probably not grow much, state tax revenues need to be developed accordingly.
- (6) ***Revitalize the State "Councils of Health":*** An important venue to communicate about health conditions and needs was the state "councils of health." These were more-or-less active among the various states. When they met they strengthened personal and institutional ties between states and LGAs, increased awareness of varying approaches among the LGAs, brought pressure to bear on non-supportive LGA governments, and clarified the state role in PHC. These ought to be revitalized.
- (7) ***Overview:*** Good governance is not a monopoly of any level of government, be it local, regional or national. If one understands "governance" to be produced by a series of actions taken by individuals facing limits of time, energy and information, along with scarcity of skills and other resources, the challenge for the organizational reformer is to locate various tasks where the best mix of resources and skills exist to perform them. Thus, local people can probably best assess their unique needs, and determine the best mix of personnel, supplies and programs to meet them. Local people can probably also best appraise personnel performance and decide what to do about it. But national personnel can probably best provide a base of scientific-technical training, and

see and develop the synergy and linkage among local efforts to solve nation-wide programs.

Similarly, all personnel work in response to incentives established by policies and institutions. Often, the incentive structure local people would construct vis-a-vis their responsibilities might work to encourage poorer performance (i.e., in finance they would pass costs on to others; in supervision they might impose less demanding expectations on themselves). In these circumstances, persons responsible/accountable to other levels of government may need to play a role in establishing policy-institutional frameworks for localities that encourage actions (i.e., raising more local finance; holding to higher technical standards) that produce more effective operations. The same logic applies to frameworks at superior levels of government: local people may need to establish those to prevent their superiors from pursuing their interests at the expense of others! A federal system with strong but appropriate and limited roles for all levels of government and links among those levels is ideally suited to this challenge.

D. Personnel and Supervision

Two related and critical problems for PHC are basic personnel skill-training levels and the supervision system. First, and as discussed above, personnel are working beyond their training in general, and managerial personnel are seriously deficient in particular in organizational and managerial preparation. Second, also as discussed above, very little hands-on supervision occurs in the PHC system. Superior-service-deliverer contact is sporadic and limited, and clinical observation or supervision virtually never occur. Furthermore, there is for the most part no consolidated or systematic approach to personnel evaluation and development in use by PHC field personnel. As a result, PHC headquarters usually appear distant from their field personnel. Also, the state-local civil service system is possibly a confusing mix. While all personnel are paid from the LGA budget, subordinate PHC personnel are employed by and responsible to the LGA, but senior PHC personnel are still employed by, responsible to and assigned/transferred by the state civil service commissions. To remedy these problems, several policy issues need to be confronted:

- (1) ***Clinical and Supervisory Skills and Incentives Need to be Strengthened at LGA PHC:*** The system has grown very rapidly, and the priority appears to have been placed on staffing-up PHC. However, the evidence of the team's research is quite clear. Until clinical and supervisory skills and performance are upgraded, the system will fail to perform effectively. This requires three things:
 - basic and in-service clinical training needs to be expanded and upgraded;

- comprehensive training in organizational and managerial skills needs to be introduced for appropriate personnel;
- salaries and other perquisites of employment need to be improved to get and retain skilled employees, and protect them from inflationary erosion;
- supervision must be measured and rewarded in the personnel system.

- (2) ***An Effective Supervision-Management System Needs to be Developed and Established at the LGAs:*** In most LGAs the current system does not clearly define a chain of supervision from service deliverer to PHC coordinator. Service deliverers are responsible to a facility head who is responsible both to the several assistant PHC coordinators, and to the PHC coordinator. But because the assistant coordinators are partially responsible (i.e., regarding their own functional area) for all PHC field personnel throughout the LGA, the responsibility is blurred. Finally, while the PHC coordinator is ultimately responsible for all personnel, the large number of personnel involved plus the burden of managing the headquarters, means that he/she cannot be an effective supervisor of the field personnel.

The team believes that a geographic focus would strengthen supervision. Each LGA should be subdivided into districts which correspond to historical communities. Each district should have a supervisor who is responsible for all health program in his/her area, and reports directly to the PHC coordinator. The assistant PHC coordinators (i.e., functional specialists) would be responsible for their headquarter's responsibilities and for providing technical assistance and quality control in the several districts. District supervisors would live in the districts and chair a district level health planning and management team with their facility heads. Their civil service grade, rank and salary, should be comparable to an assistant coordinator, and they should be a priority group for organization and managerial training. Each should have his/her own transportation (motor-scooter or motorcycle) and imprest funds account.

- (3) ***Effective Personnel Evaluation and Development Systems Should be Used and Developed Where Needed:*** Currently personnel evaluation and development is essentially non-existent. At best it is haphazard. Few if any personnel performance records could be found at any of the PHC headquarters, and in only two of the eleven LGAs visited were there some form of personnel roster listing skills, duties, deployment and the like. Nowhere was there a personnel development plan, nor had any LGA undergone a personnel audit exercise to evaluate their resources and their deployment. Where the current

Nigerian performance evaluation system (APER) is inappropriate for PHC needs, it might be revised.

Model systems of personnel audit and development should be developed by a team of LGA supervisors and persons experienced in such tasks. Such systems need to fit LGA resource realities, but nonetheless strengthen personnel management. These routines and procedures must be required and followed-up by federal, zonal and/or state officers.

- (4) ***Resources for Supplies, Medications and Facility Upkeep Must be Expanded:*** Morale in the field among PHC personnel is not good. That is partially because they lack the tools to do their jobs. If skills, supervision, personnel development are all upgraded without a proportionate increase in tools to do the jobs, it is unlikely much improvement will last. Among other things, PHC personnel do not feel their work is particularly valued, as reflected by the miserable physical facilities and inadequate supplies they work with. To ask more of them without making it possible for them to do more would be paradoxical. Resources for these goods must be expanded, as well as systems to assure they are actually spent on health care. Specific recommendations pertinent to this are covered in section V-A, above, on funding.
- (5) ***Clarity of Control and Responsibility for Personnel Needs to be Improved:*** PHC leadership needs clearer authority to manage, deploy, reassign, hire, dismiss, etc., its subordinate personnel. The relationship between the LGA leadership, the state civil service commissions, and senior PHC personnel also needs to be clarified: what authority have LGA personnel over senior PHC personnel, what prerogatives have the state civil service commissions, (i.e., Local Government Service Commissions-LGSC), and what are the civil service rights of senior PHC personnel? LGSC personnel might focus more on setting standards, general operating conditions, and filling an appellate role, and leave the LGAs to handle day-to-day personnel responsibilities. LGA political authorities must have clear authority over their senior staff, but PHC leaders need recognition of their professional status, technical expertise, responsibility to national programs, and control over the junior staff. Further consideration of these issues is needed.

E. Public Participation

As this report has argued, the absence of viable and visible public participation has weakened PHC in several ways: it has lacked a clientele to support it in the scramble for LGA budgets; it has been less knowledgeable than it might have been regarding local needs and priorities; and poor supplies, poor performances and poor facilities have been more tolerated than they might have been, given ineffective public involvement in health planning and management.

The existence of mobilized, informed and effective local publics would obviate the need for many oversight functions by state MoHs, and the bureaucratic complications they may entail. This situation has many roots well outside the short-term policy spheres of any government, including low levels of education, weak LGA-wide organizations, cynicism and apathy toward government, and the like. None the less, several policies might be pursued as a beginning effort in improving this situation.

- (1) ***Strengthen the PHC Committee System by Expanding its Authority in Health Planning and Management:*** PHC committees are weakened by their lack of responsibility and authority. Committees could play a formal role in developing both long-term and annual health plans: for the LGAs as a whole at the level of the LGA committee; and at the districts, vis-a-vis revitalized district PHC leadership in a geographic/district focused management/supervision system (see above, V-D). LGA health committees could help set priorities, suggest, comment on and approve programs, and participate in the PHC budgetary process. District health committee could do the same regarding district plans, programs and budgets. For this to occur there must be a vitalization of health planning and budgeting within the overall LGA process (see above, V-B) and the allocation of genuine authority to the health committees to approve plans, programs and budgets before they go to the LGA.

Furthermore, committees could play a role in evaluating personnel and facilities. While their input should be only one of several criteria for PHC management staff, they can have valuable input on certain areas the supervisors are not always able to see, particularly in the area of human relations, availability during and outside of conventional hours, openness to community concerns and input, and the like. Each of these changes would increase the role and importance of the committees.

- (2) ***Strengthen Representation of Organized Elements within the LGAs on Health Committees:*** Some LGA committees already include local community leaders, by default or design. This should be expanded. LGAs, it must be remembered, are usually administrative entities rather than natural or social communities. Within them are numerous natural communities, both historical-traditional, and contemporary (i.e., occupation, benevolent, religious). The ties between the leaders of these natural communities and their members are far stronger than those between the populace and leaders elected by them at some arbitrary level. LGA, district and ward/village committees should include these natural leaders, whether ex officio, or by some sort of corporate representational system. Representatives of private medical providers should also serve on this body to help avoid duplication and overlap, and to strengthen cooperation between the two sectors.

- (3) ***States Need to Oversee Committee Activities:*** One area of performance oversight by the states should be committee activity. States should review committee rosters; records of committee meetings; committee comments on plans, programs and budgets; committee inputs on personnel and facilities, and the like. They should assist LGAs which need help strengthening committees, and sanction PHC programs which do not work with committees. The latter could include personnel evaluations, denial of grants or incentive funds, and the like.

- (4) ***Strengthen the Role of Informal Institutions of Governance in Nigeria:*** Thought should be given to strengthening the role of the informal political institutions and leaders of Nigeria. For instance, one might modify selection of LGA counsellors. Few people believe the recent, general LGA electoral system worked well. While democratic principles should continue to be observed, there are other ways they can be implemented. Traditional/historical communities can be emphasized as constituencies, viable corporate groups can be used as constituencies, certain persons can sit ex officio, and the like. These and other alternatives, which might strengthen the ties between councillor and citizen, expand participation, and lead to more accountable government, should be explored.

- (5) ***Strengthen the Health Role Played by Local Organized Groups such as Women's, Market and Benevolent Associations:*** Education, surveying, supporting special vaccination campaigns, "well-baby" campaigns and the like can be supported by local organizations. Expanding their role has three benefits: it extends the programmatic reach of PHC; it expands education and awareness of health; and it helps to develop constituencies attentive to and supportive of health programs. State supervision can be used to support and encourage these programs.

F. Monitoring

It was clear to the research team that a high priority has been placed on gathering basic health data through the PHC system. There are ample good reasons to gather such data. However, it was not clear to the team that either reliable data as a rule were being gathered, or that the amount of resources expended in training for, gathering and processing these data was cost-effective given the many critical and substantial needs of the system currently not being met. Specifically, genuine supervision (as discussed above) is simply not being done. Personnel development is inadequate. Finally, facilities lack medications and supplies, and the whole system is starved for leadership in the field. An important policy issue, the team believes, is analyzing the need for and use made of the data currently gathered in the field. These questions should include:

- can the amount of data gathered be reduced and still be effective in supporting critical needs?
- are there other methods, less personnel and transport intensive, by which local health conditions can be monitored?
- can the collection of such data as is necessary be combined with management and clinical supervision activities?
- can data be gathered in a way which makes it more useful for local management information tasks (i.e., personnel and facility appraisal) as well as epidemiological monitoring?
- can data be gathered and analyzed in ways that lead to its rapid return in an analytically useful format to LGAs and their monitoring agencies (i.e., state MoHs and zonal offices);
- can data gathering be tied to a regular process of LGA problem-identification, program development, and budgeting?

The team found ample evidence that unreliable and invalid data was being reported, and little evidence that LGAs were using the data to improve their performance. A new system is needed to solve these problems. By solving the second problem (i.e., local usefulness) the first problem (i.e., validity and reliability) may also be improved.

G. Control over PHC Resources by PHC

Many PHC personnel reported difficulty in maintaining control over funds, facilities and equipment designated for PHC use, whether by the LGA government, donor grants, or grants and allotments from the state and federal governments. Circular funds for drugs and other supplies, fuel funds, vehicles and generators were particular problems. It is unrealistic to expect PHC ever to plan and manage effectively unless it can control its resources. Nor is it realistic to expect PHC or its clients to support and maintain circular-cost recovery systems unless they can effectively protect those funds from capture by non-PHC interests.

These problems develop from a number of circumstances:

- (1) rules establishing clear PHC control over its property are ambiguous and lack any effective enforcement mechanism (i.e., state or federal MoH involvement; state BLG support);
- (2) funds for LGAs tend to be kept in a single account, and post-auditing to assure budget compliance is weak;

- (3) multiple-signatory requirements are not always met for release of funds; similarly funds allocated to PHC are sometimes not released because non-PHC signatories will not sign to release them;
- (4) other LGA officials use their control over key resources for PHC to force PHC personnel to allow unauthorized use of other PHC resources;
- (5) the overall harsh economy and resource shortfall leads to an intense scramble for personal use of whatever is available.

Until "attentive publics" are concerned about health care, and/or health workers are better organized, it is unlikely PHC will be able to protect its resources without external support and supervision. This implies a need for clarified legal provisions and a strengthened role for the state ministries of health, state bureaus of local government, and state auditors to assure PHC property is not misused. Model procedures to establish and operate circular funds would also be helpful, including clarifying the role of the PHC coordinator as primary signatory to their release.

H. Strengthening Leadership Cadres at All Levels

The complexity of managing a PHC system, which tries to reach poor and uneducated people across vast distances with poor infrastructure; the difficulty of leveraging resources without strong publics to support policy makers; the challenge of leading over-taxed (and/often undertrained) personnel who lack resources to do their jobs properly; the difficulty of competing for funds with other, often more politically "connected" personnel; the problems associated with the highly centralized finance system; and the challenge of trying to link three complimentary and interdependent levels of government into an effective PHC program all combine to call for exemplary leadership at all three levels: federal, state, and LGA. Such leadership must be developed and redeveloped, encouraged and retained. The status, perquisites, salary, civil service protection, education opportunities and career lines of such personnel need to be carefully assessed and improved whenever possible. It is these personnel who will make the PHC policy and system work if it is to have any chance of long-term success.

I. Allowing for Structural-Institutional Variations Among Local Government Authorities; Developing New Local Governance Instruments

The current local government system in Nigeria does not allow sufficient flexibility for the immense diversity (cultural, regional, geographic, demographic) which exists across the vast country. A single, model LGA system is required of all areas: from the metropolis of Lagos, to the densely populated rural localities and industrial areas of the southeast, to sparsely populated and poor areas of the north, to the mixed, small town-rural areas of the southwest, and the many other demographic variations found in this large country. Similarly, there are quite varied cultural patterns which include ethnically mixed and homogenous areas

as well as areas with radically different and still influential traditional polities. Currently, all must fit under a single LGA model.

Several alternatives might be considered in increasing the institutional flexibility of local government:

- (1) metropolitan, large urban, town, and rural areas might have different institutional options to reflect their radically different needs, problems and resources;
- (2) commercial, agricultural and industrial areas might have different institutional options to reflect their different needs and problems;
- (3) functional needs (i.e., transportation and port needs, pollution abatement, industrial development, flood control, etc) when present, might have special institutions that can cross-cut existing LGA or other general purpose local government units, to authorize, manage and regulate these activities;
- (4) people of different cultural heritages might have the opportunity to define and/or choose local government units which reflect decision making procedures they are familiar with and see as legitimate; special arrangements need to be made for areas with multi-ethnic populations; and
- (5) natural, historical communities, which usually exist within (i.e., beneath) the current LGA system, might be involved in a serious way in local governance (i.e., as independent, incorporated governance entities under established charter provisions).

To address these needs, several policy changes should be explored which will increase the variety of local governance instruments available to Nigerians. This should be explored in a national conference on local governance, including academics, local government practitioners, traditional political leaders, community leaders, international experts on local government, and the like. Ideas to review might include such changes as:

- (1) Develop a system of local government "charters" which correspond to the major categories (size and density) of settlements, from metropolitan, to major urban, to minor urban, to town, and to village. Institutional form, tax and revenue authority, ordinance authority, service responsibility, etc., could be varied to fit the circumstances of each category.
- (2) Allow for several institutional configurations in each category (i.e., strong executive, weak executive; large council, small council; elected chief executive, professional administrator, etc.), and allow citizens of an area to select which one they prefer by ballot.

- (3) Establish broad charter frameworks, but allow for "home rule" where local dwellers can develop their own charters within the framework and vote it into existence (i.e., "bottom-up" rather than "top-down" institutional development);
- (4) Retain something similar to LGAs across rural areas as a "baseline" of government, but allow rural and other areas within LGAs to incorporate upon local public consent (ballot or alternate acceptable mechanisms) and take on most LGA functions under an established charter framework;
- (5) Allow states the right to design alternate charters to customize local governments to fit their historical experience;
- (6) In selected functional areas, allow people or jurisdictions the right to design and vote-in special authorities to provide for special, shared needs;
- (7) Establish federal agencies with the authority to protect minority rights at the local levels; and
- (8) Develop bodies of law establishing rights and duties among these governmental units and establish independent entities (courts) to interpret and apply these rules.

The irony of Nigeria's LGA system is that it is both too "small" and too "large." It is too small a framework for metropolitan and large urban areas; too large a framework for the natural, historical communities that exist almost everywhere in Nigeria, but particularly in rural, village and smaller urban areas. New local government options need to be established, both for larger and more populous areas and for smaller ones. The LGA may have a future as a provider of base-line government in unincorporated areas, as an agent to perform state or federally mandated activities, to keep records in such areas as birth, death, epidemiology, revenue, and perhaps as a base for judicial functions. But most service delivery activities will work better if managed at demographic and/or social community levels, ones which rarely correspond to the LGAs.

A final, strategic point should be made regarding this policy area. Nigeria has historically developed its institutions on a strictly "top-down" basis, and usually via decrees from only the executive branch of government. This has presented several problems for good governance at the local level:

- (1) single, model systems are established for the entire, diverse nation;
- (2) local learning and experience has no way to participate in or contribute to the systems as they are chosen and established;

- (3) there are no structures by which localities can change their systems as they discover institutional flaws, and develop alternate improved and informed methods of performing local tasks; and,
- (4) there is no role for the informal institutions and leaders which often exist as parallel and trusted agents of governance at the most local level, either in selecting systems of local governance or in their operation.

For local governance to fit the varied conditions of Nigeria, to adapt and learn from local experience and to include the people and their historical leaders in its affairs, the "top-down" institutional development system must be replaced. Instead, procedures and processes which allow Nigeria's people the right and ability to select and develop their own mechanisms of local governance must be developed and put in place. The ideas suggested in this section are offered to this end. Discussion and thinking about additional ideas is needed.

VII. SUMMARY AND CONCLUSIONS

Primary health care has made great strides in Nigeria. Nothing in this report should be seen as qualifying those achievements. A radical change in health policy has been made which has gone a good distance to bringing health services to Nigeria's poor (and often rural) majority for the first time in its history. Personnel and budgets have been redeployed from the major cities and from largely curative medicine into the smaller towns, villages and rural areas. Major campaigns have been launched to vaccinate children, provide maternal and infant care, strengthen education and sanitation, and bring basic care to the grassroots. New facilities have been built, supervisory structures established at the regional level, and a national agency dedicated to primary health care has been put in place. Much indeed has been accomplished.

Nonetheless, much remains to be done. Overall, the various parts are not working well as a system. Personnel, supplies and facilities are not always deployed where they are needed, training is uneven, supervision and quality control are often lax to non-existent, programs are not well articulated to local needs, resources are terribly short, and the quality of care delivered to the client is often unreliable. In summary, a strategy with great potential has been put in place, but that potential has so far not yet been reached.

Using the "governance" framework as a guide and agenda of research, a team of researchers (three Nigerians and one American), assessed and analyzed PHC's field performance and problems. The team concluded there were severe shortfalls in three key governance areas. These were:

- organizational and managerial efficiency;
- accountability; and
- transparency.

Needs for improvement were also found in the governance areas of:

- policy pluralism; and
- responsiveness.

Analyzing the PHC system further, the team concluded that these "governance" problems were caused by a number of environmental, organizational and policy patterns characteristic of Nigeria in general and of PHC and local government in particular. These included:

- resource shortages throughout the Nigerian economy;
- a harsh and demanding natural environment on equipment and personnel;

- absence of informed or mobilized publics in the health care area;
- instability in the national institutional, political and policy environments;
- instability in the local institutional, political and policy environments;
- the size and diversity of Nigeria juxtaposed to its resources in communications and transportation;
- dissension in PHC at the LGA level;
- the speed of construction and expansion of the PHC and LGA systems;
- weak leadership (below the top levels) in PHC;
- little local funding of PHC, and a national revenue system which discourages local funding; and
- donor preemption of much leadership and initiative in the PHC system.

Overall these eleven circumstances worked together to institutionalize four broad strategic problems for good governance in PHC:

- weak accountability;
- poor reward systems;
- weak personnel and organizational capabilities; and
- misfit between organization, organizational responsibilities and tasks.

The team believes these problems are remediable. In another report the team presented recommendations for a program of workshops, training, and extension-field support to help strengthen LGA and PHC personnel. In this report the team has suggested a number of policy areas which need to be addressed by Nigerians in order to resolve the institutional and contextual problems which have hindered effective PHC. These include:

- finance and revenue options and requirements;
- organizational and managerial procedures and systems;
- inter-governmental relations and linkages;
- personnel systems and supervision;

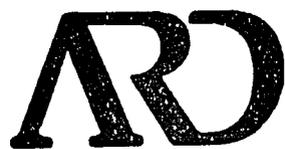
- public participation;
- monitoring;
- control over PHC resources by PHC;
- strength and ability of PHC leadership cadres at all levels;
- institutional flexibility and choice in the design of local government.

When the team was able to achieve consensus on the scope and nature of the problem and where the policy sciences offer fairly clear instruction on options and consequences, the team has attempted to offer specific recommendations. Where these requisites could not be reached the team has offered alternative options including at times a recommendation for further study of this issue by Nigeria's people.

In conclusion the team wishes to reaffirm its strong conviction that primary health care and decentralization are not only appropriate for Nigeria's goals of basic health care for all, they are the optimal strategies if it is to be achieved. Nonetheless, all revolutionary reforms, which this is, require sustained attention, follow-through and fine-tuning to reach their potential. It is to support the people and governments of Nigeria in these tasks that this report is offered.

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Associates in Rural Development, Inc.

Principal Offices:

110 Main Street, Fourth Floor
P.O. Box 1397

Burlington, VT 05402 USA

Telephone 802 658 3890 Telex 957032 FAX 802 658 4247

Washington, D.C. Offices:

ARD, Inc.

1915 I Atreet, N.W., Sixth Floor

Washington, D.C. 20006 USA

Telephone 202 223 2533 FAX 202 223 2540

