LOCAL GOVERNMENT CAPACITY IN MANAGING THE EDUCATION AND HEALTH RELATED MILLENNIUM DEVELOPMENT GOALS PROGRAMMES IN KADUNA AND ZAMFARA STATES, NIGERIA

BY

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A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFULMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DOCTOR OF PHILOSOPHY (Ph.D) IN LOCAL GOVERNMENT AND DEVELOPMENT STUDIES

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JUNE, 2015

DECLARATION

I hereby declare that this dissertation entitled **"Local Government Capacity in Managing the Education and Health Related Millennium Development Goals Programmes in Kaduna and Zamfara States, Nigeria"** has been written and presented by me in the Department of Local Government and Development Studies under the supervision of Dr Usman Abubakar, Dr Bello Ohiani and Dr. Hamza Yusuf. All sources consulted have been duly acknowledged in the text and the list of references provided. No part of this dissertation has been presented in any previous application for a higher degree in any university or higher institution of learning.

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CERTIFICATION

This is to certify that this dissertation entitled **"Local Government Capacity in Managing the Education and Health Related Millennium Development Goals Programmes in Kaduna and Zamfara States, Nigeria"** by MOHAMMED Dalhatu Jumare meets the regulations governing the award of the Degree of Doctor of Philosophy (Ph.D) in Local Government and Development Studies of Ahmadu Bello University, Zaria and is hereby accepted and approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to the poor, hungry and oppressed people at the Grassroots level of Nigeria, who have been, or are presently, suffering from the ineffectiveness and poor performance of the Local Government institutions. Also the dissertation is dedicated to my loving father late Dr. Mohammed Abubakar Jumare (Sardaunan Zazzau) for his fatherly love, support and guidance that form the moving spirit behind this programme.

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ABSTRACT

This study examines the capacity of the Local Governments in managing the education and health related Millennium Development Goals (MDGs) programmes in selected Local Governments in Kaduna and Zamfara States. The federal government has sunk in enormous

resources and effort to strengthen states and local government's capacities in managing the MDGs programme yet there is a wide gap between the performance of the local government and the attainment of the MDGs targets in education and health. Four hypotheses are formulated thus; the MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education; the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in education; the MDGs intervention effort in health has no significant impact on the capacity of the local government to manage primary health care and finally, the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in health.. The multi stage sampling technique was used to draw our sampled size. Interviews, questionnaire and observation techniques were also employed to generate our primary data and to complement that the secondary data were sourced and extensively used. The model (framework) for service delivery developed by Soucat, Agnes and Manju Rani (2003) whose focus is on relationship of accountability for service delivery was used as a theoretical framework for this study. The study found out that those MDGs intervention efforts have not significantly impacted on Local Government's capacities in providing education and health care services and thus the local government capacity significantly undermined the attainment of the MDGs targets in education and health. The study therefore recommends that the MDGs intervention funds should be made sufficient and emphasis should be given to infrastructural, human, managerial skills and competence of the LGEA AND PHC managers and staff.

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LIST OF ABBREVIATION

ANC Antenatal Care

CBOs Community Based Organizations

CGS Conditional Grant Scheme

CHEW Community Health Extension Worker

CHO Community Health Officer

CORPS Community Resources Persons

DHC District Health Committee

DRF Debt Relief Funds

DV Dependent Variable

ECA Economic Commission of Africa

ECCDE Early Childhood Care Development Education

ESP Education Sector Project

ESSPIN Education Special Sector Project in Nigeria

FRN Federal Republic of Nigeria

GDP Gross National Product

GNI Gross National Income

HIPC Heavily Indebted Poor Countries

IGR Inter Governmental Relations

IV Independent Variable

JCHEW Junior Community Health Extension Worker

KEPA Kaduna Environmental Protection Agency

KSUBEB Kaduna State Universal Basic Education Board

LGA Local Government Area

LGEA Local Government Education Authority

LGSC Local Government Service Commission

M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDRI	Multilateral Dept Relief Initiative
NCE	National Certificate in Education
NEEDS	National Economic Empowerment Development Strategy
NGOs	Non - Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
ODA	Official Development Aid
ORT	Oral Dehydration Therapy
OSSAP	Office of the Senior Special Adviser/Assistant to the President
PHC	Primary Health Care
PTA	Parent Teachers Association
SBMC	School Based Management Committee
SEEDS	State Economic Empowerment Development Strategy
SUBEB	State Universal Basic Education Board
SPHCDA	State Primary Health Care Development Agency
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TRCN	Teachers Registration Council of Nigeria
UBE	Universal Basic Education
UBEC	Universal Basic Education Commission
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organisation
USAID	United States Agency for International Development
VHW	Village Health Workers

WHO	World Health Organization
WMHCP	Ward Minimum Health Care Package
ZSUBEB	Zamfara State Universal Basic Education Board

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

There is a growing expectation for increased access to Basic Education and better health care services the world over. Indeed, people demand more and better services for their education and health care systems. These increasing demands for better education and health care services call for concern among policy makers at various levels, particularly at the local level where the bulk of the people live. Thus, the need to scale-up the performance of the education and health care systems become paramount, so as to match the growing expectations of the people.

It is in view of these growing demands for increased access to basic education and better health care services that the United Nations (UN) General Assembly called for the Millennium Declaration that resulted in the birth of the Millennium Development Goals (MDGs). The Declaration was signed in September, 2000 by 189 member nations at UN headquarters, including Nigeria. The MDGs is an eight- goal time bound programme, with 21 targets and over 60 measurable indicators that are supposed to be met by the year 2015 (UN, 2006). Specifically, five of the goals are targeted at education and health related issues. They are; achieving Universal Basic Education (UBE), eliminating gender disparities in education at all levels, reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases. The rest of the goals are development related; eradication of extreme poverty and hunger, ensuring environmental sustainability, and finally developing global partnership for development (UN, 2006).

The Local Government being a government at the grassroots level which is closest to the local people is expected to enhance the achievement of basic, protective and infrastructural service delivery better than the central government. A national public opinion survey (Lewis, 2000) shows that citizen rating of government performance on service delivery was higher for local government compared to national government. The survey responses suggest that perception of performance is affected by proximity. These demonstrate the potential of local government toward effective service delivery. In Nigeria, the functions and responsibilities of local government on Education and Health are contained in the 1999 constitution of the Federal Republic of Nigeria under the concurrent legislative list as amended 2011.

"Local government functions shall include participation in:

I. The provision and maintenance of primary, adult and vocational education.
II. The provision and maintenance of primary health components.
III. The development of agriculture and natural resources other than the exploitation of minerals.
IV. Such other functions as may be assigned to the local government by the House of Assembly of the state."(2011 amended constitution of Federal Republic of Nigeria).

It is important to note that the objectives of the MDGs on Education and Health care are embedded in the Primary Health Care (PHC) and UBE programmes which are partly managed by the local government through the Local Government Education Authority (LGEA) and the PHC Department of the Local Governments. Although, the two programmes preceded the MDGs, they both adopted the MDGs targets and strategies and re-directed their efforts towards attaining the set targets in that direction. Some scholars like Atteran (2005) and Godwin (2005) argue that it is the failure of the PHC programme to attain Health For All (HFA) by the year 2000, particularly in developing and less developed countries that informed the inclusion of the health targets in the millennium declaration of 2000.

In Nigeria, the National Primary Health Care Development Agency (NPHCDA) was established to provide support to states and Local Governments in matters relating to implementation of Primary Health Care (PHC). In this regard, the NPHCDA has designed minimum standard requirement of PHC structure, system, staffing and equipment for PHC service delivery at local government (NPHCDA, 2013). For instance, the manual maintained that each political ward within the Local Government Area should have a well-equipped PHC center running 24 hours with a capacity to handle both in and out patients cases. In addition, PHC clinic should also be established within the political wards at least 1 per group of villages or community of about 2000 – 5000 persons. Also required is the establishment of Health Post at least 1per village or neighborhood of about 500 persons as many as the number of villages within the Local Government Area.

Again, the manual has spelt out the kind of health workers to manage these three categories of health facilities at local level. These comprise of Community Health Officers (CHO), Nurses and Mid Wives, Community Health Extension Workers (CHEW), Junior Community Health Extension Workers (JCHEW) and Community Resources Persons (CORPS) who are trained community volunteers, such as the Traditional Birth Attendants (TBAs) and Village Health Workers (VHW) and other community based service providers that are duly trained and recognized. The manual also recommends a ratio of one Doctor or medical personnel to 500 patients or less. In the same vein, the UNDP (2009) and WHO (2008) have recommended 34% to 36% of the total budgetary allocation of a national or sub national government be committed to the health sector or 24% of the GNP.

On the other hand, the UBE policy documents in terms of manpower requirement have recommended National Certificate of Education (NCE) as the minimum qualification to teach at any level within the basic education cycle. It also suggests 40:1 pupil teacher- ratio and further maintained that distance between the school and the community in which children

live should not be more than 1-2 kilometers (FRN, 2004; ESP, 2008). In the area of management, the institutional requirements include effective and regular supervision and monitoring of the basic education sub-sector. In the area of finance, 26% of the total budgetary allocation of any level of government should be assigned to education.

However, midway to the 2015 date line still there are key challenges in many delivery areas and aspects of MDGs programmes which might serve as bottlenecks to the attainment of the 2015 date line if not carefully handled. Thus, the ability and capacity of the local government to manage and tackle these challenges is one of the determinants of achieving the MDGs by 2015. This study is therefore prompted by series of complaints by members of the public in general and scholars in particular that three years to the end of 2015, the MDGs targets are far from being achieved, especially at local level. The study set out to assess the journey so far and identify the challenges facing the Nigerian local governments in implementing the Primary Education and Primary Health care aspects of the programme.

1.2 Statement of the Research Problem

In Nigeria, all tiers of government and other key stakeholders have been working hard to achieve the MDGs set targets by 2015. To facilitate the attainment of these goals, strong policies and programmes were put in place that directed all tiers of governments including Ministries, Departments and Agencies (MDA) to incorporate MDGs targets in their activities. Also, MDGs intervention initiatives were put in place to support the capacity of local governments in managing the MDGs activities. Some of these initiatives have direct bearing on education and health. Such as the MDGs Conditional Grant Scheme (CGS) to State and Local Government, and the UBE matching grants arrangement to states. Most if not all of these initiatives are MDGs intervention programmes geared toward enhancing the capacity of states and local governments in attaining the MDGs goals and set targets in that direction.

The MDGs set targets in education is to ensure that every school going age child is enrolled in school and retained to complete the basic education cycle. Thus, the school environment is to be well equipped with all the necessary teaching and learning facilities to accommodate the population of the pupils. The set standard is targeted at ensuring a classroom ratio of 40 pupils to one classroom, one teacher to 40 pupils, adequate pupils' textbooks, writing materials, furniture, toilet facilities and other teaching and learning materials. The health related MDGs targets that have bearing to Primary Health Care (PHC) are to reduce child and maternal mortality by $^{2}/_{3,}$ and ¾ respectively, achieving universal access to reproductive health, treatment of HIV/AIDs for those who need it and attending to incidence of malaria and other diseases among others. To attend these targets PHC facilities are to be made adequate and well equipped with necessary health equipment, personnel and infrastructures. Overall these targets are geared towards increased access to basic education and health care services.

The Federal Government has committed a lot of energy and resources to support states and local government capacity in the realization of the MDGs targets. For instance, from 2007 – 2011 the MDGs – OSSAP has released the total sum of 181.29 billion naira to States under the MDGs Conditional Grant Scheme arrangement (the amounts include the 50% counterpart funding) Primary Health Care and water & sanitation have received about 90% of the total grants allocated (MDGs, 2011). Equally, from 2011 to 2013 the Federal Government has released the total sum of 47.3 billion naira to 473 selected Local Governments in batches (113 LGAs, 144 LGAs, 216 LGAs in 2011,2012 and 2013 respectively) to support Local Governments in managing the MDGs programmes (MDGs, 2013). In addition, the sum of 180.74 billion naira was disbursed to the 36 States including Federal Capital Territory, Abuja by the UBE National Commission from 2005 – 2012 to support States and Local Governments in the provision of basic education (UBEC, 2012c).

However, despite the efforts to enhance the capacity of the States and Local Governments, the challenges are numerous. For instance, the Basic Education Sector faced serious challenge of ensuring that every school age child has completed the 9 years basic education cycle. UNESCO (2012) reports that out of 61 million children out of school globally, half of them are from Sub Saharan Africa. In Nigeria, 6 million children are reported to be out of school as a result of either non-enrollment or cases of drop-out (MDGs Watch, Jan. 2009: 7). The quality of instruction and learner outcomes, coupled with the problem of inadequate capacity of teachers and supervisors, infrastructural decay, especially the dearth of teaching and learning material among others are also posing serious challenge to the achievement of the UBE goal.

In the area of health, the emerging trend in child mortality was on the increase from 184 per 1000 live births in 2000 to 201 per 1000 live birth in 2007 (FRN, 2008). Similarly, reducing maternal mortality is another major challenge for Nigeria. According to the National Demographic Survey 2013 about 2/3 of all Nigerian women and ¾ of the rural women deliver outside the health facilities and without medical skilled attendant present. As a result, about 2 million women of reproductive age do not survive pregnancy or child birth.

It therefore follows that the achievement of the MDGs set targets on education and health depends on the enhanced capacity of the local government to plan projects, mobilize resources, organize and utilize resources. It also depends on the infrastructural and manpower capacity, managerial competence and skills, political will and the existing institutional mechanism for coordination and monitoring education and health related MDGs service delivery.

Looking at the time frame of 2015 and the slow progress made so far in achieving the MDGs set targets, most particularly in the area of education and health, it therefore becomes

clear that despite all efforts, there is still a capacity gap in the implementation of the MDGs declaration that undermined the achievement of the MDGs set targets in education and health care.

1.3 Research Questions

The study is therefore set to address the following research questions:

i. What efforts are made by the MDGs programme to enhance the capacity of the Local Governments in managing the MDGs activities?
ii. To what extent has the MDGs intervention efforts in education impacted on the capacity of the local government to implement basic education?
iii. How has the enhanced capacity of the local government enhanced or undermined the attainment of the MDGs targets in education?
iv. To what extent has the MDGs intervention efforts in health impacted on the capacity of the local government to implement the primary health care?
v. How has the enhanced capacity of the local government enhanced or undermined the attainment of the MDGs targets in health?

1.4 Objectives of the Study

The broad aim of this study is to assess the MDGs intervention on local government and the extent to which it enhanced the capacity of the local government to handle MDGs targets on Education and Health programmes. The following specific objectives are targeted by the study:

i. to review the philosophy, origin and strategies of the MDGs programme;
ii. to assess the capacity enhancement efforts of the MDGs programme on Local Governments;

iii. to determine the extent to which the MDGs intervention has impacted on the capacity of the local government to provide primary education;

iv. to ascertain the extent of attainment of the MDGs targets in education;

v. to determine the extent to which the MDGs intervention has impacted on the capacity of the local government to provide primary health care; and

vi. to ascertain the extent of attainment of the MDGs targets in primary health care;

1.5 Statement of the Hypotheses

This study is based on the following hypotheses:

i. Ho.1: The MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education.

ii. Ho.2: The enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in education.

iii. Ho.3: The MDGs intervention effort in health has no significant impact on the capacity of the local government to manage primary health care.

iv. Ho.4: The enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in health.

1.6 Significance of the Study

Today, more than ever before, education is undisputedly recognized as the bedrock of any meaningful development. On the other hand, there is the popular saying that 'health is wealth' and by extension a healthy nation is a wealthy nation. Also, there is an Arabian proverb that says, "He who has health has hope, and he who has hope has everything." Thus, the above statement underscores the importance of education and health as basis for human development. Thus, it is a truism that the main reason for the existence of any level of government is to ensure the welfare of the citizens through provision of Education and Health services.

Recent survey (Otive, 2006; Kabeer, 2010; Olufemi, 2010) have shown that there is an overwhelming support, determination and optimism and high level of expectation by many Nigerians for the realization of the MDGs targets by 2015. However, much public attention is focused on policies and programmes from the central and often state governments which are of distance to the greater majority of Nigerian because, family, village, community, traditional rulers and local politicians constitute the real world for most Nigerians. It is at this level that an assessment of local capacity to implement and manage the MDGs targets on education and health become truly meaningful.

In Nigeria, governments at all levels have demonstrated the strong commitment to the achievement of Universal Basic Education (UBE) programme and have equally committed huge amount of resources to the attainment of the health related MDGs targets by 2015 (UBEC, Annual Reports, 2009-2013). Similarly, International Communities, NGOs, local communities have all demonstrated considerable support for the fight against illiteracy and diseases, that negatively affect human development (UN, 2010). It is therefore rational to undertake a study of this nature in order to examine the capacity gap that undermined the attainment of the MDGs targets despite all the efforts put in by various stakeholders to support the implementation capacity of the local government. The study has explored the nature and quantum of the MDGs intervention efforts in order to ascertain the extent of impact the intervention has on the local capacity. It also tries to establish the capacity gap that undermined the attainment of the MDGs targets in education and health.

Again, there is an international concern for increased local capacity for service delivery most particularly in the area of basic education and health, as significant investment have been made in that direction by NGOs and other stakeholders (MDGs; Nigeria, 2010d). It is however, our hope that this study will provide NGOs and other stakeholders with better understanding of the capacity gap that undermined the attainment of the MDGs targets. This

will go a long way to guide and direct them in their support policy programmes for local governments. It is also our hope that this study will serve as a reference material for students of local government and development studies. It is our wish that this study will provoke and trigger further research into local government capacity for service delivery.

Nigeria considers the attainment of MDGs by 2015 as a national priority and has since committed resources and efforts toward this direction and has also identified the importance of States and Local Governments in securing and accelerating the achievement of the MDGs targets by 2015, particularly in the area of education and health (MDGs: Nigeria, 2010c). However, government efforts has been very slow in meeting most of the set targets, this has prompted series of complaints by members of the general public and has raised a serious point of concern for governments at all levels on what should be done and how it should be done to meet the deadline especially now that we have only three years to the end of the 2015, so if nothing is done Nigeria is not likely to meet the MDGs deadline. It is our hope therefore that this study will provide possible suggestions on what is to be done in order to attain the MDGs targets by the deadline.

1.7 Scope and Limitation of the Study

The study covers the period from 2005 -2013, which is a span of nine years and the reason for the choice of the period is that a span of 9 years is enough period to assess the progress of any given programme. The choice of the year 2005 was informed by the fact that it marked the commencement of the UBE matching grant scheme to assist States and Local Governments in the delivery of basic education in Nigeria. The same year, the debt relief negotiation was reached with the Paris Club of creditors which served as the major mover and financier of the country's reform efforts and the Millennium Development Goals programmes.

However, what informs the choice of the North West comprising of seven states (i.e Kaduna, Katsina, Kano, Jigawa, Zamfara, Kebbi and Sokoto States) is the fact that the zone represent over 25% of the National population but could only account for 10% of the National enrollment figure in primary school in 2001 and less than 13% ten years later in 2011 which further dropped to 12% in 2012 (UBEC, 2012). Similarly, the choice of Kaduna and Zamfara States were informed by the fact that Kaduna being the former capital of the defunct Northern Nigeria is expected to serve as a role model and a pace setter for other states in the North to emulate. Unfortunately, it is still lagging behind in many delivery areas. For instance, the state has less than 50% qualified teachers in primary schools, the quality of teaching and learning is very low as shown from the 2011 NECCO results when the state fall among the 5^{th} states with the worst result in the whole country (KSMOE,2011). While Zamfara state has the lowest rate of girl child enrollment in the country, from 2000 - 2008 the state recorded an enrollment figure of less than 100,000 for all the years. Again, 70% of its primary school teachers are unqualified per UBE standard. The state also has the least number of pregnant women that registered in clinics or have received any ante natal care from 2004 – 2008 in the country (ZSUBEB, 2012). These two states therefore, provide a good ground for research and comparison.

Due to many facet and integrated nature of the MDGs targets on basic education, this study has focus on the implementation of the UBE programme. Again since the study is on local capacity, emphasis was on primary education which is the responsibility of the local governments. This is because most states are yet to incorporate the junior secondary schools into the Basic Education. Although the basic education covers adult literacy and other special form of education like Nomadic, Islamiyya/Quaranic and special education, our focus was on primary education that affects majority of the population. Emphasis was on public primary schools, their human and financial capacity, structure, management and performance.

Our focus on PHC was on health related MDGs, such as; maternal and child health care, immunization activities and fighting malaria and other diseases. The study has assessed the capacity of the Local Government to reduce child mortality and improve maternal health as well as the diagnosis, treatment and prevention of malaria and other major diseases. This is because the other health related MDGs programmes like; curbing the spread of HIV/AIDs, Tuberculosis and to some extent Family Planning programmes are mostly managed by secondary health care facilities owned by the State Governments and the focus of this study is on Local Government activities. Similarly, due to non-cooperative tendencies of many private health providers when it comes to data collection, our assessment was therefore limited to only public health facilities that were managed by the local government. Although mention was made of secondary health facilities within the local government however, emphasis was on primary health care facilities and operation.

The study also assesses the various MDGs intervention initiatives that have bearing to improve capacity for the provision of Primary Education and Health care services locally; human, technical and managerial support, financial, material and infrastructural support. Emphasis was on specific activities and intervention that have direct bearing on education and health related MDGs targets.

As part of limitation, many of our respondents were civil servants and thus reluctant in answering the questionnaires or attending to our interview because of the tight schedule and often fear of being implicated or accused of licking official information. We have to persuade them, assuring them that the research is meant for academic purpose only and that their names were not necessary.

Also, the study is constrained by a number of factors such as absence of official statistics on the health status and indicators of local communities in Nigeria and the lack of

access to certain official documents and expenditure due to certain official restriction or classified nature of the document. Again, due to time and resource constraints and also for an in-depth study, the study was able to cover only selected states from North West zone of Nigeria.

1.8 Definition of Terms

For the purpose of this study the following concepts are operationally defined.

Assessment: This is a systematic process of examining a particular situation or projects in order to pass judgment over it (OSSAP - MDGs, 2008). It's a systematic evaluation of the various aspects and components of a programme in order to determine its viability, capacity, impact, success or otherwise (Jumare, 2000). It calls for careful examination of programme guidelines and activities to determine the required capacity needed to implement the programme successfully.

Operationally, assessment refers to an in-depth evaluation of the local government capacity to provide and manage MDGs activities at local level particularly delivery of Primary Education and Health care and the extent to which these services are provided. It involves an examination of the quality and quantity of local man power need and the personnel management required for the implementation of these programmes. It also refers to the financial resources of the local government, it sources, base and viability as well as the local financial management system of accounting and auditing.

It also involves an examination of the administration and political structure and behavior of the local bureaucrats, the pattern of appointment or election, their level of education and experience in programme planning, organizing and coordinating capacity, and their monitoring and evaluation ability. Other yardstick involves the attitude of the local

politician and top bureaucrat toward institutional procedures and rules, the ability to implement programmes using the intersect oral approach and developing the mechanism of planning, implementation, monitoring and evaluation of Primary Education and Health care services.

To sum it up, assessment operationally refers to an depth analysis into the:

i. the ability and quality of local government planning and staffing;
ii. the organizing, coordinating and directing ability of the local bureaucrats;
iii. the reporting and evaluating capacity of the local bureaucrats;
iv. the quality and quantity of MDGs intervention given to Local Governments; and
v. the extent to which these support initiatives have impacted on the capacity of the local government in providing primary education and health care related MDGs services.

Local Government Capacity: Local Government capacity refers to overall institutional arrangement of the local government system in terms of legal and policy framework that determine and delineate the entire policy environment under which the local government system operates, such as, the constitution, reforms and other legislation that establish and define the structure, composition and function of the local government system.

Other parameters of local capacity include the;

i. Infrastructure of local capacity in terms of the adequacy or other wise of physical structures and facilities necessary for the provision of Primary Education and Health care services. Items like classrooms, clinics, furniture

and equipment, textbooks, essential drugs and other assorted materials require for the delivery of Primary Education and Health care services.

ii. Human resource dimension of the local government in terms of quality and quantity of man power requirement and management, aspects like number of staff required to handle these services, mode of their distribution (i.e evenly or uneven) within service units, the quality requirement of these manpower in terms of their qualification and years of experience.

iii. Managerial dimension of local capacity involved management experiences and practices as well as motivational issues that affect staff performance on the job. Management experiences and practices that deal with the local initiatives for service delivery, nature and quality of planning, mode and frequency of monitoring, coordinating ability for service delivery, nature of intersectoral collaboration for service delivery, motivational ability and initiatives to mobilize, enforce and ensure staff performance

The ability of the local government to manage these factors determine to a large extent its capacity to provide service delivery most particularly in the area of primary education and health.

MDGs Intervention: This refers to the intervention initiatives designed to support States and Local Governments in the implementation of the MDGs programmes. These interventions come from mostly two sources Federal Government and Donor Agencies. Although, local communities do provide same level of support but more often than not the support are initiated by either of the two sources. The MDGs intervention initiatives are various and multi dimensional cutting across all the eight aspect of the MDGs programme. However, for the purpose of this study the MDGs intervention refers to those support activities provided for

the delivery of Primary Education and Health care services locally. These includes among others:

i. Financial support in a form of matching grants to support States and Local Governments in the discharge of the primary responsibilities in the provision of Primary Education and Health care services.
ii. Technical support provided through staff training programmes to boast the managerial skills of the local providers and managers of Primary Education and Health care services.
iii. Material and infrastructure provided to support existing infrastructures and facilities. These include construction of classroom and clinics, toilets and boreholes, procurement of furniture, clinical equipment and drugs, textbook and other assorted material require for the delivery of Primary Education and Health care services.
iv. Recruitment and posting of qualified teachers and health workers to serve in rural areas within the Local Government Areas in order to support the existing local workforce and strengthen the manpower capacity of the Local Governments.

These are the parameters within which the MDGs intervention initiatives at Local Government levels are been assessed.

Attainment of MDGs targets: MDGs as a programme has set targets of all its goals and several measurable indicators to ascertain the attainment of each goal. Thus, the attainment of MDGs targets on education and health care within the context are measured by the following:

i. 100% pupils enrollment and retention
ii. 100% pupils transition from one grade to another.
iii. 100% completion of 6 years primary education
iv. Reduce child mortality by 2/3

v. Reduce maternal mortality by ¾

vi. Ensure access to treatment of malaria and other diseases

The rates at which these are achieved determine the attainment of the MDGs targets in education and health care.

1.9 Outline of Chapters

The study is made up of six chapters. Chapter one is an introductory chapter which contains the Background of the study, Statement of the research problem, Research Questions, Objectives of the Study, Research Hypotheses, Significance of the Study, Scope and Limitations of the Study, and definitions of Key Concepts. Chapter two, deals with the review of related literature and theoretical Framework. The researcher presented some of the major works that have been done on the subject matter, shows their relevance to this study and such were adequately critiqued.

Chapter three is the research methodology that contains Sources of data, Research population and sampling, Justification of selected samples, Data presentation method, Data analysis method and method of testing hypothesis. Chapter Four discusses the institutional framework and strategy guiding the implementation of the MDGs programmes in Nigeria. Chapter Five presents data and their analysis through testing of hypotheses. Chapter Six is the summary of Findings, Conclusion and Recommendations.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

Literature review and theoretical framework set the base for every research work. It helps to bring the study into real essence and perspective. The main trust of literature review is to highlight and present available and existing literature or studies related to the subject matter under investigation. It tries to identify such literature, acknowledge the various authors, bring out their major findings, conclusion and recommendations, assess and evaluate their efforts and contributions. For the purpose of this study, this chapter is divided into five sections. The first part deals with the introduction. The second discusses the major conceptions of the MDGs. The third dwells on some debates and issues surrounding MDGs, the fourth provides an overview of local government capacity for service delivery in Nigeria. The final segment deals with the theoretical framework content and how it is being applied to the research work.

2.2: Major Conceptions of the Millennium Development Goals (MDGs)

Millennium Development Goals are a group of measurable development targets agreed to by 189 United Nation (UN) member states as part of the 2000 Millennium Declaration. The MDGs Declaration and Movement are perceived differently by many scholars and groups. There are two major conceptions of MDGs by scholars. First those that sees MDGs as assistance to poor countries. The second group perceived MDGs in a broader perspective of the need for global approach to development. Some scholars like Olufemi et-al, (2010) and Kabeer, (2010) view the MDGs as assistance to poor countries. Thus MDGs is an attempt by the richer and developed countries of the world to help promote core development goals and targets in the poorer states (Olufemi et al, 2010). They argued that the

success of the MDGs centered on the attainment of Goal 8 which is directly linked to the role expected to be played by Official Development Aid (ODA). The Multilateral Debt Relief Initiative (MDRI) of 2005 that was backed-up by the G.8 is a good example. The negotiation led to the cancellation of 40 – 55 billion US dollars debt owed by Heavily Indebted Poor Countries (HIPC). On the condition that the forgiven debt be re-channeled to social programmes for improving health, education and alleviation of poverty (Kabeer, 2010) in these countries. Another example as argued by these scholars was the UN assigned commitment to developed countries to provide 0.7% of their Gross National Income (GNI) as official development assistance to assist poor states and countries to attain the MDGs. These are testimonies to confirm the assertion that MDGs is an attempt by the rich to assist the poor countries.

On the contrary, some scholars like Olufemi, (2010) and UN, (2010) look at the MDGs in a more general and broader perspective. First the MDGs is borne out of the recognition that for several decades hundreds of millions of people are struggling to survive below unacceptable living standard, as a result of many factors, environmental, economic, political and social that the effect and consequence of these factors are as a result of action or in action of the global leadership. A time the development of one state might be responsible for the underdevelopment of another. Thus the issue must be given a global perspective and a global approach (Olufemi, 2010). Secondly, with the advent of modernization, trade liberalization, growing information and globalization, nation states are now seen as single and common house for the entire home family. All nations therefore have a duty to all worlds' people, especially the most vulnerable and in particular the children of the world, to whom the future belong (UN, 2010).

Whichever way you look at it, the MDGs is a unique social intervention package that tries to address issues of poverty and development. Although the programme mostly targeted

pro-poor and the most vulnerable groups in the society yet the end result is shared by all. Essentially because, development is about security, peace, increase social amenities, equality and improve standard of living that all together make the world a better place for all races.

2.3: Contentious Issues Surrounding MDGs

There are a number of contentious issues or debates surrounding the MDGs, targets and indicators. Some scholars like Atteran, (2005) and Olufemi, (2010) are of the opinion that the MDGs lack justification for the chosen objective. Given the uneven progress in addition to the MDGs date line (2015), they argue that the MDGs provide unrealistic expectation for region and state particularly Asia and African countries that are starting out at a lower economic threshold than others. For example, Atteran, (2005) contends that MDG 2, which calls for all countries to achieve Universal Primary Education by 2015, is unrealistic for many poor countries because, it asks them to achieve in 15 years what other countries have taken over a century to attain. Such unrealistic expectation, critics argue set countries up for failure rather than success. This is considered by many scholars as the major setback or flaw of the MDG (Atteran, 2005).

In the same vein, Amir Atteran an associate Prof. and a Canadian research chairman of population Health and Global development Policy at University Ottawa, (2005) feels that the goals are difficult or even immeasurable. He argues that goals related to maternal mortality, malaria and tuberculosis are in practice impossible to measure using the current UN estimate which he believes lack scientific validity (Atteran, 2005). The household survey often used by the UN to estimate data on health MDGs are poor measurement instrument for the data they are trying to collect because, the focus was on current records rather than measure of past and current records. He further opins that countries with the highest level of maternal mortality, malaria and tuberculosis often have the least amount of reliable data

collection due to the crude way in generating data. Atteran finally contends that without accurate measure of past and current data for the health related MDGs, it's impossible to determine if progress has been made toward the goal, thereby leaving the MDGs as little more than a rhetorical call to arms (Atteran,2005)

Olufemi, (2010) and the Atteran, (2005) are concerned with the future of the MDGs after 2015. They noticed that the MDGs lack emphasis on sustainability. It does not stipulate what to do after 2015. If the goals are attained, they need to be sustained and if not attained, are they to be abandoned, is a question unanswered (Olufemi, 2010). Although the MDGs are a tool for tracking progress toward basic poverty reduction and provide a very basic policy road map to achieving these goals yet, they do not capture the entire element needed to achieve the ideals set out in the Millennium Declaration (Atteran, 2005). Infact Olufemi, (2010) is of the view that the idealistic aspects of the MDGs may detract from actual development success because of its time and target bound. For instance, a country may achieve historic (but not universal) increases in primary school enrollment or access to reproductive health, but technically 'fail' to achieve MDG 2 and 5, critics argue that rather than being branded as failure for not achieving the MDGs, countries should be applauded for their achievement (Olufemi,2010).

In another perspective, the issue of aid volume versus aid effectiveness is also another issue surrounding the discussion on MDGs policy. Some mostly recipient countries asserted that lack of progress on MDGs can, in many ways, be attributed to the insufficient level of foreign aid, the more the volume of aid, the higher the chances of meeting the MDGs (Helen, 2010). Others contended that there is very little evidence to show that the volume of aid has lead to greater development impacts. (John, 2012). Records have shown that many developing countries have demonstrated an inability to use aid effectively (UN, 2010). Infact,

some even argue that aid can be counterproductive to development, as it can distort economic incentives, flood capacity, and create dependency (Michelle, 2011).

Again some experts like John, (2012), Michelle, (2011) and UN, (2010) have attributed the limited progress of the MDGs to absence of accountability mechanism stipulation in the MDGs policy framework. Thus if a government or a donor does not deliver on to its promises, whether due to poor design, corruption or other factors, the intended recipient generally have no recourse (UN, 2010). Thus, the question of who and what is held accountable for MDG progress is still hanging. Although governments are primarily responsible for fulfilling the MDGs, at the same time, it's unclear to whom, if anyone, governments are accountable if they fail to achieve the goals.

Despite these short comings, the MDGs are intended to increase the individual human capacity and advance the means to a productive life (UN, 2009). The MDGs programme is said to have focus on three major development aspects: The focus on human capital development that centers on improved nutrition, health (including reducing the level of child and maternal mortality, HIV/AIDs and other disease) and education. The second is the infrastructural focus; the objectives include improving infrastructure through increasing access to safe drinking water, energy, modern technology and preserving the environment. The third focus is on increasing social, economic and political right, which centers on women empowerment, equality, political awareness, equal access of public service and security (UN, 2009). All these focus are geared towards improving basic standard of living for peace and development.

From the onset a fifteen-year timetable for implementation of the MDGs appeared reasonable in 2000, but with 5 years to go it seems inevitable that a number of goals will not be met by many African countries. As concluded by the European commission (2009) that

most developing countries are projected not to meet most MDGs and sub-Saharan Africa lags very much behind. This position is further confirmed by the UN Secretary General's Report in February, 2010 that "the prospect of falling short of achieving the Goals because of lack of commitment is very real". Therefore the most basic question is why are the MDGs not more easily achievable in Africa? Is this because of the absence of political will or the weak economic structure of the African region or perhaps due to internal conflicts and instability, or the dependency nature of aid, or weak management structure and capacity or some combination of all or some of the above? The answer perhaps depends upon whom you ask.

However, several factors were said to be responsible which could be broadly categorized into three. The first category has to do with the kind of intervention put in place. Evidence has shown that many developing countries are used to the 'copy-and-paste' style of policy intervention. Some policy makers in the developing countries are of the notion that what is good for the west is good for them. Thus, western policy programmes are packaged and applied unmindful of the difference in culture, resource capacity and other local factors (Ogunlela, 2012). The second category is associated with the policy implementation programme itself. Many of these countries have a record of weak and often very poor implementation procedures. Many of our beautiful policy programmes were poorly and half harzardly implemented, thereby, undermining the objectives for which the programme were meant to achieve (Jega, 2007). Several factors were attributed to these, such as, corruption, weak administrative structure to handle the programme implementation, poor finance, low political will, low management and monitoring capacities among others. The last category has to do with other external and natural factors, such as, natural calamity, extra ordinary conditions placed by donors, spillover effect of economic recession or fall of oil price, national strike, tribal or religious conflict and the likes that might constrain the smooth delivery of an intended policy programme.

In this regard, a high level forum on the health MDGs, conducted an assessment study in 2004 on achieving the health millennium goals in fragile states in which Nigeria is identified as one among the eight consistently mentioned in various categorization of fragile state (ECA, 2004). The study identified certain characteristic features associated with fragile states. State collapse (Somalia) loss of territorial control (Sudan) low administration capacity (Niger) political instability (Congo) conflict affected (Angola and Afghanistan) repressive politics (Myanmar) and poor governance (Nigeria). These eight countries because of these features are together said to hold 58% of people living on less than a dollar a day and 54% of total under five mortality (out of the 46 fragile states as defined by World Bank).

To further confirm the earlier categorization, the study discovered that achieving the health MDGs in these states is a complex and challenging task particularly because of their low-income and poor deteriorating economic and social condition, weak governance and ineffective government-donor relationship. It was noted that in some of the fragile states, government lack the will to provide basic health care services rather than the capacity to pay for the health care delivery. While in others, they do not have the requisite resources due to poor economies and thus, even if an adequate percentage of the national budget were spent on health, a substantial health financing gab will continue to exist due to weak economy.

To make matters worse, many donor countries avoid partnership with most of the fragile states due to poor governance, lack of transparency and accountability. Sometimes, Donor states avoid partnership with the recipient states and channel its resources through non-state providers due to low level of trust between the two that make Development Co-operation very difficult. This may undermine the long term objectives of supporting the state to improve its capacity to provide health service to its people. The study therefore, recommends a full-fledged health package to be made available and accessible to every community or on the alternative a basic health care package that provide basic facilities for

the treatment of common diseases and illnesses. Either of these packages should be made universally available and affordable to the local communities. How visible and practical are these recommendations to Nigerian situation will depend on a number of factors. The extents to which these factors are handled determine the capacity of the government in managing health care delivery services. However, there is the need to keep our focus relatively tight and thus ask whether the local governments have the capacity to manage some of the chosen intervention programmes on the education and health related Goals.

In Nigeria, one of the best intervention programmes in education is the UBE scheme that was introduced to create and increase access to gender parity in the delivery of basic education. In the area of health, the PHC programme is another very important intervention programme on health care delivery, although both programmes were introduced before the MDGs. The two programmes have been able to capture and incorporate the MDGs targets in their policy programme. For instance, the overall goal of the UBE programme is to increase access to basic education and promote gender parity in the basic education sub-sector in particular and gender equality in general which are Goals 2 and 3 of the MDGs programme.

Although, scholars like Aluede, (2004) and Fabunmi et-al, (2002) are of the view that the UBE programme is not in any way different from the UPE programmes of previous administrations that has failed to achieve the desired goals, they were meant to achieve. They argued that the programme like its predecessor is over ambitious in its scope and coverage, weak in its implementation strategies, constrained in its resource capacity and thus, if history is anything to go by, the programme according to them, is bound to fail. On the contrary, some scholars like Tahir, (2007) and Adebola, (2007) are of the opinion that the UBE is different from the former UPE programme of 1950s and 70s and thus be adjudged differently. The word ‘Basic’ goes beyond primary education to include early childhood education (ECCDE), adult education, nomadic, almajiri, girl child education and other forms of special

education. Also, apart from UBE being Universal, it is to be made free and compulsory to every Nigerian child of school age between 6-15 years and beyond (UBE Digest, 2001). Also, the federal government in its determination to make a difference has enacted the UBE Act in April 2004. The UBE law urged all states and local governments to see to their constitutional responsibilities of providing basic education to their citizenry. The law also, compels parents and other stakeholders to look on to their moral obligation to support the education of their children and wards. In line with these, the UBE Act is said to have provided a practical avenue for widening access to basic education through:

i. Abrogation of tuition fees and other forms of school fees in public schools,
ii. Imposition of sanctions for failure to enroll or withdraw a child from school before completing the 9 years education cycle,
iii. Provision of mid-day-meal in school,
iv. Provision of financial and other forms of assistance to state government by the federal to support them in implementing the basic education, and
v. Delineation of roles and sharing of responsibility in basic education delivery between and within stakeholders. So that each is aware of its functions and what is expected of it by law (UBEC, 2010c).

No wonder the UBE Act has been adjudged by the UNESCO General Conference held in Paris in October, 2005 as one of the best legal documents on basic education in sub-Saharan Africa, and therefore requested the UBEC to organize a regional or sub-regional seminar on Nigeria's UBE law for possible adaptation by other developing countries. However, the question is to what extent have these all inclusive UBE package been implemented? The answer to this is quite obvious. A number of questions could be raised concerning the UBE policy and implementation. Such as:

i. How effective is the UBE law in compelling parents to send and retain their children or wards in schools?
ii. What sanction have been enacted to states and local governments for not meeting their constitutional responsibility in this direction?
iii. How free is the provision of the UBE programme with parent shouldering between 40-70% (in public) and 100 (in private) responsibilities of their children basic education?
iv. Is access to UBE all about increase enrollment only or is the quality of education measured by enrollment?
v. What and how effective are the retention, transition and completion mechanism in the basic education sub-sector?
vi. Is the style of ensuring equality adopted by the scheme really facilitating inclusion or is another form of exclusion due to the introduction of the quota system in enrollment figure by the UBEC?
vii. How practicable is the provision of the day-meal in schools?

These are some of the issues that surround the implementation of the UBE Policy and programme in Nigeria that need to be carefully addressed for the effective implementation of the UBE programme generally. We will discuss the UBE policy framework later in chapter four meanwhile, we will review literature on the capacity of the Local Government to manage MDGs intervention programmes locally.

2.4: An Overview of Local Government Capacity for Service Delivery in Nigeria

Local governments in Nigeria are legal entities established by law to provide certain services to the people. The 1976 Local Government Reform resulted in a national system of democratic local government. The 1979 constitution further guaranteed the position of local governments by making it a third tier of government with some level of autonomy. The 1979

constitution presented certain basic function for Local Governments and also provide for statutory transfer of public revenue from the national and state levels to local governments.

The 1999 constitution section 7(1) guarantees the system of democratically elected local government councils and task every state to ensure their existence under the law that provide for their establishment, structure, composition, finance and functions. This provision makes local government subject largely to state statutes. The constitution listed the functions that are exclusive to local governments. Such as, provision and maintenance of cemeteries, slaughter slab, public convenience, collection of rate, issuances of petty licenses, naming of streets, registration of birth, economic planning and development among others. The constitution also, stipulated that local governments shall participate in performing a number of functions concurrently with the state governments (FRN, 2000). These functions includes: provision and maintenance of primary education, health care, agriculture and natural resource among others.

This implies that local governments were established and recognized as a third tier of government responsible for participating in the delivery of most local public services like primary education and health along with the state and entitled to statutory federal allocation of 20% and state allocation of 10% from their internally generated revenue. To add to this, the UBE Act 2004 has directed the establishment of local Government Education Authorities (LGEAs) in each local government. The LGEAs is responsible for the day-to-day running and management of primary education at the local level. Also, the current National Health Policy document 1996 revised 2004, indicates that local governments are expected to be the main implementors of PHC policies with the federal government responsible for formulating overall policy and for monitoring and evaluation, and state governments for providing logistical support to the local government authorities such as personnel training, financial assistance, planning and operation to quote.

> *With general guidance, support and technical supervision of state health ministries, under the aegis of ministries of* local governments. *Local Government Councils shall design and implement strategies to discharge the responsibilities assigned to them under the constitution, and to meet the health needs of the local community (NHP, 1996:p26).*

Although the current 2011 amended constitution of Nigeria has placed primary education and health care delivery in the concurrent legislative list, yet the extent of participation of local governments in the execution of these responsibilities has been enormous. Infact, proponent of decentralization are of the view that local government is in a better position, among the 3 tiers of government, to not only serve as a principle decision maker but a provider of most basic service like primary education and health care delivery. Their argument is based on closeness and proximity to local community (JICA, 2007). In the same vein UNDP in 2004 shared the opinion that Local Government in Nigeria are immediate and more tangible environment for identifying local needs and articulating strategies for service delivery that are more effective and sustainable than any other tier of government because of their proximity to the local community (2004).

Similarly, other studies show that MDGs strategies which are service delivery governments, civil society and the private sector work closely with the national government (MDG, Synthesis Report, 2010a). When national and local government cooperate, MDGs localization can result in quick impacts through the targeted transfer of resources and capacity investments. It has been proven that local actors are crucial in the achievement of MDGs .Many countries have shown that when investments are made at the local level, progress towards the MDGs is made more quickly and it is more sustainable (UN, MDG Report, 2010).

For instance, in Napel, enrollment rate has substantially increased in targeted areas when education responsibilities were transferred to local elected committees. Even in conflict zone, Somaliland Local Transitional Authorities have been the only channels of delivery of

essential services and protection of communities. Again Rwanda and Sri Lanka, despite years of conflicts are making progress in maternal and child health by transferring responsibilities and funding of health services to local communities (UN, MDG, 2010). These go to show the central importance and potential of Local Governments in the attainment of the MDGs targets.

Again, the general Economic theory of fiscal federalism postulates that the provision of services should be located at the lowest level of government consistent with incidence of cost and benefit analysis. Since lower tiers of government have greater information about local condition and can therefore provide services that are better suited to the needs of the local population (Anyanwu, 1999). The underlying rationale behind the position of the economic theory is that communities will choose an effective level of services in accordance with their preference, equating the marginal tax cost of providing the service with the marginal benefit they receive from it. If in certain localities with lower tax base, there is a shortfall in delivery service, according to some defined minimum standard, the central government may therefore supplement local income through equalizing transfer thereby filling the gap between local own revenue and expenditure (Anyanwu, 1999). However, in developing countries like Nigeria the marginal difference is expected to be paid for by locally generated revenues instead of fiscal transfer from federal government as in the case in developed countries (Khemani, 2004). Perhaps, this is one of the issues that are undermining the financial capacity of the local government in providing effective services to the local people.

However, some scholars like Linus, (2014) and Khemani, (2004) are of the opinion that local governments lack the management and financial capacity to effectively handle basic social service delivery. Their argument was based on legal framework, local structure, composition and the performance of local government authorities in recent times.

The survey carried out by USAID in 2001 on the assessment of Local Government position and performance in Nigeria, noticed that the current Local Governments legislation as entrenched in the 1999 constitution (section 7(1) that guarantee the system of democratically elected Local Government Councils and tasks each state to ensure their existence under state laws that provide for their establishment, structure, composition, finance and function, has reduced Local Government to babies of the states. In essence, states are empowered to create, dissolve and even establish new local jurisdiction for local governments. And in exercising their powers over Local Government, it was noticed that the state has imposed administrative and political control that reduce the autonomy of the Local Governments to effectively perform (USAID, 2001).

The UNDP study on local government in 2004 further observes that many state governors have dissolved elected Local Government Councils on the pretext of non-performance and appointed caretaker committees. Also, many states have encroached on local revenues by making purchases on behalf of Local Governments, withheld state statutory allocation meant for Local Governments and took over constitutionally assigned local functions under the pretexts that they were not effectively performed by the local governments. For instance, cases of commercial markets and waste management, particularly in urban areas are taken over by some state governments. The Kaduna central market and the service provided by Kaduna Environmental Protection Agency (KEPA) are good examples (Idris, 2014). This is a clear case of undue interference into local affairs by the state government.

To further support the above position, Abbas (2010) maintains that the existing laws that guide the operation of Local Governments in Nigeria has created a situation whereby the state participate and dominate the affair of the Local Governments. He reiterates that the Local Government is reduced to an administrative unit of the state because of the joint

account system that empowers the state to control local government resources. Thus, this issue, he pointed out, has manifested in an intricate control with no autonomy for Local Governments to manage local resources, thereby frustrating the spirits enunciated in the decentralization of authority.

Again, Nze (2010) further observes that the current policy environment under which Local Governments operate in Nigeria is somehow ambiguous essentially because, the constitution has identified Local Governments as third tier of government within the federal democratic system, and have spelt out both Exclusive and Concurrent functions and certain amount of Federal share is been allocated to the Local Government Councils in order to discharge their duties effectively. Surprisingly, in the same constitution, section 8 (1-4) the state is empowered to take total control of Local Government affairs. This ambiguity have weakened the performance of Local Government, so much that many perceive it as an institution with assigned responsibilities without corresponding authority and autonomy to perform and function effectively. Thus, legally one may conclude that local government is an appendage of the state government.

However, some scholars like Khemani, (2004) and Gboyega, (2000) are of the opinion that Local Governments in Nigeria lack the financial capacity to effectively manage local service delivery. They noticed that Local Governments in Nigeria largely depend on Federal transfer and thus, argue that exclusive reliance on Federal transfer creates condition for lack of accountability, as Local Government may always shift blame and responsibilities for service delivery to higher tiers of government that control the bulk of the resource and revenues. By extension the local population may not hold the Local Government accountable either because they perceive them as having no financial power to deliver the goods or because they are not as informed or vigilant about monitoring resources that arrive from external sources outside the community (Khemani, 2004).

To further support this position, Jumare (2009) notes that the fiscal transfer from the Federal Account constitutes over 90% of the total revenue proportion of Local Governments in Nigeria. He argues that this over dependency on external source weakens the effort of the Local Government toward Internal Revenue Generation thereby, undermining the capacity of the Local Government to decide and provide basic services.

However to be fair to the Local Governments Idris, (2014) opines that the reasons for insignificant percentage of the Inter Governmental Relations (IGR) locally could be associated to the constitutionally assigned revenue sources to Local Governments that are difficult to collect and meager in yields with the exception of property /tenant rate which favour only urban Local Government Areas. Again, the internal revenue effort is also undermined by corruption, wide spread tax evasion, lack of incentive for revenue collectors and politically motivated imposition of taxes at local level.

In addition, Atelhi, (2014) maintains that the Local Government internal fiscal base apart from being weak are also encroached upon by the state as cited earlier that some state governments have taken over local statutory functions in urban areas and collect the revenue derived from them. In some cases, markets and motor parks were built on huge loans taken by state governments on behalf of the Local Governments and the need to repay such loans provided an excuse or justification for state encroachment in the management and appropriation of the fee collected from them.

Again, evidence has shown that local finances are further stretched due to imposition by State and Federal Government, compelling the Local Governments to assume responsibilities that are not theirs. Such as, up keep of State and Federal officials serving in the Local Government Areas, bearing the cost of security officials or routine visit of key

political office holders and the like (Jumare, 2008). This further weakens the inadequate financial resources of the local government.

Similarly, Silas (2012) further argues that Fiscal Transfer from external source (i.e. Federal Account and VAT) is subject to statutory deduction before reaching Local Governments coffers. Such deduction include 1% training funds managed by Local Government Service Commission (LGSC) and 15% total wage bill managed by Local Government Pension Board (LGPB) and in some state 5% traditional rulers upkeep as well as primary school teachers' salaries which is far the largest of the statutory deduction are all taken at sources. There are also non-statutory deduction that were made at source or at first charge by the State Governments on the pretext of joint project or have made a purchase on behalf of the Local Government such as; fertilizer, drugs, tractors and other such purchases. These deductions, according to Abbas (2010) weaken the financial capacity of the Local Government to provide effective service delivery.

In the same vein, the policy brief on MDGs NEED Assessment and financial strategies for Nigeria (2009) in MDGs: Nigeria (2010d) expressed serious skepticism, about the capacity of the Ministries, Departments and Agencies (MDAs) most particularly at Sub-National levels, to absorb the huge budgetary resources envisaged for the MDG interventions. It noticed that the trends that are now becoming established in governments fiscal operation indicate very low absorption capacity for budgetary resources at the federal level – equally true of most State Governments and worst of all Local Governments. For instance, in 2008 over N400 billion was recovered from MDAs as unspent capital funds released in 2007 which represents 51% of the total capital budget for that year (CBN, 2007). At the sub-national level, some states could not access the Debt Relief Conditional Grand Scheme (CGS) due to none completion of previous grant capital projects, while many Local Governments could not

effectively utilize their capital budget, thus you find the same capital estimate continued to appear year in year out in their annual budget proposals (MDG, 2010c).

Some of the reasons attributed to these are inadequate human resources to effectively utilize and manage the budgetary funds, inadequate complimentary facilities and other administrative bottleneck, such as, the due process mechanism, late budget passage and releases of budgeted funds for project implementation among others. The policy document therefore suggested that the causes of low absorptive capacity need to be investigated thoroughly so as to address it squarely because if it is allowed to continue, it means that MDGs intervention risk being unimplemented and the goal unachieved (MDG, 2009).

These therefore points to the issue of manpower capacity for service delivery at local level. In the area of personnel requirement, studies have shown that many Local Governments are even over staffed with larger number of non-professional staff and fewer numbers of qualified professional staff in required number to adequately carry out important technical functions and services (Abbas, 2010). It was noted that most of the over staffing is in the lower categories where Local Government can hire without State Government approval (i.e. Local Government Service Commission). The popular perception and the traditional believe that Local Governments are employment generating institutions is responsible for the over staffing coupled with political pressure on Local Government chairmen to employ party supporters and their family members. The result has always been huge increase in salaries which add to the already unbearable Local Government expenditure, thereby making capital project very difficult if not impossible (UNDP, 2009). This has been the story in many local governments in Nigeria. Too much redundant staff particularly, unskilled with no schedule and less of technical staff.

Olaniyi (1999) provides some analysis of manpower capacity constraints at the local levels. In a survey carried out by the United Nation Development Programme and the States and Local Government Affairs Department of the Presidency in 1998, it was found that of the 750 respondent Local Government Authorities, only 151 had planning department, and even amongst these, there was no representation in the local government of professionals like economists, medical doctors, or engineers. With regard to the basic educational background of the local government staff surveyed, about 33% were secondary school certificate holders, and another 25% had Ordinary National Diploma (OND) as their highest qualification and only less than 10% had university Degree. Although, some may argue that educational qualification of local staff is not imperative to the allocation of expenditures according to constituents and for the delivery of services however, it's obvious that for the pattern of allocation to be responsive to local needs and for service to be planned, implemented, monitored and evaluated effectively and efficiently a good educational background is inevitably required.

However, the real challenge lies in the personnel management pattern of the Local Governments. The institutional arrangement provides that LGSC are agencies of the state governments responsible for the appointment, promotion, transfer and discipline of senior staff of the Local Governments. These arrangements according to Omar (2014) deprive local elected executive with the power to control their staff and also question the loyalty of the unified staff thereby affecting staff performance.

Again, the control of the Local Governments staff through the LGSC is often politicized and polarized along political party line, sectional, tribal and a times religious attachment depending on the social composition of the state. UNDP Survey (2004) of Local Government System in Nigeria, discovered that there are cases of indiscriminate transfer of key Local Government functionaries like Treasurers and Directors of Departments, who are

supposed to be reassigned after 3 years on average, but too often rotation occurs more frequently. For instance, in some states like Kogi and Nasarawa it was discovered that some key officers of the Local Government have been transferred 3 – 5 times in one year (UNDP 2004). Also, is the issue of staff training which is managed by LGSC which is again another contentious area. Evidence have shown that the selection of the staff to go for training apart from being unfair, the training itself is not regular, and a times training mangers or consultants hired lack the requisite skills and expertise, to handle the training programme thereby, amounting to waste of resources (Sallah, 2012).

Another aspect of local capacity has to do with the political and management structure of the elected executive whose main roles under the presidential system is to pass bye-laws, approve budgets and monitor their implementation. Abbas (2010) argues that the State House of Assembly and the State Government through the Ministry of Local Government has constrained the elected local council in performing their assigned functions. The current trends according to him show that the State Assembly decides what should or should not be in the budget, because they are the final approving body of all Local Governments budget proposal while, the state control the implementation through the ministry of Local Government that approves all capital expenditure. Even monthly allocation for recurrent expenditure has to be approved by the Ministry at Joint Account meeting. This arrangement goes a long way to kill the creative initiative of the elected officials of the Local Government and thus affect service delivery (Abbas, 2010).

At this point, the question of whether or not Local Government has the capacity to manage basic service delivery at local level is still a point of contention among scholars. However, the issue of local management and accountability remain the central focus in determining the performance of local authorities. A recent survey conducted by the World Bank in 2004 in Kogi and Lagos states on local governments' accountability for service

delivery revealed that many local governments in Kogi and few in Lagos state could not pay the salaries of their health workers for months. This problem is reminiscent of a similar problem of non-payment of teachers' salaries in primary school nationwide in the 1990s when primary education was decentralized to local government (Abdullahi et- al, 2011 and Wunsch, 1997). The solution has always been deduction at source for teachers by Federal Government or deduction at first charge by State Governments for health workers. Although the solution is successful in ensuring that the beneficiaries get paid, it however undermined the overall ability of local governments to manage resource.

In the same vein, local government claimed that deduction at source lead to "zero allocation" thereby preventing them from carrying out meaningful essential social services like education and health care (World Bank, 2011). Other evidence reveal that what local government receives as transfer is some time treated as personal funds of local politicians (World Bank 2011). The issue has been floating between increased of the intergovernmental transfer – large enough to persuade local government to relinquish their capture of existing resource to reduced autonomy and increase monitoring to ensure effective state control.

Akpan et-al (1999) argues that the immediate challenge facing Local Governments capacity for service delivery is not one of the additional revenue but rather of undertaking public expenditure more effectively under current resources constraints. According to him, it is unclear whether the marginal benefit of an additional naira of public resources would justify the marginal cost of revenue creation. Thus, he suggested that since Local Governments have jurisdiction over taxes like the property/tenant taxes, increasing economic growth may itself translate into a stronger local tax base.

Similarly, Khemani (2004) stresses that there is no conclusive evidence with regard to what kind of decentralization reform actually lead to improvement in service delivery; are

elected local representative more accountable than centrally appointed bureaucrats? Or is fiscal decentralization necessary to improve accountability and public service delivery or can political and administrative decentralization achieve the same, without substantial fiscal independence? The answers remain contentious.

From the foregone discussion, it follows therefore that the management of Local Governments takes place in a complex environment of overlapping jurisdiction, shared responsibilities and undue control over resources, and personnel. In the overall arrangement however, Local Government do not have full or effective control over both financial and human resources necessary for performing their functions satisfactorily. Even where some of these resources were made available, they were often controlled directly or indirectly by the other higher authorities' mostly State Governments through imposition and other forms of interference. Thus we are of the opinion that increased autonomy and allocation for Local Government will go a long way to boost the human and financial capacity of the Local Government in providing service. As rightly observed by some scholars (Abubakar, 2014; Jumare B, 2009; Abbas, 2010 and Gboyega, 2000) that the main challenges facing local government is that of undue interference and imposition by the state government and inelastic revenue base thereby making them dependent on federal allocation which the state control through joint account system.

On the other hand, there is the contention that the mechanism for accountability and transparency within the Local Government system is weak and often completely absent, thereby undermining the capacity of the Local Governments to deliver service effectively. To further confirm Akpan's position, the World Bank Report 2011 reveals that in Nigeria, public spending has tended to yield poor outcomes and has limited impact on social conditions, because so much emphasis is placed on input and less on output. Thus, the quality of spending has been so low in efficiency and effectiveness, that the resources spent annually

are grossly disproportionate to the limited output realized. The report discovered that the accounting factor for this is corruption, which is endemic. Hence the World Bank Report (2011) concludes that the real problem with Nigeria's service delivery system is low efficiency of budget spending, not inadequate funding and therefore suggested that major improvement in service delivery both in short and medium term should come as much from further expenditure growth as from much better utilization of the existing allocation (The World Bank, 2011). We quite concur with the conclusions of the World Bank that corruption is a bane that undermine the capacity of the local government in providing effective and efficient service delivery and thus suggest that the anti corruption laws, commissions and agencies be re-structured to handle corrupt practices. Also, the society's cultural orientation towards public property (as nobody's property) should be revisited and people be sensitized on good and decent cultural orientation that say no to corruption and corrupt practices.

Given the above position, it therefore follows that whichever way, one looks at the issue of Local Government capacity and accountability for service delivery, practically, the idea run contrary to the conventional wisdom in many development policy circles that by "bringing government closer to the people" local government will be more accountable in the management of public resources. Thus, the question of whether or not local governments have the capacity for service delivery depends on the interplay between the intergovernmental transfer of resources and local management and accountability. How best this is approached is another issue all together. However, the overall focus here is intended to assess the local capacity to manage and account for the attainment of MDGs targets on primary education and health care.

2.5: Theoretical Framework

For the purpose of this study, the Accountability framework for service delivery was adopted to explain the capacity, working and operation of local governments in the implementation of the education and health related goals of the MDGs. The Accountability model provides an alternative to effective delivery and quality of outcome of the MDGs.

2.5.1 Accountability Framework for Service Delivery

The model was developed by Soucat, Agnes and Manju Rani (2003) and adopted by the World Bank in 2004 as a framework for making services work (delivery) for the poor. The framework acknowledges that many societies around the world have tried different alternative service delivery arrangement, but with mixed results. Some governments contracted service out to the private sectors, NGOs and even other public Agencies. Other governments sell concession to the private sector (i.e. privatizing public services). Some societies transfer responsibility (finance, monitoring or provision) to lower ties of government. Responsibility is sometime transferred to communities or even household, with some good or very bad results.

The model is based on the framework of relationship of accountability between four sets of actors in the service delivery chain. These actors are:

i. Citizens/clients. Patients, students, parents, voters. It is important to note that Individuals and households have dual roles, as citizens and as direct clients. As citizens they participate both as individuals and through coalitions (communities, political parties, labor unions, business associations) in political processes that define collective objectives; they also strive to control and direct public action in accomplishing those objectives. As direct clients of service providers, individuals and households hope to get clean water, have their children educated, and protect the health of their family. The role of citizens and clients as service beneficiaries does not

imply that all citizens are alike or have the same views; some are rich and can afford the shot-route of service delivery. Others are poor and have to manage the long-route of accountability relaying on the voice and compact mechanism for service delivery.

ii. Politicians/policymakers. What distinguishes the sovereign state from all other institutions is its monopoly on the legitimate use of physical force within its boundaries. From this monopoly, politicians derive the power to regulate, to legislate, to tax—to set and enforce the "rules of the game." Politicians are defined here as those who control this power and discharge the fundamental responsibilities of the state. Politicians set general directions, but policymakers set the fundamental rules of the game for service providers to operate. They are responsible for designing and enforcing the legal capacity for service delivery (by regulating entry, enforcing standards, and determining the conditions under which providers receive public funds). This category of policy markers include; Prime ministers, presidents, parliamentarians, mayors, ministers of finance, health, education.

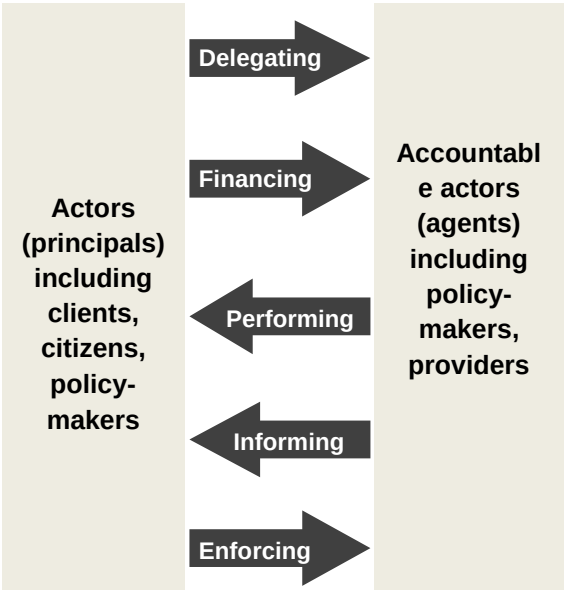
iii. Organizational providers. A provider organization can be a public line organization, whatever the name—ministry, department, agency, bureau. It can be a ministry of education that provides education services, an autonomous public enterprise (autonomous public hospitals), a nonprofit (religious schools), or a for-profit (private hospital). It can be large (public sector ministries with tens of thousands of teachers) or small (a single community-run primary school). There can be several types of providers (public, nonprofit, and for profit hospitals) and several providers of each type delivering the same service in the same area (many independently operated nonprofit and for-profit private hospitals). When the organizational provider is in the public sector, one needs to be clear about the analytical distinction between the policymaker and the head of the provider organization. The policymaker sets and

enforces the rules of the game for all providers—including the organizational provider. The head of the provider organization makes internal "policies" specific to the organization.

iv. Frontline professionals. In the end, nearly all services require a provider who comes in direct contact with clients—teachers, doctors, nurses, midwives, pharmacists, engineers, and so on.

The concept of accountability was used to explain a relationship among actors within the service delivery chain. The concept has five features: delegation, finance, performance, information about performance, and enforceability. The relationship could be simple as buying an item from the market or complex as running a public organization. In buying an item you ask for it (*delegation)* and pay for it (*finance*). The item is made for you (*performance*). You use the item (which generates relevant *information* about its quality). And you then choose to buy or not buy such item again (*enforceability*), affecting the profits of the seller. Whereas, in running a public organization or agency the citizens choose their representatives to serve as policy makers, to manage the tasks of the public organization (*delegation),* including tax and budget decisions (*finance).* The policy markers act, often in ways that involve them in relationships of accountability with service providers (*performance).* Voters then assess the service provider's performance based on their experience and *information.* And they act to control the service provider—either politically or legally (*enforceability*). In theory, the actors can be categorized into two; principal actors (includes the clients, citizens and policy markers) that demands accountability from other actors, that is the agents (I.e policy markers, and service providers) who are the accountable actors, as shown in the diagramme below.

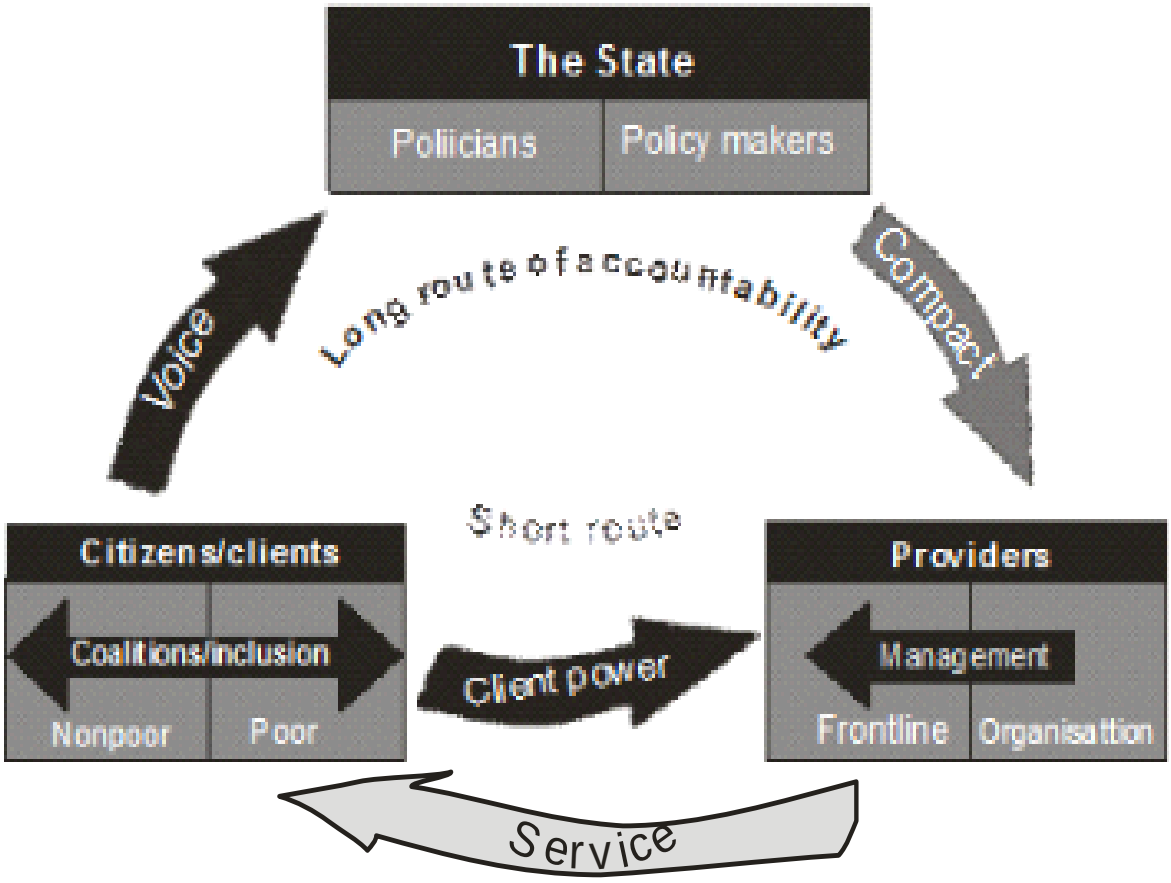
FIGURE 2.1: The Five Features in the Relationship of Accountability



Source: World Development Report; Framework for Service Delivery (2004.p47).

Ideally, these actors are linked in relationship of power and accountability. The citizen exercise voice on politicians. Policy makers have compact with organizational providers. Organizations manage frontline providers. The model uses the term *voice* to express the complex relationships of accountability between citizens and politicians. Voice is about politics, but it covers much more. The voice relationship includes formal political mechanisms (political parties and elections) and informal ones (advocacy groups and public information campaigns). Delegation and finance between citizen and state are the decisions about pursuing collective objectives and mobilizing of public resources to meet those objectives. Citizens need information about how actions of the state have promoted their well-being. They also need some mechanism for enforceability, to make sure those politicians and policymakers are rewarded for good actions and penalized for bad ones. If politicians have abused their position or even not pursuing objectives aggressively and effectively, citizens using the voice mechanisms (periodic elections) may make politicians and policymakers accountable.

FIGURE 2: Key Relationship of Power in the Framework for Service Delivery



SOURCE: World Development Report; Framework for Service Delivery (2004.p49).

On the other hand, the relationships between policymakers and service providers can be thought of as *compacts*. The compact is not always as specific and legally enforceable as a contract, though a contract can be one form of a compact. Instead, it is a broad agreement about a long-term relationship. The policymaker provides resources and delegates powers and responsibility for collective objectives to the service providers. The policymaker generates information about the performance of organizations. Enforceability comes into play when the compact also specifies the rewards (and possibly the penalties) that depend on the service provider's actions and outputs.

Furthermore, the relationship between frontline and organizational providers is that of management. In every organization, formal and informal tools of management provide frontline workers with assignments and delineated areas of responsibility, equipping them with the resources to act. In public agencies, this management function is at times blurred because providers are employees of the government. They have to create a relationship of accountability with their frontline providers.

At times, clients exercise powers through interaction with frontline providers directly, because the policymaker cannot specify all actions of providers in the compact, citizens must reveal to providers their demand for services and monitor the providers' provision of services. Clients and organizational providers interact through the individuals who provide services—teachers, doctors, engineers, repairmen—the frontline professionals and frontline workers. This is reffered to as the shot route of accountability. While the voice and compact make-up the main control mechanism of the citizens in the long route of accountability.

It is important to note that in the shot route of accountability, the relationship is simple and often more effective to monitor and efficient in providing services to the clients. This is because; it is a more direct relationship between the clients and the organizational providers, by passing the policy makers and the cumbersome bureaucratic channels. However, it is not feasible in public service delivery, such as Education and Health care services. Essentially, because of the prevailing nature of accessibility and affordability of the services which the client – provider relationship arrangement could not effectively address due to its market oriented arrangement.

In theory, when it comes to making the interest of citizens matter to service providers, two different ways are usually considered; the direct way through clients' own choice of providers which is referred to as the shot-route of accountability relationship for service delivery, and the indirect way through citizens holding policy makers accountable for the

quality of services publicly provided which is reffered to as the long-route. The question as to which of these routes is the best route for effective service delivery remains a point of contention and highly debated. However, in the context of this study, we find the long- route more appropriate and applicable.

In the context of this study, the citizens delegate the right to provision of basic education and health care services, for themselves and their families, to their politicians representing them (the state). These sets of actors determine the legal, institutional and financial capacity for the provision of education and health care services. In this respect, refers to, the Federal, States and Local Governments, who through the instrument of the state within their disposal will assign roles and functions to each tier of government (legal capacity) as well as design and develop the structures (institutional capacity) required for the effective delivery of these services. The law makers will also finance the organizational providers (financial capacity) who in this respect refers to the Ministries of Education, Health, UBEC, NPHCDA, SUBEBs, SPHCDAs, LGEAs and the PHC departments and units in the LGAs

The organizational providers on the other hand, relying on the three capacities given to them by the state (legal, institutional and financial capacities) will ensure the procurement, construction and provision of basic infrastructure and facilities required for the effective delivery of education and health care services (material capacity). These facilities are to be made available to the front line providers who in this case, refers to the; classroom teachers, school/health inspectors/supervisors, Doctors, Nurses and midwifes, CHOs, CHEWs, other Health workers and field officers. After making these things available to the front line providers, the organizational providers using the instrument of management will put in performance, through planning, organizing, coordinating and managing the activities of the frontline providers (managerial skills). The front line providers using their managerial skills

and competencies will effectively and efficiently teach pupils in schools and attend to patients in clinics. It is important to note that the effectiveness of the organizational and frontline providers is also determined by the quality and quantity of human resource (human capacity) the higher the quantity and competence of the human resource, the better the performance.

The citizen will in turn serve as clients to the frontline providers, by sending their children to the schools to learn or attending the health facility next to them as patients or sending their families to the available health facility for health care services. In the process of management between the organizational and the frontline providers, and also at the cause of accessing the education and health care services by the citizens as clients, information about the performance of both the frontline as well as, the organizational providers is being generated, on either they have or have not performed to the expectations of the clients. The clients through their power of "voice" as citizens will ensure enforceability as a form of rewarding good or penalizing bad performance, either through political or legal means, depending on the level of orientation of the citizens and the nature of the existing political system.

In the context of this study, the citizens could use the PTAs, SBMCs, Old Pupils Associations, and Health Committees existing at the facility, wards, districts and local government levels, as channels to reach their policy markers (voice). This could be directly through personal contact, or indirectly through the media. These community education and health committees and associations could as well facilitate the management of the frontline providers, through visitation and contact to monitor the quality of education and health services rendered. Also, the NUT, NULGE, M&HWS, and other staff unions at the local government level can strengthen the compact mechanism through consultation, lobby, and other form of negotiation between the organizational providers and the frontline providers on

issue of management and finance, targeted at motivating the frontline providers (teachers and health workers) to put in their best in providing basic education and health care services to the clients (pupils and patients).

In summary, the model explains a chained relationship between three sets of actor determined by the voice and compact mechanism and the legal and institutional capacities as well as the adequacy or otherwise of the financial, material and human capacities, in addition to the managerial competencies and skills of both the organizational and front line providers. The stronger these are, the better the relationship of accountability and Vis - visa. The voice and compact mechanism is determined by the level of political socialization of the citizens to organize and anchor their grievances and needs for their political representative, and the political will and determination of the politicians to use the instrument of the state to compel the organizational and frontline providers to perform to the expectation of the citizenry, coupled with the legal, institutional, financial, material and human capacities as well as the management skills and competencies of the organizational managers and frontline providers. In practice the model is designed to develop support and sustain government capacity for service delivery particularly social services like education and health.

Therefore, the study assessed the capacity of Local Governments in managing the education and health related MDGs programmes in selected Local Governments in Kaduna and Zamfara States. We also examined the roles played by each of the three actors in the accountability relationship within the service delivery chain/framework.

CHAPTER THREE

RESEARCH METHODOLODY

3.1 Introduction

This chapter discusses the research methodology adopted in the course of this study. The chapter is divided into seven sections namely the research design, population and sampling technique, method of data collection, instruments for the administration of data and method of data presentation and analysis.

3.2 Population of the study

The population of this study covers the six selected local governments from the two selected states (three from each state). However, in selecting these sampled Local Governments from the two states the multi stage sample technique was used where the state was further divided according to senatorial zones and using the quota random sampling technique, each zone represents a quota and thus one Local Government was allotted to each. In each of the three senatorial zones, one Local Government was chosen using the purposive random sampling technique bearing in mind the conventional categorization of urban, semi-urban and rural Local Government Areas.

The Local Governments in the state capitals are selected to represent urban Local Governments because of their proximity to the center, thus Kaduna North and Gusau were selected from Kaduna and Zamfara states respectively. In choosing the semi urban and rural Local Governments, deliberate and conscious effort was made to ensure that the most vulnerable within the zone is selected, in terms of remoteness, relative access to social amenities and revenue base, so as to have a good basis for comparison. In selecting a semi urban Local Government from zone 1 in Kaduna state, Lere Local Government is been

categorized as semi urban and in Zamfara state Kaura- Namoda Local Government appears to match the specification. Some of the requirement of semi urban Local Government are the presence of a comprehensive health center manned and managed by the local government, fair revenue base and presence of social amenities among others. The rural local governments are mostly those at the hinterland with little access to social amenities and revenue base. Sanga and Bakura in Kaduna and Zamfara states respectively seem to match these specifications of typical rural Local Government

Thus, using the 2006 population census figure of the Federal Republic of Nigeria, the total population for this study was 1.7 million see break down as shown in tables 3.1 and 3.2. The research population was further broken down into four main groups or categories:

i. The first group was made up of the Local Government legislatures and officials other than those in the health and LGEA in each of the selected Local Government Area. Also, in the group are staff of the Local Government Service Commission (LGSC) and Ministry of Local Government (MOLG). These sets of people were adjudged to be directly involved in the planning, and day-to-day management of the Local Government. Therefore they are supposed to be familiar with the operational guidelines and requirements in terms of personnel, structure and procedures, resources and other requirements that made up the capacity of the Local Government. The study intends to generate useful information from them on the capacity of their respective Local Governments to manage education and health programmes of the MDGs.

ii. The second group comprises of the managers of Primary Education. These include the teachers and supervisors of education and management staff of the LGEA as well as school inspectors, MDGs Desk officers at LGEA levels and staff of the state UBE

boards who are directly involved in the day to day running of primary education at local levels.

iii. The third group comprises of the managers of Primary Health care services. These include the health workers at facility level, MDGs focal person at ward levels, supervisors and management staff of the Health Department of the Local Government in addition to the staff of the state PHCD agency boards who are directly involved in the day to day administration of primary health care services at the local levels.

iv. The fourth group of the research population is the key stakeholders and beneficiaries of the MDGs programmes like community leaders, officials of school PTAs/SBMC, women attending clinics and officials of the District Health Committee who are supporter and partners in the management of education and health programmes of the MDGs as well as direct beneficiaries like women who are adjudged as the vulnerable group in all MDG intervention activities. Also inclusive are selected top MDGs and Government officials directly involved in the management of MDG activities in Primary Education and Health care who are purposively selected for interview.

3.3: Sample Size of the Study

The table below shows the population of the selected Local Governments from the two states under review.

Table 3.1: The Population of the Selected Sampled Local Governments in Kaduna State

S/N	Category	L. G. A.	Male	Female	Total
1.	Semi urban	Lere	167,392	163,769	331,161
2.	Urban	Kaduna North	186,263	171,431	357,694
3.	Rural	Sanga	76,284	73,049	149,333
	Sub-Total		**429,919**	**408,249**	**838,168**

SOURCE: Census NPC Kaduna Office 2006.

Table 3.2: The Population of the Selected Sampled Local Governments in Zamfara State

S/N	Category	L. G. A.	Male	Female	Total
1.	Semi urban	Kauran Namoda	145,150	136,217	281,367
2.	Urban	Gusau	199,823	183,339	383,162
3.	Rural	Bakura	92,864	94,041	186,905
	Sub-Total		**437,837**	**413,597**	**851,434**

SOURCE: Census NPC Kaduna Office 2006

Given the population size of 1,689,602 (i.e the combined total population of the six selected Local Governments from the two states) the sample size is computed using the formula suggested by Yamane (1967.p 886). Yamane provides a simplified formular to calculate a sample sizes as shown below:

$$n = \frac{N}{1+N(e)2}$$

Where n is the sample size, N is the population size, and e is the level of precision. When this formular is applied to the population of this study, we get the following result as shown below:

$$n = \frac{N}{1+N(e)2} \quad \frac{1{,}689{,}602}{1+1{,}689{,}602(.03)} = 1{,}111$$

Thus the sample size for 3% Precision levels where Confidence Level is 97% and p = .3 is equal to 1,111 as calculated above. Why we choose 3% level of precision instead of the usual 5% is because the greater number of respondents the wider the coverage of a given population. Thus 3% precision level gives us a higher number of respondents than 5% precision level. Again, in order to address the problem of unreturned questionnaires and non responses of people slated for interview, the calculated sample size is further increased by 35% making the total sample for this study 1,500. Although the population of the two states was unequal (6,113,503 for Kaduna and 3,278,873 for Zamfara based on the 2006 census figures) but going by the relative equal size of the total population of the sampled Local

Governments in the two states (i.e 838,168 for Kaduna and 851,434 for Zamfara) the quarto sampling technique was employed.

It should be noted therefore that the 1,500 selected sample served as the overall sample size for this study which is equally shared among two states (750 each). 4% of the allotted figure to each state is set aside for personal and focus group interviews (30 per state). This is because interview is time consuming and requires smaller and manageable group and within each state the quarto random sampling is still employed were each of the three selected Local Government Areas get equal proportion of 240 questionnaires each. Within each Local Government the figure is again equally distributed among the three groups of the research population listed earlier, 80 per each (i.e. Local Government functionaries, providers and managers of Primary Education and Health care services). However, the allotted figure to each Local Government is purposively shared among local government functionaries, managers of Primary Education and Health care (as shown in table 3.3.3 below.). The 4% is equally shared among the two sets of interviews (i.e. personal and focus group interview) groups. 2% is proportionally allocated to focus group interview for women attending clinics and school PTAs/SBMCs officials accordingly and the remaining 2% is purposively distributed among community leaders, top MDGs and Government officials who are involved in the administration of Primary Education and Health care making an overall total of 100% (as shown in table 3.3 below).

TABLE 3.3: Distribution of Selected Respondents among Local Government Functionaries, Primary Education and Health Care Providers and Managers

		Kaduna state				Zamfara state			
S/N	**L. G. Functionaries /State Government Agencies**	**Lere LGA**	**Kaduna North**	**Sanga LGA**	**Sub Total**	**Bakura LGA**	**Gusau LGA**	**Kauran Namoda**	**Sub Total**
1.	**Local Council and Executive**								
*	Chairman	1	1	1	3	1	1	1	3
*	Councilors	10	10	10	30	10	10	10	30
*	Secretary	1	1	1	3	1	1	1	3
*	DPM/HODs	5	5	5	15	5	5	5	15
*	**Other Departments**								
*	Agriculture (field officers)	11	11	11	33	11	11	11	33
B.	Works (technical staff)	11	11	11	33	11	11	11	33
*	ESD staff	15	15	15	45	15	15	15	45
*	Treasury & Budget staff	11	11	11	33	11	11	11	33
*	Administration	11	11	11	33	11	11	11	33
*	LGSC Officials	-	-	-	6	-	-	-	6
*	MOLG Officials	-	-	-	6	-	-	-	6
	Sub-total	**76**	**76**	**76**	**240**	**76**	**76**	**76**	**240**
2.	**Education Department**								
*	Education Secretary	1	1	1	3	1	1	1	3
*	HODs	6	6	6	18	6	6	6	18
*	District Education Supervisors	15	15	15	45	15	15	15	45
*	Head Teachers	24	24	24	72	24	24	24	72
*	Teachers	30	30	30	90	30	30	30	90
*	State UBE officials	-	-	-	12	-	-	-	12
	Sub-total	**76**	**76**	**76**	**240**	**76**	**76**	**76**	**240**
3.	**PHC Department**								
*	PHC Coordinator	1	1	1	3	1	1	1	3
*	Asst. PHC Coordinators	5	5	5	15	5	5	5	15
*	MDG Focal Person (if any at ward level)	15	15	15	45	15	15	15	45
*	District Health Supervisors	25	25	25	75	25	25	25	75
*	Medical Health Workers at Facility Level	30	30	30	90	30	30	30	90
*	State PHC Agency staff	-	-	-	12	-	-	-	12
	Sub-total	**76**	**76**	**76**	**240**	**76**	**76**	**76**	**240**
	Total	**228**	**228**	**228**	**720**	**228**	**228**	**228**	**720**

Source: *Survey Research, 2013*

TABLE 3.4: Distribution of Selected Respondents for Personal and Focus Group Interviews

S/N	Respondents to be Interviewed	Kaduna	Zamfara
1.	Personal interview		
*	MDGs Focal person	6	6
*	Directors LGSC, SUBEB & PHCDA	3	3
*	Opinion Leaders	6	6
2.	Focus group interview		
*	PTAs/SBMCs	6	6
*	Women attending clinics	6	6
*	District Health Committee officials	3	3
	TOTAL	30	30

Source: Survey Research.2013

3.4 Method of Data Collection

For the purpose of this study, two sources of data collection are employed to generate data. These are primary and secondary sources.

Primary Data: The primary data was generated through the use of three instruments of data collection, namely: questionnaires, interview and observation techniques.

1. **Questionnaire:** Three sets of questionnaires were used one, for selected local government functionaries and the other two for Primary Education and Health care managers and providers respectively.. The questionnaires contain both open-ended and close-ended questions (tick the correct response). The questions are designed to elicit information from the respondents on a range of issues surrounding the capacity of the Local Government to manage the Primary Education and the Health related MDGs programmes. Such as the man-power requirement in quality and quantity, the adequacy of the financial resources, the local management capacity, the institutional and legal position, powers and status of the Local Government in providing Primary Education and Health related MDGs services as well as the challenges associated to the management of MDGs programmes locally. The questionnaires

seek to establish if there exist any significant correlation between the local management capacity and the achievement of the MDGs targets in Primary Education and Health care programmes at local levels.

The second and third questionnaires try to explore the various MDGs Intervention activities and the extent to which these activities have improved on the local capacity to provide Primary Education and Health care services respectively. Each of the questionnaire seek to establish if there is any significant relationship between the MDGs Intervention initiatives and the capacity of the Local Government in managing Primary Education and Health care services respectively.

2. Interview: In order to generate further information on the operation and management of MDGs programmes at local levels, the interview technique in addition to the questionnaire were used. The interview explores issues on the process and procedure in planning, implementation, monitoring and evaluation of MDGs programmes. How and when it is done, with who, and the resource requirement, the progress made and some of the challenges encountered, as well as issues on community perception and support. The personal and focus group interview formats are used; the respondents are asked questions based on the interview schedule, record of responses are written down and where permission is granted the interview was recorded on tape.

3. Observation: In the process of conducting this study, we also employed the method of observation to gather additional information that will complement and validate some of the answers obtained from questionnaires and interview methods. The observable traits are: the quality of projects output, the impact of the programmes which could be observed through frequency and magnitude of usage, the size and nature of the facilities, the attitude of the local community towards the programmes; as indicator of community willingness to

participate, partnership and support of the programmes. The study also, observed the attitude of teachers and health workers to work, punctuality, dedication to duty, as well as the availability and functionality of the facilities and infrastructures for the programmes at local level.

Types and Sources of Secondary Data

The secondary sources involve the fraction of information from the following documents particularly as they relate to this study.

1. MDGs Projects and Support initiatives	• Plans, budgets and Reports
2. MDGs Conditional Grant Scheme	• Account and Reports
3. Other funds for MDGs Projects	• Account and Reports
4. Local manpower in PHC and LGEA	• Staff records in the LGCs
5. Existing Health and Education facilities	• Statistics and Records
6. Assessment of LG performance in service delivery	• Official Reports, NGOs, Scholars e.t.c.

Other relevant sources includes Journals, Articles, Periodicals ,as well as research by individuals, groups and other unpublished materials on the subject as well as Press releases, media reports, internets and other publication in that respect. These secondary information sources compliment the primary sources.

3.5 Administration of Data Instruments

The method of administration of this research instruments was based on the personal effort of the researcher with the help of field assistant‘s’ to distribute, assist in completion where necessary and collect the completed questionnaires. The responses of the respondent are measured based on five to four Likert scale viz: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD) and Undecided (U) and other varying scales.

The second method which is the interview technique, the unguided and somehow unstructured face-to-face interview style is used. The opinion of those involved was sort on range of issues based on the subject matter of our study.

3.6 Method of Data Presentation and Analysis

For the purpose of this study, appropriate tables and graphs are used to summarize the data in a manner that will easily be understandable. Frequency and percentages were used to compare results of responses to the questionnaire and answers from the interview respondents, while normal descriptive and narrative form of data presentation was used to report result of some interviews and the researcher's direct observation carried out during the course of the study.

Again, there are numerous instruments for data analysis. However, we find Multiple Regression analysis most appropriate. This is because this type of statistical tool is used mostly to measure the impact of variable X on Y. In other words it tries to predict the variable X on the knowledge of the variable Y. the formular for calculating the regression is:

$$Y = a + x^1, x^2, x^3$$

Where y = dependent variable
x = independent variable(s)
a = constant

The regression coefficient is a measure of how strongly each independent variable predicts the dependent variable. The standardized coefficient (beta) is measured in standard deviations. A beta value of 2 associated with a particular independent variable indicates that a change of 1 standard deviation in that particular independent variable will result in a change of 2 standard deviations in the dependent variable. The R represents the correlation between the observed values and the predicted values of the dependent variable. The R Square is the square of R and gives the proportion of variance in the dependent variable accounted for by the set of independent variables chosen for the model. The R Square values could be as high as 0.99 (99%), or as low as between 0.20-0.10 are acceptable in social science research (Ajai, 2009). The adjusted R Square gives more information about the fitness of the model. We

used the Statistical Package for Social Science (SPSS 16.0) to run the multiple regressions where the dependent variable (Attainment of MDGs targets) is regressed against the independent variables (infrastructural capacity, human capacity and managerial capacity).

Decision Rules: These rules state as follows:

I. The hypotheses are stated in a null form

II. The level of significance is set at 0.05 or 0.01

III. If the F calculated value of the Anova test statistics is greater than the F critical value (2.60) and P calculated is less than 0.05 we reject the null hypothesis and accept the alternate. We then conclude that there is a significant relationship or effect.

IV. If on the contrary the F calculated value of the Anova test statistics is less than the F critical value (2.60) and P calculated is greater than 0.05 we accept the null hypothesis and reject the alternate. We then conclude that there is no significant relationship or effect.

CHAPTER FOUR

EDUCATION AND HEALTH RELATED MGDs PROGRAMMES IN NIGERIA

4.0: Introduction

This chapter discusses the institutional framework and strategy guiding the implementation of the MDGs programmes in Nigeria. The chapter is divided into ten sections. In section one, discussion centers on the MDGs programme in Nigeria. Section two examines the structure for MDGs programme implementation in Nigeria. Section three looks at the institutional structures of the MDGs programme in Nigeria. Section four discusses the State Government structures of the MDGs programme in Nigeria. Section five examines the Local Government structures of the MDGs programme in Nigeria. Section six looked at the funding structure of the MDGs programme in Nigeria. Section seven discusses the capacity requirements for the implementation of education related MDGs programmes in Nigeria. Section eight examines the capacity requirements for the implementation of health related MDGs programmes in Nigeria. Section nine deals with the background of Kaduna State while, section ten examines Zamfara State in context.

4.1: MDGs Programme in Nigeria

The MDGs are a series of eight time-bound development goals that seek to address issues of poverty, education, gender equality, health, the environment and global partnerships for development, agreed by the international community at the United Nations Millennium Summit in November 2000. The goals are to be achieved by the year 2015 and 1990 was set aside as the baseline. The MDGs targets in Nigeria are consistent with the National Economic Empowerment and Development Strategy (NEEDS) targets (2003 – 2006), the 7 point Agenda (2007 – 2011), the Jonathan's Transformation Agenda and vision 20:2020, and act as

the baseline for Nigeria's development to 2015 (MDGs, 2012). However, these initiatives do not require the setting up of separate institutional arrangements, but rather the introduction of an effective system of monitoring and evaluation that will efficiently track down government resources and expenditure in the direction of the MDGs set targets. Thus, the Federal Government established the Office of the Senior Special Assistant to the President on Millennium Development Goals (OSSAP-MDGs) to oversee and monitor the implementation of the MDGs initiatives and directed all tiers of government, Ministries, Departments and Agencies to key in into the programme.

It is important to note that Nigeria is a Federal Republic made up of 36 states, a Federal Capital Territory and 774 Local Government Areas. Under the Constitution, each of these tiers of Governments has responsibilities for defined aspects of public service delivery. The Federation Account funds are shared among the three-tiers of government (i.e. Federal, State and Local Governments) according to a prescribed formula. The Federal Government Ministries, Departments and Agencies (MDAs) are responsible for policy and quality assurance, while States and Local Governments which have better knowledge of their local environments and their needs – thereby placing them in a better position to implement projects.

In view of these, the OSSAP-MDGs came up with a monitoring and evaluation mechanism called Overview of Public Expenditure in NEEDS (OPEN) now Overview of Public Expenditure in Nigeria. OPEN is an enhanced version of the Virtual Poverty Fund (VPF). The VPF is a coding system within an existing budget classification structure that enables the 'tagging' and 'tracking' of poverty-reducing spending. The codes label a portion of government expenditures as poverty-reducing either funded by Debt Relief gain or both. While VPF concentrated on activities and outputs OPEN has added three additional aspects to enhance the effective utilization of the debt relief in the federation. These are:

i. Identifying and tracking down the available resources at the planning stage (Inputs)

ii. Designing what the programme does (Activities).

iii. Oversee and monitor the goods or services provided by the programme (Output).

iv. Note the effect of outputs on beneficiaries (Outcome) and

v. Finally, examine the long term generalized effects on beneficiaries (Impacts) (MDGs, 2012:28).

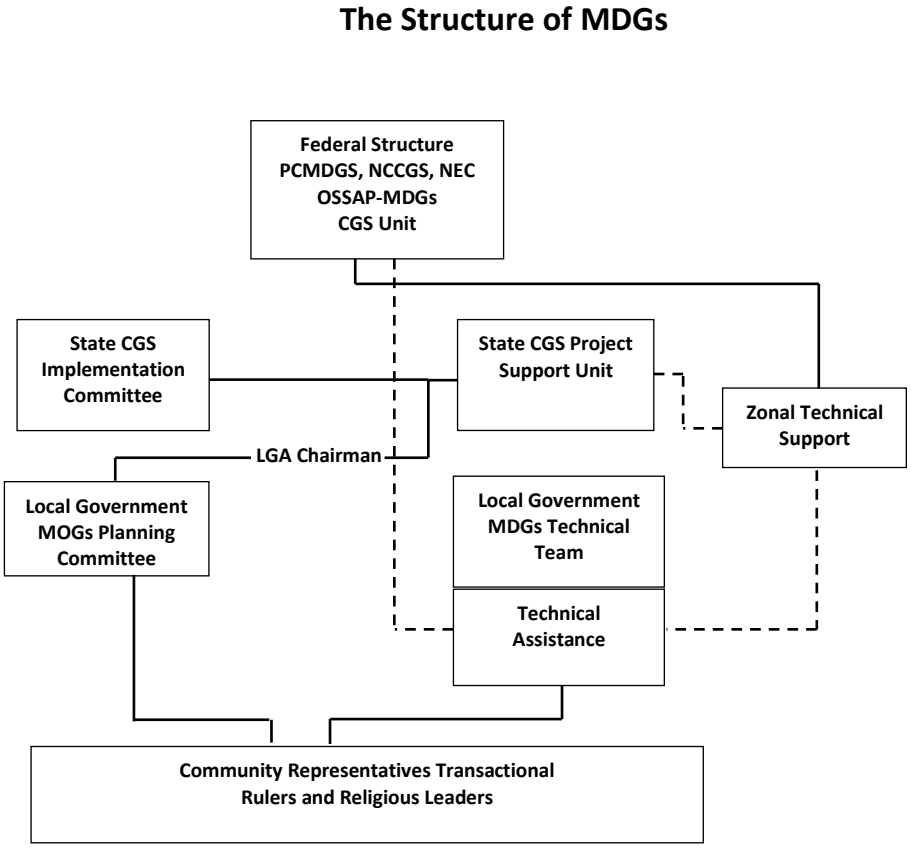
4.2: Structures for MDGs Programme – Implementation (Education and Health)

The MDGs programme in Nigeria is partly funded by the Debt Relief Gain (DRG) negotiated with the Paris Club of Creditors in September 2005. The DRG resulted in the saving of about one billion US Dollars per annum to Nigeria. Nigeria has pledged before the Paris Club of Debtors on the 23th of June 2005 to spend the gains on pro-poor projects and programmes in support of a national effort towards the achievement of the MDGs targets. For the Debt Relief savings to contribute more effectively to the achievement of the MDGs, a mechanism for results-oriented expenditure was put in place by the Federal government. The mechanism ensures that a proportion of the Federal share of the Debt Relief Gains is appropriated in the Federal Government annual budget as Conditional Grants to States to leverage additional resources and policy reforms at the sub-national level.

4.3: Institutional Structures of the MDGs Programme

The MDGs programme operates through specific Federal, State and Local Governments structures as shown below:

Figure 4.1: The Organizational Structure of MDGs in Nigeria



Source: OSSAP-MDGs, 2011

As shown in the figure 4.1 above the federal government structures has three sets of offices work harmoniously to ensure the effective management of the MDGs activities. These are:

i. The Presidential Committee on the Assessment and Monitoring of MDGs (PCAM-MDGs) is chaired by the President. Membership of the Committee is drawn from public and private sectors, civil society and the international development partners. It assesses and monitors progress of MDGs projects towards the achievement of the MDGs set targets in Nigeria.

ii. The National Committee on Conditional Grants Scheme (NCCGS). This committee is chaired by the Minister of Finance. Its membership composed of:

i. The Minister of the National Planning Commission,

ii. The Ministers of key MDGs line Ministries (Education, Health, Agriculture, Works, Environment, Economic Planning and Water Resources),

iii. The Director General of the Budget Office of the Federation,

iv. The Accountant General of the Federation and

v. The Senior Special Assistant to the President on MDGs.

The NCCGS is responsible for:

i. Taking the final decisions on CGS project areas for each year.

ii. Setting State and Local Government application limits for the year.

iii. Reviewing technical reports from the Secretariat of NCCGS on the evaluation of all applications received from States.

iv. Proposing selected projects to Federal Executive Council for final approval.

v. Reviewing progress on implementation and

Determining the final allocation of CGS funds to States (FRN, 2011).

iii. The Office of the Senior Special Assistant to the President on MDGs (OSSAP-MDGs). The OSSAP-MDGs serves as the Secretariat to the PCAM-MDGs and NCCGS. It is responsible for:

i. Reviewing Guidelines based on due consultation with relevant stakeholders,

ii. Communicating the proposed timetable, project areas, total available funds as well as limits for the Conditional Grants Scheme to State and Local Governments,

iii. Calling for CGS fund applications from State Governments, receiving and evaluating all grant applications from the States and issuing no objections for Local Governments exclusive projects,

iv. Consulting with the relevant Federal MDAs for any queries, technicalities, or assistance pertaining to the CGS applications submitted by the State and Local Governments and ensures that all projects and to national policy framework and standards, and

v. Communicating the final outcomes of the evaluation process and other operational issues of Conditional Grants Scheme to the State and/or Local Governments (FRN, 2012).

However, to ensure that these functions and responsibilities are discharged accordingly, the Secretariat of the NCCGS can engage the services of Consultant(s) to provide technical support and to collaborate with the Secretariat in areas of Policy and Sector Analysis, Training/Capacity building, and Information Technology Data Management and Reporting. The Secretariat will also collaborate with relevant Federal MDAs, the UNDP, DFID, Private Sector and Civil Society Organizations to ensure policy coherence, coordinate initiatives, provide technical support, delivery of infrastructure and human resources, and feedback on monitoring and evaluation.

4.4: The State Government Structures of the MDGs

The state government structures as shown in figure 4.1 above has two sets of committees; the state MDGs Implementation Committee and the state CGS Project Support Unit (PSU) that work closely together. The State Committee on the Implementation of the MDGs Projects shall include, but not limited to the following members:

i. The Commissioner of Economic Planning of the Government or any other competent officer appointed by the Governor as Chairman (The appointee must not be below the level of Special Adviser to the Governor).

ii. The Appointee of the Governor on MDGs (who should be the State MDGs focal person as secretary)

iii. Representative of the relevant MDAs not less than the rank of a director

iv. Chairman of the State Chapter of Association of Local Governments of Nigeria (ALGON),

v. Secretary of the State Chapter of Association of Local Governments of Nigeria (ALGON)

vi. State CGS Project Management Consultant

vii. Chairmen of Participating LGAs (this is in relation to CGS to local government tracks only)

viii. Representative of the Office of the State Accountant General

ix. Representative of the Local Government Service Commission (FRN, 2011).

Responsibilities of the State Committee on the implementation of the CGS Projects are as follows:

i. guiding, overseeing, monitoring and assessing the implementation of the MDGs projects in the State and Local Governments;

ii. providing overall policy guidance and effective direction to State PSU, LG MDGs Planning Committee and LG MDGs Technical Team based on emerging experiences in the state (in project identification, preparation of proposals, etc);

iii. ensuring full institutional support for all MDGs projects;

iv. serve as the Project Tender Board for both the CGS to the State and Local Government Areas;

v. reviewing the Local Government CGS Project Plan to ensure community participation as well as compliance with other requirements;

vi. monitoring various stages of project cycle as well as ensuring that milestones are met within set timelines;

vii. reporting to the State Government on the Status of MDGs projects Implementation (State and LG Tracks); and

viii. In order to forestall possible operational bottlenecks, the state implementation committee shall not interfere in the day to day running of the PSU.

The running of the PSU is the responsibility of the focal person who is the head of the PSU (FRN, 2012).

The second body is the State Focal Person/Project Support Unit (SFP/PSU).The office of the State MDGs Focal Person shall serve as the secretariat of the Committee. He shall be appointed by the State Governor. She/he could be a political appointee or a career civil servant not less than the rank of a Director in the Ministry of Planning/State Planning Commission. The office shall:

i. Serve as the Project Support Unit to the Committee and implementing MDAs,

ii. Coordinate the preparation of applications to access the CGS fund,

iii. Coordinate the implementation of MDGs projects through approval, pre-implementation and implementation phases as directed by the State Implementation Committee,

iv. Maintain relations with relevant MDAs at the State and Federal levels that have stake in the MDGs projects being implemented,

v. Initiate processes for collecting and analyzing locally-collected information that will support the planning and execution of MDGS projects,

vi. Maintain relations Local Governments MDG structures and communities to ensure sustainability of MDGs projects,

vii. Respond to queries and requests for information as and when they are made by the Secretariat of the NCCGS and other stakeholders,

viii. Coordinate relevant MDAs‟ strategic planning and implementation functions in respect of MDGs,

ix. Arrange for meetings of the Committee to discuss operational matters or developments related to the MDGs,

x. Coordinate MDGs project monitoring and evaluation,

xi. Maintain up to date information on the status of State's MDGs implementation, and

xii. Ensures that monthly, quarterly, mid-year and yearly reports are forwarded to the Secretariat of the NCCGS and other stakeholders.

xiii. Provide technical support and hold periodic meetings with the Local Government MDGs Technical Team and

xiv. Serve as communication lines between all three tiers of Government in the implementation of CGS to Local Governments (FRN, 2012).

The Project Support Unit will be supported by the following staff:

i. State MDGs desk officer, who is to assist the State Focal Person in the running of the office and shall be the Secretary/Head of Administration,

ii. Desk officers from the implementing MDAs

iii. Desk officer for the MDGs to Local Government deployed from the Ministry of Local Government

iv. State MDGs Project Management Consultant.

The MDGs – CGS implementation manual (2012) maintained that the State MDGs Project Management Consultants shall be appointed by the OSSAP- MDGs and deployed to the State on short term basis. The responsibilities of the consultants shall include: Assist in building capacity of the State's team in management of MDGs projects; Assure that best recognized practices are followed in selection of contractors and issuing of contracts documents; Ensure that project milestones are appropriate and achievable; Ensure compliance

with set guidelines, standards and entire work plan. It was also stated in the manual that the project management consultant shall not interfere with the activities of the State Committee on the implementation of the MDGs but is expected to submit periodic observation reports to the secretariat of the NCCGS.

Additionally, the implementation manual further spelt out the role of other State MDAs *a*s follows:

i. In states where the Office of the Commissioner/Special Adviser/Senior Special Assistant (MDGs) exists, it is envisaged that the office will serve in coordinating and catalyzing political support for CGS processes in the State.
ii. State Planning Ministry/Commission for generation and management of data and coordinating interventions.
iii. State Ministry of Local Government to provide support for institutional development of LGAs.
iv. State Ministries of Health, Education, Agriculture and other relevant MDGs implementing MDAs to provide harmonization of sector policy analysis as well as technical support in project execution and management.
v. State Local Government Service Commission for capacity building and human resources (FRN, 2012).

Note that the MDGs office in each state serve as the secretariat that coordinates all the state MDGs programmes, the Special Adviser to the Governor on MDGs is the overseer of the MDGs office, assisted by a handful of officers deployed from other service ministries as project planning, monitoring and evaluation officers. However, the institutional arrangement of the state MDGs office is at the discretion of the state Government. In Kaduna state, the MDGs Adviser is assisted by four principle Directors; Monitoring and Evaluation, Administration, Finance and supplies and Project Manager (who is acting as the MDGs focal

person for the state in terms of project implementation). While in Zamfara state the Special Adviser is assisted by a permanent secretary (who is also a political appointee) before the other four Directors.

4.5: The Local Government Structures of the MDGs

The Local Government structures as shown in the figure 4.1 compose of two Committees: First is the Local Government MDGs Planning Committee which Compose of sixteen people namely; Chairman of Local Government (LG) as the Chair; Secretary of LG; Treasurer of LG; Director (Personnel Management) or equivalent; Two Representatives of the Local Government Legislative Council; Supervisor of Health LGA; Supervisor of Education LGA; Supervisor of Agriculture or an alternative Supervisor of Works LGA; Five Representatives of CBOs, FBOs, Traditional Institutions and the private sector (At least 2 Females); Technical Assistant and Local Government CGS Desk Officer(FRN,2012).

The responsibilities of Local Government MDGs Planning Committee shall be:

i. reviewing and endorsing the Local Government MDGs Plan;
ii. incorporating the Local Government MDGs Plan into the Local Government Budget;
iii. reviewing and endorsing the CGS to Local Government's project proposal to State MDGs implementation Committee;
iv. ensuring that Local Government obligations for the operation of the CGS to Local Governments are met;
v. ensuring synergy of the CGS to Local Governments projects with other projects at the Local Government; and
vi. Resolving conflicts amongst Local Government stakeholders (FRN, 2012).

The next horizontally in the hierarchy is the Local Government MDGs Technical Team that composes of: The Technical Assistant (TA) deployed by the Zonal Technical Support Office, who led the team, other members includes; Head of Health Department; Head of

Education and Social Development Department; Head of Agriculture Department; Head of Works Department; Education Secretary Local Government Education Authority; Local Government Planning Officer or where none exists the Budget Officer.

The responsibilities of the Team include:

i. preparation of MDGs-compliant LG Plans (Agreed Projects, justification for selected project, implementation timeline and work plan, project design, budget including detailed costing, recurrent costs, sustainability provisions, etc) in collaboration with community members;
ii. preparation of Reports to States, Zonal Technical Officers office and Federal Government;
iii. local Government wide MDG budgeting;
iv. assisting in the local coordination of survey and data collection;
v. local coordination of the Local Government Needs Assessment Analysis; and
vi. facilitating the process of project prioritization and identification by the community members as well as preparation CGS to Local Government's project proposal (FRN, 2012).

The specific tasks of the Technical Assistant shall include:

i. to assist the Local Government in setting up key structures for the Conditional Grants Scheme to the Local Government;
ii. to coordinate the functions of the CGS to Local Government Technical Team;
iii. to liaise with the Secretary of the Local Government to ensure that the CGS to Local Government Planning Committee meets regularly;
iv. to identify human resource needs through a capacity assessment within the institutions of Local Government for effective planning and implementation of MDGs-related activities;

v. to assist the Local Government in applying a sector – by – sector needs assessment for the achievement of the MDGs using instruments and tools provide;

vi. to facilitate the identification and design of effective interventions to meet LGA needs. This will draw from a menu of interventions to be determined in the agreement with States and LGAs;

vii. to coordinate the preparation of the costs associated with Local government integrated development plans;

viii. to advise on the institution and development of timely monitoring activities by the Local Government;

ix. to report to the designated Zonal Technical Officer on the activities and progress of implementation of MDGs Projects within the LGA and the status of the planning and monitoring tools within the LGA;

x. to liaise with other local government and relevant bodies at the State level through existing mechanisms in order to share lessons and ensure consistency of interventions;

xi. to interpret and communicate the outcomes of the baseline survey and needs assessment of the Local Government to Local Government institutions;

xii. to undertake and promote appropriate and targeted capacity building for staff of the Local government in response to needs, or to facilitate /organize appropriate technical training and capacity building where needed;

xiii. to provide additional technical support and advise to Local Government Institutions in relation to MDGs processes, interventions and outcomes as and when required;

xiv. to engage with a number of regional and global networks to connect Local Governments to the information and expertise of key partners including the UN, World Bank and Earth Institute; and

xv. to initiate and convene workshops with key stakeholders at the Local Government level to address emerging issues and challenges (FRN, 2012).

Note that this institutional arrangement is mostly if not only applicable to LGAs that benefit from or preparing to receive the CGS. As in the case of Kaduna state only fourteen benefited LGAs have complied with the above institutional arrangement (Ikara, Lere, Birnin Gwari, Kachia, Giwa, Kajuru, Sanga, Kagarko, Kudan, Makarfi, Chikun, Igabi, Kubau and Jaba LGAs), while the remaining are not strictly adhering to this MDGs institutional structures. While in Zamfara state all the 14 LGAs with exception of Gusau LGA have strictly adhered to the MDGs institutional structures. More so the MDGs-CGS institutional arrangement recognized Zonal Technical support unit situated in each geo-political zone to provide technical backstopping to States and Local Governments particularly in the implementation of CGS to Local Governments as well as facilitating peer learning between LGAs and States within each geo-political zone. The Zonal Technical Officers are domiciled in the capital of one of the States within the geo-political zone selected based on accessibility and willingness of the State Government to provide facilities and personnel for the Office. The current locations of the offices are:

i. Dutse (Jigawa) for North West ;
ii. Minna (Niger) for North Central ;
iii. Gombe (Gombe)for North East;
iv. Owerri (Imo) for South East;
v. Asaba (Delta) for South South and
vi. Ado-Ekiti (Ekiti) for South West.

The salaries of the Zonal Technical Officers are currently being paid by the UNDP while the host State Governments makes available office space, required staff, operational materials, tools and consumables to enable them perform their functions.

4.6: The Funding Structure of the MDGs Programme in Nigeria

The MDGs programme in Nigeria is partly funded by the Debt Relief Gain (DRG) negotiated with the Paris Club of Creditors in September, 2005. The DRG resulted in the saving of about one billion US Dollar per annum to Nigeria. Nigeria has pledged before the Paris Club of Debtors on the 23th of June 2005 to spend the gains on pro-poor projects and programmes in support of a national effort towards the achievement of the MDGs targets.

The MDGs Conditional Grants Scheme is one of the programme in which State and Local Governments are availed the opportunity to access funds annually from the Federal Government's share of the Debt Relief Gains. The CGS intervention is a way of making financial grants available to State and Local Governments in a clearly designed conditional partnership agreement where the States and/or Local Governments contribute equal amounts (i.e. fifty percent as cash counterpart contribution) for the execution of projects in line with the objectives of the MDGs. The CGS is seen as an opportunity to maximize the use of information and expertise at every level of government and share the burden of expenditure responsibility among different levels of government (Khor, 2012). The scheme also seeks to foster genuine commitment among the Federal, State, Local Governments, communities and civil society, this will engender sustainability.

In addition, the scheme offers a unique opportunity to build a platform on which States and Local Governments harmonize their budgets fully with the nation's Medium Term Fiscal Framework. Indeed, it is an opportunity to leverage spending towards supporting State and Local Government programmes that are fully aligned with national policy objectives and the MDGs. Some are of the opinions that the Conditional Grants Scheme seeks to build the capacities of States and Local Governments in order to improve governance, service delivery, financial management, transparency, and accountability as well as the attainment of the MDGs (Dele et-al, 2011; FMOE, 2011; UNDP, 2012). The CGS is therefore one of the

Federal Government's ways of intensifying its efforts at achieving the MDGs at all levels of government in the country. It is clearly designed as a means of funding MDGs -related projects at State and Local Government levels.

Conditionalities and Procedures of Accessing the Funds

Every State and Local Government implementing CGS-funded projects must have in place a Financial Management System (FMS) that will:

i. facilitate State PSU in deploying project resources to produce the required out puts and with attention to economy, efficiency and effectiveness;

ii. be capable of producing timely, understandable, relevant and reliable financial information that will enable the PSU to plan, coordinate, monitor and appraise the project's overall progress towards the achievement of its objectives as well as ensuring that costs are under control and project funds are used for the purposes intended efficiently and effectively;

iii. be capable of tracking financial disbursement vis-à-vis physical performance; and

iv. assist in guiding resource use and serve as a check to ensure effective financial management (FRN, 2011).

For the implementation of the CGS projects, the following bank accounts shall be maintained:

i. State CGS to State Special Project Account; in this account the State's 50% Cash Counterpart Contribution and the Federal Government CGS fund will be deposited (State should open an account for each round (year) of CGS to accommodate audit procedures and oversight requirements).

ii. State Project Support Unit (PSU) Operational Costs Account

iii. CGS to Local Government Special Project Account. In this account, the Local Government 20% and the State's 30% Cash Counterpart Contribution and the Federal Government CGS fund will be deposited.(Each local government is expected to have an account for each round of CGS to accommodate audit procedures and oversight requirements).

iv. Local Government CGS operational cost account (FRN, 2011).

The various operational cost accounts shall contain 5% of each tier's contribution to the CGS and will form part of their counterpart contributions. These operational costs shall cover project management and sustainability, fees, staff incentives and other incidental expenses. Also, signatories to the state and local governments" accounts will be in line with the requirements of the State's Financial Instructions and Local Government Financial Memoranda. The manual further maintain that the CGS to State Special Project Accounts and CGS to Local Governments Special Project Accounts will be reconciled with bank statements on a monthly basis by the PSUs and Local Government Treasurers respectively. Thus The State and Local Governments should, in line with government practice, maintain the following financial books:

i. Cash Book to account for all expenditures by type,

ii. General Ledger Book,

iii. Bank reconciliation statements,

iv. Fixed Assets Register and

v. Contract Register (FRN, 2011).

It is important to note that the UBE and PHC programmes are the major interventions that support the MDGs targets on Education and Health care in Nigeria. Thus, at the state and local government levels, MDGs targets and strategies are incorporated into all ministerial and departmental policy programmes. States and Local Governments have design their political

agenda and programme in line with the MDGs targets and strategies. The UBE and PHC programmes were identified as the best strategy for the attainment of and health related MDGs targets, thus given priority attention by States and Local Governments. Infact, OSSAP-MDGs report 2010 shows that majority of the DRF from 2005- 2010, has gone to the core social sectors of government. Water and Sanitation 16%, Education 22%, Health 27%, Power and Roads (Infrastructure) 7%, Environment and Housing 7%, Agriculture 5%, Social Safety Nets 5%, Youth and Women 3% and Other 5%. Thus, of all, Education and Health have received roughly half of the DRF. It should be noted that the CGS to states started in 2007 and the grants were focused on Health, Water, Power and Public Private Partnership. 28 States including FCT applied out of which 19 of them were able to access the funds. The value of the accessed projects by these states including counterpart funding stand at 18.4 billion naira, Zamfara and Kaduna States were among the 19 benefiting States (MDGs, 2010).

The UBE Funding Structure

It is important to note that the UBE as an intervention programme is a funding arrangement of the federal government to provide financial and technical assistance to states and local governments in support of their effort to deliver basic education. The programme is partly financed through the 2% of the Consolidated Revenue Funds (CRF) of the federal government. This amount translated into N24.30 billion in year 2005 when it was first released and later rose to N30 billion in 2006. The sharing formular and components of the CRF directed that:

i. 70% of the UBE fund be given to the 36 states and FCT on equality basis as matching grant

ii. 14% is to be shared to states to correct educational imbalance within and between states.

iii. 5% to states that are doing very well in the implementation of the UBE programme as incentive.

iv. 5% dedicated to school feeding and health programme

v. 2% to address issues of special needs education specifically physical and mentally challenged children

vi. 2% for monitoring the implementation of the programme

vii. 2% as UBE commission's implementation fund. (Tahir, 2007)

However, the criteria for assessing the 70% matching grant fund by the states is predicated on a number of conditions. These are:

i. enactment of the State Universal basic Education law in compliance with section 12(1) of the UBE Act 2004;

ii. establishment of State Universal Basic Education Board (SUBEB) in each state with appointment of principal officers to manage the Board and implement the programme;

iii. opening of a separate Bank Account with the Central Bank titled "UBE matching grant account" with executive chairman of the board and senior seasoned civil servant in the board as signatories to the account;

iv. lodgment of states counterpart contribution of 50% of the same amount; and

v. development and submission of state action plan to UBEC for negotiation and eventual approval.

In utilizing the funds, the state should assign the following percentage to the following level of basic education;

i. Pre-primary education 5%

ii.	Primary Education	60%
iii.	Junior secondary education	35%
		100%

And further allocate each of this level to be utilized on the following major components of the UBE programme:

i.	Infrastructural development	70%
ii.	Provision of instructional materials	15%
iii.	Teacher professional development	15% (Tahir,2007)

Indeed, the UBE programme offers a unique opportunity for state governments to access funds for the development of basic education in their respective states.

4.7: Capacity Requirements for the Implementation of Education Related MDGs Programmes in Nigeria

The UBE Act 2004 has provided that the UBEC should set out minimum standard for basic education delivery though out Nigeria in line with the National Policy on Education and the directive of the National Council on Education. A standard that established the Norms and requirements the UBE programme should work towards achieving. These standards would result in producing an environment that is child friendly and conducive to teaching and learning and produce the desired learning out comes for the achievement of UBE goals and consequently the attainment of MDGs targets on Education. There are three types of standards namely, Resource standards, Process standards and Performance standards in the operational implementation of the UBE programme.

Resource Standards; UBEC (2010) has spilt out the minimum Human, Infrastructure and Logistic requirements for the implementation of basic education in Nigeria. These are;

i. Distance and proximity measures in locating a school maintain that schools should be located in such a way that the average number of pupils does not walk more than 2km to get to the nearest school.

ii. School classification; public primary schools are classified into three types, Rural/small schools with less than 200 pupils enrolled but a minimum of 60 pupils, Semi urban Schools with not more than 1000 pupils. The last one is the Urban Schools with more than 1000 pupils enrolled.

iii. For management purposes the minimum and maximum desirable school size for Rural Schools should be between 1 to 2 streams of 240 and 480 pupils. And Semi Urban Schools should be between 3 to 4 streams of 720 to 960, while the minimum and maximum size for Urban Schools should be between 5 to 6 streams of 1200 to 1440 pupils' enrollment respectively.

iv. The functional requirements of schools of various sizes are presented in a table 4.1 below.

v. School should not be located immediately close to the market squares or religious centers to avoid the spillover effect of such facilities during school hours unless there is absolutely no alternative.

vi. The maximum number of pupils per classroom is 20 for pre-primary, 40 for primary and 45 pupils for secondary schools respectively.

vii. The mandatory Pupil-Teacher Ratio is 20:1, 40:1 and 35:1 for pre-primary, primary and secondary schools respectively (UBEB, 2010).

Table 4.1: Functional Requirements of a Primary School by UBEC Standards

Requirements	**Rural School**		**Semi urban school**		**Urban school**	
No of streams	1	2	3	4	5	6
Maximum enrollment	240	480	720	960	1200	1440
Classroom actual Requirement	6	12	18	24	30	36
Laboratories	-	1	1	1	1	2
Workshops	-	1	1	1	1	2
Libraries	-	-	1	1	1	2
Toilets separate for males and females	6	12	18	24	30	36
Headmaster's/Principal's office	1	1	1	1	1	1
Asst. Head Master's/ Principal's office	-	-	1	1	1	1
General office	-	-	-	1	1	1
Staff Room	-	-	-	1	1	1
Store	1	1	1	1	1	1
First-Aid Box/Sick Bay	1	1	1	1	1	1

Source; UPE Standard Guidelines, FMOE, Lagos, (1975) reviewed 2002 and adopted by UBEC as preferred capabilities/sizes of public schools.

Process Standards; These are aspects that affect policy guidelines and regulations governing the operation of the basic education programme. Some of these policy requirements are;

i. The maximum number of weeks per year for all levels- pre- primary, primary and secondary schools is 39 weeks mandatory, 45 weeks optimal and 42 weeks ideal.

ii. The entry age per standard specification for Pre-Primary is between 1-3 years of age,6 years for Primary and 12 years for JSS on completion of primary education.

iii. The curriculum most adopts 9 compulsory subjects for Primary School and minimum of 10 compulsory subjects for Junior Secondary Schools.

iv. Transition of pupils within the curriculum and from class to class shall be based on competency-Based Continuous Assessment (CA).

v. Complete disarticulation of the JSS from SSS for effective administration and application of the UBE Intervention Funds is necessary.

vi. Accelerated Girl-Child Education and other disadvantage groups' initiative (AGCI) is mandatory (UBEB, 2010).

Performance Standards; These are aspects that affect the quality of teaching and learning. Some of the standard specifications that affect quality of instructions and learning outcomes are;

i. Teachers minimum entry qualification into the basic education sector is NCE registered with the TRCN as professional teacher.
ii. The minimum Routine Monitoring/Supervision by SUBEB shall be twice a term, LGEA thrice a term and that of community and school continuous exercise.
iii. Quality Assurance department shall be created at UBEC, SUBEB and LGEA levels to monitor the quality of teaching and learning procedures and outcomes.
iv. Assessment of Learning Achievement based on pupils' performance in core subjects and life skills using cognitive and non cognitive test should be conducted by SUBEB and LGEA annually.
v. Each SUBEB and LGEA should have strategic plan of action derived from State Education Sector Plan together with a Short term plans targeted areas to fast-track the achievement of EFA and education-related MDGs (UBEB, 2010).

4.9: Capacity Requirements for the Implementation of Health Related MDGs Programmes in Nigeria

The National Primary Health Care Development Agency (NPHCDA) has set out Minimum Standards in the areas of health infrastructure, human and financial resources as well as the provision of essential drugs and equipment for primary health facilities in Nigeria. The NPHCDA sees the Minimum Standards as a robust system that is fundamental to the effective functioning of any health facility and therefore an essential element for the delivery

of quality health care. The policy document defines a set of Minimum Standards in the following areas:

i. Health infrastructure: Types/Levels of PHC facilities including recommended infrastructure dimensions, furniture and equipment.
ii. Human resources for health: Minimum recommended staff number and cadre for each type of health facility.
iii. Service provision: Recommended minimum PHC services for each facility type including the minimum requirement of medical equipment and essential drugs (From the National essential Drugs list) required to achieve these services (NPHCDA, 2013).

The overall goal of the manual is to set uniform standard for the various levels of health facilities and the Minimum Standards for PHC structures, systems, staffing and equipment as basic capacity requirement for PHC service delivery at Local Government Level. In order to improve access and quality of services the minimum standard focuses on PHC infrastructure and management; human resources; service provision and essential drugs. Health facilities are either static or mobile in structures. These health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered. Many terminologies have been used over the years including dispensaries, health clinics, health centres, primary health centres, maternities, health posts and comprehensive health centres. However based on the Ward Health System approved by the NPHCDA, the three recognized primary health facility types are: Health Posts; Primary Health Clinics and Primary Health Care Centres.

Health Posts: The Health Posts are supposed to provide health care services at neighborhood and village level, serving an estimated population of not more than 500 people. The infrastructural requirement of the Health Post include among other thing:

i. Building and Premises requirements such as; two rooms with cross ventilation, functional doors and netted windows and the walls and roof must be in good condition; Functional separate male and female toilet facilities with water supply within the premises; Availability of a clean water source; Be connected to the national grid and other regular alternative power source; Have a sanitary waste collection point and a waste disposal site; Be clearly signposted – visible from both entry and exit points; Be fenced with gate and generator houses (NPHCDA, 2013).

ii. Furnishing requirement include among others 2 Benches, 2Chairs, 2Cupboards, 1 Examination couch, 1Screen , 1Stove, 1Wash hand basin and, 1Writing table.

Medical equipment requirements are: 2 Dressing forceps,1Fetoscope, 2Geo Style Vaccine Carrier (GSVC), Ice Packs- 4 per GSVC, 1Injection safety box, 2Kidney dish, 1 set of ORT Demonstration Equipment (Cup, jug, wash basin, towel, bucket, standard beer or/and soft drink bottles), 2 Scissors, 1 Solar Refrigerator, 2 Sphygmomanometer, 2Stethoscope, 1Tape rule, 1 Thermometer and 1Weighing scale(NPHCDA, 2013 :P12).

Personnel requirements: The minimum standard manual recognized the following category of health staff, these are; Community Health Officer (CHO), Nurse/Midwife, Community Health Extension Worker CHEW), and Junior Community Health Extension Worker (JCHEW). The manual proposed that a Health Post should be headed by at least a JCHEW, who supervises Community Resource Persons (CORPs) working within the community. CORPs is a trained Community Volunteers including, TBA, VHW and other community based service providers that have been duly trained and are recognized by the LGA.

Service requirements: The types of recommended services to be provided by the Health Post are as follows:

i. Health education and promotion services on prevailing health issues and problems of the local community.
ii. Collect data in respect to Health Management Information System and sent to M&E unit of the PHC department.
iii. Routine home visit and community outreach to identify health issues affecting the community.
iv. Provide maternal, newborn and child care (routine pre, ante and post natal care to pregnant women).
v. Family planning counseling services and dispensing of condoms to prevent unwanted pregnancy.
vi. Promotion of proper nutrition and food education through health education.
vii. Participating in immunization campaigns and immunization trend fellow up.
viii. Participate in mobilizing the local community on the prevention and misconception of HIV/AIDS.
ix. Sensitize the community on the contact tracing, prevention and misconception of tuberculosis.
x. Prevention and treatment of malaria particularly among women and children.
xi. Provide curative care services on minor diseases and injuries.
xii. Maintain the Essential Drugs Funding System within the community.
xiii. Promotion of personal and community hygiene.
xiv. Advice and counsel community on mental health prevention of drugs and substance abuse (NPHCDA, 2013: P, 25-27).

Other requirements of the Health Post include recommended hours of operation from 9.00am – 4.00pm (open for at least 8 hours every day). The managerial system provided that the Health Post is to be co managed with the Village Development Committee (VDC) who

represents the community in the planning, implementation and monitoring of the services rendered by the Health Post.

Primary Health Clinic. This is the second type of PHC facility that is expected to offer services to a group of neighborhoods and villages with an estimated population of 2,000 – 5,000 people. The manual proposed for the Infrastructural requirements that the building and premises of the Primary Health Clinic should be a detached building with at least 5 rooms, Walls and roof must be in good condition with functional doors and netted windows, functional separate male and female toilet facilities with water supply within the premises, availability of a clean water source: at least motorized borehole, connected to the national grid and other regular alternative power source, have a sanitary waste collection point, have a waste disposal site, clearly signposted – visible from both entry and exit points, fenced with gate and generator houses and staff accommodation provided within the premises (2 bedroom apartments). The manual recommends that the building must have sufficient rooms and space to accommodate: Client observation area, consulting area, delivery room, first stage room, injection and dressing area, lying-in ward (4 beds), pharmacy section, record section, staff station, store, toilet facilities (or VIP Toilet), waiting/reception area. Other furnishing requirements include among other 8 benches,10 chairs, 2 cupboards, curtains for windows and doors, 1 delivery bed, 2 examination couch, 4 observation beds, 2 screens, 2 wash hand basins, 1 wheel chair, 3 writing tables. (NPHCDA, 2013: P, 28). On the other hand, the medical requirements. Includes the following listed in figure 4.2 below.

Figure 4.2: List of Medical Requirements Recommended in PHC Clinics

Adult weighing scale – 2	Ambo bag – 1	Artery forceps – 2
Baby weighing scale – 1	Bed pan – 4	Bed sheets, 2 per bed
Clinical thermometers – 2	Cold boxes – 1	Cord clamps
Curtains	1 per window	Cusco speculum – 2
Disposables (facemask, gloves e t c) 1 pack each	- Multisite test kits - 1 pack of 100	Dissecting forceps
Dressing trolley – 1	Enema kits – 2	Episiotomy scissors
Foetal stethoscope – 2	Instrument tray – 2	Kidney dishes – 4
Kidney dish – 2	Lanterns, Buckets	Needle holding forceps – 2
Refrigerator – 1	Scissors – 2	Sims speculum
Solar Refrigerator – 1	Sphygmomanometer – 2	Stadiometer
Stethoscope – 2	Sterilization equipment – 1	Stove
Suction machine or (mucus extractors) 1	ORT Demonstration Equipment - 1 set	Tape rule
Urinary catheter 2 of each size	Ice Packs - 4 per GSVC	Geo Style Vaccine Carriers (GSVC)

Source: (NPHCDA, 2013: P, 33).

Personnel requirement for the Primary Health Clinic include 2 Midwife or Nurse Midwife, 2 CHEW, 4 JCHEW (they must work with the standing order). Other supporting staff includes 2 Health Attendant/Assistant and 2 Security personnel. These staff is to provide all the services provided by the Health Post in a more in-depth manner and even attend to some cases of referral from the Health Post. The facility should run 24 hours services and a complete Essential Drugs list is to be utilized at this level.

Primary Health Care Centres

The Primary Health Care Center is supposed to be located in every political ward to service an estimated population of 10,000 to 20,000 people. The building and premises infrastructural requirements include in addition to all the requirements for Primary Health Clinic, a detached building of at least 13 rooms. The building should have sufficient rooms and space to accommodate; Waiting/Reception areas for Child Welfare, Antenatal Care (ANC), Health Education and Oral Rehydration Therapy (ORT) corner; Staff station; 2

consulting rooms; Adolescent health service room; Pharmacy & Dispensing unit; 2 delivery room; Maternity/lying-in section; In-patient ward section; Laboratory; Medical records area; Injection/Dressing area; Minor procedures room; Food demonstration area; Kitchen; Store; Toilet facilities (Male and Female). Again, the premises should be fenced and have a waste disposal site with staff quarters or accommodation within the community provided. The premises should be connected to the national grid and provided with alternate power sources.

The center should be well furnished with all the basic equipment that will make the place look like a PHC center. In terms of medical requirements, the center should have the following sections; female ward, infant and child welfare unit, first stage room, labour room, antenatal/interview room, laboratory, dressing and injection room, staff room, male ward, family planning section, consulting cubicle, nutrition and sterilization section, cleaning and utilization facilities. In these sections/units, the manual have described basic items required in each of this section/unit ranging from 14 items to 61 items depending on the section/unit in question.

Personnel and service requirements: The minimum standard manual deed recommends the following number and category of health staff for a PHC Center. These are: 1 Medical officer if available, 1 CHO (must work with standing order), 4 Nurse/midwife, 3 CHEW (must work with standing order), 1 Pharmacy technician, 6 JCHEW (must work with standing order), 1 Environmental Officer, 1 Medical records officer and, 1 Laboratory technician. Other support staff includes 2 Health Attendant/Assistant, 2 Security personnel and 1General maintenance staff (NPHCDA, 2013). These health personnel are to provide the following PHC services:

i. Health education and promotion services.
ii. Health management information system services.
iii. Routine home visit and community outreach.

iv. Family planning services.

v. Promotion of proper nutrition and food education services.

vi. Immunization services.

vii. HIV/AIDs counseling, testing and treatment services.

viii. Tuberculosis diagnosis, tracing and management services.

ix. Malaria treatment services.

x. Curative care services

xi. Maintaining the essential drugs management system.

xii. Promotion of water and sanitation services.

xiii. Advice and treatment of oral health services.

xiv. Identification, counseling, management and prevention of community mental health.

xv. Effecting referrals for all cases above the other two levels (health Post and PHC Clinic).

xvi. Provide basic laboratory services.

xvii. Provide counseling and support to Adolescent Health.

xviii. Monitor and supervise Health Clinic and Health Post under their jurisdiction (NPHCDA, 2013: P 48-51).

Other requirements include; an Ambulance Vehicle, a bicycle, communication facility (1 Mobile phone or Communication Radio), 2 sets of computers, access to internet services, 1 motorcycle or small motor boat for riverine area. In addition, the center shall be open for service 24 hours.

4.10: Kaduna State in Context

Kaduna State is in the North West geographical zone. It is the twelfth largest State in Nigeria accounting for some 5 percent (46,000 square kilometers) of Nigeria's total land mass. It is the third most populous state in Nigeria, that is culturally diverse and has an

estimated population of 6.114 million (2006 Census) and a population density of 130 people per sq km and an annual rate of increase of around 3 percent. Kaduna State share border with Niger State to the West, Zamfara, Katsina and Kano States to the North, Bauchi and Plateau State to the East and the FTC and Nasarawa State to the South. It has 23 Local Government Areas (LGAs) spread within the 3 Senatorial Districts in the state. The Central District housed; Igabi LGA, Giwa LGA, Birnin Gwari LGA, Kaduna North LGA, Kaduna South LGA, Chikun LGA and Kajuru LGA. Zone 1 District comprise of Zaria LGA, Sabon Gari LGA, Soba LGA, Kubau LGA, Lere LGA, Ikara LGA, Makarfi LGA and Kudan LGA respectively. While Zone 3 is the southern District that comprise of the following Local Government Areas; Kachia LGA, Kagarko LGA, Zangon Kataf LGA, Jama'a LGA, Kaura LGA, Sanga LGA, Jaba LGA and Kauru LGA. Kaduna State has 255 political wards. Local Governments in Kaduna state operates the presidential system structure with the Executive Council which is headed by the Chairman that operates separately but interdependently with the Legislative Council as shown in the diagramme below.

The state in compliance with the MDGs CGS guidelines has established the Office of the Senior Special Adviser to the Governor on MDGs matters and charges it with the responsibilities of accessing and managing the MDGs CDS funds. The state MDGs Office has been able to access the total sum of N535, 480, 000 in the year 2007, N1, 971,080,348 in 2008, N1, 699,820, 678 in 2009 and the sum of N, 534,092,502 in 2010 from the MDGs CGS projects funds to States (MDGs, 2010b). Again in 2011 four Local Governments Areas of the State have benefited from the MDGs CGS projects funds to Local Governments, a sum of 100 million naira each was been allocated as Federal Government own share of the CGS projects counterpart funding arrangement. The Local Governments are Lere, Kachia, Birnin Gwari and Ikara LGAs respectively. The first three LGAs were selected based on the OSSAP-MDGs CGS Need Assessment Report while Ikara was chosen because of the

Millennium Village projects run by USAID. These 4 LGAs were made to contribute 20 million each as part of their contribution to the counterpart funding while the state is to provide 30 million naira to each of these LGAs to complete the 50% counterpart funding arrangement. In other words, each of these 4 LGAs is expected to have design and completed MDGs projects on priority area worth 200 million naira by 2012. Four additional LGAs are selected to benefit from the 2012 CGS projects funds, these LGAs include Kagarko, Kudan, Giwa and Sanga LGAs respectively and probably 4 or 5 more LGAs to be selected for 2013 CGS allocation. Although up to the time (October, 2013) of compiling this study, the 2012 CGS funds to States and Local Governments is yet to be release, not to talk of 2013 allocation but we are optimistic it will be released before the year runs out or at worst by the first quarter of 2014.

Kaduna State has over 1100 health facilities out of which 1020 are PHC facilities (KSLGSC, 2013) and the state government has recognized that health is the basic ingredient for any sustainable development, as part of its commitment to ensuring that the people attain high standards in health, the state government formulates the vision statement to serve as the long-term policy thrust for the health sector. Kaduna state health sector vision statement is based on creating a state where quality health care services are available, accessible and affordable to its citizens in an equitable manner and on a sustainable basis through active participation of all individuals and communities (KMOH, 2008).

The local government councils are responsible for the management of primary health care services and facilities throughout the state. The department of health in the local governments are now called PHC department in line with the primary health care policy guideline and the department is further sub divided into seven units to effectively handle all the components of the PHC and by extension the health related aspects of the MDGs at local level. These units include;

i. Medical unit,

ii. Disease Control unit,

iii. Essential Drugs unit,

iv. Maternal and Child/Reproductive Health unit,

v. Monitoring and Evaluation/Disease Surveillance & Notification unit,

vi. National Programme on Immunization unit and

vii. Social Mobilization /Health Education unit.

For effective monitoring and control, each of these units is manned by an assistant PHC coordinator who shall be a senior health officer on grade level 14 and above with a minimum qualification of a Diploma on Community Health Officer (CHO).The Maternal & Health Care unit handles all matters on family planning, reproductive and child health. The unit controls the activities of all health facilities in the local government (see organizational chart in the appendix).

Similarly, the State Government in its effort to achieve Education for All via the UBE has formulated its state KADSEEDS in 2004 as a follow-up to the NEEDS which recognized education as a vital transformation tool and a formidable instrument for socio economic empowerment. The same year, the UBE Act was passed into law which makes Basic Education free and compulsory. The goals therefore, in respect to basic education as spelled out in KADSEEDS and other subsequent documents are: The attainment of 40 – 50% pre-primary school enrollment; 80 – 90% increase in primary school enrollment; the attainment of 100% transition from primary to JSS; ensure 40:1 pupils teacher ratio in basic education sector; enhancing the quality of education at all levels; increasing the share of female enrollment attendance, retention, completion and transition at all levels within the basic education sub-sector and even beyond (KADSEED,2004). In essence these targets are geared

toward increasing access to basic education in the state and the attainment of the UBE goals and by extension the MDGs targets in that direction.

Report has shown that the State has a population of 6,064,683 million people which are spread within 23 Local Government Areas of the State. Out of which 3,111,111 million are male and 2,953,572 millions are female (NBS, 2009). This indicates a gender ratio of 105 male for 100 female. The National Bureau of statistic gives the percentage distribution of the population by age group, where 5 – 14 years age bracket received the highest percentage of 33.4% even higher than the National average of 28.2%, followed by 15 – 29 years age bracket that received 25.4%. While between 0 – 4 years age group recorded 14.6% (NBS, 2009). The two age groups 0 – 4 and 5 – 14 years fall within the basic education category and thus recorded a combined total of 48% of the population, which is all most half of the entire population of the state. This shows that the Basic Education Sector has a large and a growing population to accommodate. Thus, in its quest to increase access to basic education, the state has over 4,000 public primary schools (KMOE, 2012) which are managed by the SUBEB through the LGEAs and has been able also, to access the total sum of N5, 895, 941,929.57 billion for Basic Education from 2005-2013, from the UBEC Matching Grant Scheme (UBEC 2013) plus the same amount as counterpart contribution. In utilizing these funds, the state have from 2007 – 2010 constructed 1139 and 1034 number of classroom and nursery game villages, sunk 124 boreholes and 38,781 pupils and teacher furniture (KAD SUBEB, 2011). Also, the state in collaboration with the 23 Local Government Councils commenced the provision of free textbooks, in the four core subject areas and school uniforms to primary school pupils in phases. So far from 2006-2009, 86,777 pupils from all over the state have benefited from the school uniforms and free textbooks. All these are geared toward increased access to basic education sector.

4.11: Zamfara State in Context

Zamfara state was created on 1st of October, 1996 by Gen. Sani Abacha. It was carved out of the old Sokoto state. It is largely a rural State located in the Northwest region of the country. It covers a landmass of about 38,000 square kilometers and has a 2010 population of about 3,697,565 with about 147,903 being infants (under one). Zamfara is bounded by Sokoto State on the North, Niger and Kaduna States on the South, Kebbi State on the West, and Katsina State on the East. The State is administratively divided into 14 LGAs (districts) and 147 political wards (sub districts).The Local Governments are: Anka, Zurmi, Maradun, Talatan Mafara, Gusau, Kaura Namoda, Bungudu, Tsafe, Maru, Bakura, Birnin Magaji, Bukkuyum, Gummi and Shinkafi Local Governments Areas respectively.

Zamfara state MDGs Office has been able to access the total sum of N1, 216, 000, 000 in the year 2007, N1, 957, 814, 132 in 2008, N1, 077,336,206 in 2009 and the sum of N1, 534,092,502 in 2010 from the MDGs CGS projects funds to States (MDGs, 2010c). Again, in 2011 three Local Governments Areas of the State have benefited from the MDGs CGS projects funds to Local Governments, a sum of 100 million naira each was been allocated as Federal Government own share of the CGS projects counterpart funding arrangement. The Local Governments are Chafe, Bakura and Birnin Magaji LGAs respectively. These LGAs were selected based on the OSSAP-MDGs CGS Need Assessment Report and each is made to contribute 20 million as part of its contribution to the counterpart funding while the state is to provide 30 million naira to each of these LGAs to complete the 50% counterpart funding arrangement. Thus each LGA is expected to put up MDGs projects worth 200 million naira by 2012. Four additional LGAs are selected to benefit from the 2012 CGS projects funds, these LGAs include Kauran Namoda, Bukkuyum and Gummi, Bungudu LGAs respectively and probably 4 or 5 more LGAs might be selected for 2013 CGS allocation.

Zamfara has a total of 696 'functional' health facilities out of which 435 are PHC facilities. The Chief Executive of the State is the Executive Governor who heads the State Executive Council, the highest policy decision making body in the State. Health activities are coordinated by the State Ministry of Health which is headed by the Honorable Commissioner, a member of the State Executive Council. The MOH has 8 key departments, one of which is that of Primary Health Care (PHC) where maternal and child health including immunization services lie (Francis, 2009). A Hospital Services Management Board also exists which coordinates activities of all the secondary health care facilities in the State. There is also a ministry for Local Government and Chieftaincy Affairs that coordinates the activities of the 14 LGAs in the State. The chief Executive of an LGA, which is the third tier of Government in Nigeria (the first being the Federal Government and the second, State Government) is the LGA Chairman. Each LGA is semi-autonomous, and has LGA PHC department headed by a LGA Director, who coordinates health activities within the LGA. The State has recently (2011) established a State PHC Board which is to be responsible for the coordination of PHC services at both the State and LGA levels in order to eliminate the fragmentation with respect to PHC services that was caused as a result of low funding and weak environment in which PHC facilities operate couple with the uneven State – Local Government relations.

Zamfara State population rose from 3,278,108 in 2006 (the last population census by NPC of Nigeria) to 3, 697, 565 in 2010 and 3,860,753 in 2012, comprising of 1,937,456 males and 1, 923, 297 females (using the annual projection rate of 0.028% to calculate the 2010/2012 figures). When disaggregated age-wise, children of Pre-primary school age 3–5 totalled 436,580 with 227,688 males and 208,893 females. Those of Primary school age 6 – 11 are 353,301 males and 331,906 females totalling to 685,207 in all. Those of Junior secondary school age 12 – 14 comprise of 135,569 males and 134,371 female adding up to

269,940 which give us an overall total of 1,391, 727 (Zamfara state of Nigeria, 2013), this show that almost half of the population are within the basic education range.

In an effort to promote basic education Zamfara State Universal Basic Education Board was created and saddled with the responsibility of implementing all basic education policies and programmes in conjunction with the Universal Basic Education Commission especially in achieving Education for All (EFA) and the Millennium Development Goals (MDGs). It also coordinates the activities of the 14 Local Government Education Authorities (LGEAs) in order to ensure provision of quality basic education.

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS

5.1 Introduction

This section deals with the presentation and analysis of the data collected. It has presented the quantitative and qualitative analysis of the data and used these to test the hypotheses. For relevant data, focus was placed on the objectives of the study, the critical variables of the hypotheses and the theoretical framework guiding the study. In summary, one of the objectives of the study is to assess the nature and quantum of MDGs intervention given and the effect it has on the capacity of the local governments to manage the primary education and health care services. The other objectives examined the extent to which the capacity of Local Governments enhanced or undermined the attainment of the MDGs set goals in education and health. The data analyzed in this section came from the use of the questionnaire, personal observation, interviews and secondary materials that have direct bearing with the subject matter of this study.

For clarity of focus, this chapter is divided into four sections. The first section is the introduction and the second section is the summary of data collected. While the third section presents and analyzes data and the last section dwelled on the test of hypotheses. The overall emphasis here is to assess the extent to which the MDGs intervention efforts has impacted on the local government capacity to manage primary education and health and the extent to which the local government capacity has enhanced or undermined the attainment of the MDGs targets on primary education and health.

5.2 Summary of Data Administration

On the whole, 1,440 questionnaires were administered in the two states under study. Out of which 940 representing 84.6% of the total questionnaires administered were returned and 500 questionnaires representing 15.4% were unreturned. Therefore, 940 formed the basis of our

analysis and interpretation, which were considered sufficient for valid conclusions (Tabachnick & Fidell, 2007 in Rigim, 2012). The data collection period took about seven months (June – December 2013) due to difficulties in reaching out the respondents.

Table 5.1: Number of Respondents

Sample size	**No of Returned Questionnaires**	**No of Unreturned Questionnaires**	**Total**
1,440	640 (84.6%)	500 (15.6%)	1,440 (100%)

Source: Survey Research, 2013

Below is the percentage distribution of the returned questionnaires per States, Local Governments and Sectors.

Table 5.2: The Distribution of the Returned Questionnaires Administered

Questionnaires	Kaduna State			Zamfara State			**Total**	%
	Kaduna North LGA	Lere LGA	Sanga LGA	Bakura LGA	Kauran Namoda LGA	Gusau LGA		
Local legislatures/stakeholders	18	18	14	18	12	14	**94**	10%
Health providers & managers	90	98	40	40	60	96	**424**	45.1%
Education providers and managers	80	80	34	56	70	102	**422**	44.9%
Total	**188**	**196**	**88**	**114**	**142**	**212**	**940**	**100%**

Source: Survey Research, 2013

From table 5.2 above, out of the 940 (100%) returned questionnaires, Gusau LGA in Zamfara state has the highest frequency of 212 representing 22.6% of the total returned questionnaires followed by Lere LGA in Kaduna state with a frequency of 196 representing 20.9% of the total returned questionnaires. Kaduna North LGA from Kaduna state recorded 20% of the total returned questionnaires while, Kauran Namoda LGA from Zamfara state registered 15% of the returned questionnaires. Bakura LGA from Zamfara state came next with a frequency of 114 representing 12% of the total returned questionnaires\where as Sanga LGA from Kaduna state had a frequency of 88 representing 9.4% of the total returned questionnaires.

Similarly, respondents from the health sector across the two states recorded the highest frequency of 424 representing 45.1% of the total returned questionnaires followed by the education sector which registered 422 representing 44.9% of the total questionnaires. Local legislatures and stakeholder has a total of 94 returned questionnaires representing 10% of the total.

Table: 5.3. The Distribution of the Stakeholders Interviewed

Stakeholders	**Kaduna State**	**Zamfara State**
MDGs officials	3	3
Women attending clinics	6	6
PTA/SBMC officials	3	3
Opinion leaders	3	3
Total	15	15

Source: Research survey, 2013.

The study also conducted a focus group interview with women attending clinics and primary school PTA/SBMC officials. On this note, personal interviews were carried out with top MDGs officials and opinion leaders. Table 5.3 above shows the distribution of the stakeholders' interviewed. 60 interviews were slated out of which only 30 interviews were conducted, representing 50% of the total interviews intended. This is because of the tight schedule of some management staff selected for the interviews and the difficulties we had in organizing group interviews. 6 focus group interviews were conducted in each state with women attending clinics representing 20% each of the conducted interviews. Again, 3 focus group interviews were conducted with PTA/SBMC officials in each of the state representing 10% each of the conducted interviews. Also, personal interviews were conducted with 3 MDGs officials (10%) and 3 opinion leaders (10%) from each of the two states under study.

However, for reason of convenience and the fact that there is no much discrepancy in the mode of responses among respondents from the local governments sampled for this study, we decided to present the data on a state basis. All the same, mention was made of communities for further emphasis and recording their contributions to primary education and health care programmes.

Demographic Information of the Respondents

The statistics presented below is the frequency distribution of the respondent profiles of the returned questionnaires.

Table 5.4: Demographic Profile of Respondents

Particulars	**Kaduna state**		**Zamfara state**	
	Frequency	Percentage	Frequency	Percentage
Qualification				
Primary	70	14.8%	82	17.5%
Secondary	89	18.9%	92	19.7%
Post secondary	285	60.4%	234	50%
Others	28	5.9%	60	12.8%
Department				
Education	189	40%	187	40%
Health	165	35%	158	34%
Legislature/executives	118	25%	123	26%

Source: Survey Research, 2013

The table 5.4 summarizes the demographic characteristics of the respondents. It can be deduced that the bulk of the respondents from the two states have post secondary certificates (60.4% and 50% from Kaduna and Zamfara state respectively) which placed them in a better position to read, comprehend and fill the questionnaires appropriately. Overall, 14.8% and 17.5% of the respondents are primary school leavers while, 18.9% and 19.7% are secondary school graduates from Kaduna and Zamfara state respectively. Only an insignificant percentage of the respondents from Kaduna state (5.9%) and Zamfara state (12.8%) have no formal education. This implies that all the categories of our respondents are knowledgeable enough to read and respond to our set questions which further validate our questionnaires.

In terms of department, the table revealed that 40% of the total respondent from the two states are from the education department while 35% and 34% from Kaduna and Zamfara states respectively are from the health department while only 25% and 26% of the

respondents are from legislature and executives within the local government. This implies that our respondents covered a large number of staff of Local Governments that have adequate information on primary education and health care programmes which are needed for this study.

5.3 Research Hypothesis One

Ho: The MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education.

Here, MDGs intervention effort in education is the independent variable while the capacity of the local government to manage primary education is the dependent variable. Three variables were used as measures of MDGs intervention efforts in education. These are financial intervention, infrastructural intervention and lastly, human and technical intervention efforts. On the other hand, three more variables were used as proxy for local government capacity to manage primary education. These are infrastructural capacity, human capacity and managerial capacity to manage primary education. Below, we present and analyze data relating to these variables and finally test the hypothesis using multiple regression analysis.

MDGs Intervention for Basic Education

There are two major interventions for the basic education programme in Nigeria. These are the UBE Matching Grants and the Community Self-Help Project arrangement. These funds are accessed on conditional grounds part of which States Governments must provide counterpart funds equivalent to the total sum allocated before accessing the funds as in the case of matching grant and 10% counterpart funds as in the case of Community Self-Help project (refers to chapter 4 for details). In addition, states and local governments are expected to provide additional funds from their budgets in support of basic education in their respective areas. The UBE funding arrangement is based on 50% counterpart funds from

accessing state. The counterpart arrangement between the state and local government is based on 60% - 40% and often 40% - 60% arrangement depending on the dictate of the State Government. Sometimes, Local Governments pay 40% and a time 60% in Kaduna state while in Zamfara State Local Government often pay 60%. It is important to note that the Local Government pays equal share into the counterpart account and deduction was made at source from the State - Local Government Joint Account. We will now examine the funds accessed, utilized and the impact it has on Local Governments' capacity for the delivery of basic education in the two states under study.

Table 5.5: Total Funds Accessed by Kaduna and Zamfara States from UBEC from 2005-2013 (N)

States	2005-2006	2007-2008	2009-2010	2011	2012	2013	Total
Kaduna	1,04 billion	1,46 billion	1,15 billion	873 million	853 million	1,03 billion	6,41 billion
Zamfara	1,04 billion	1,46 billion	1,15 billion	873 million	853 million	1,03 billion	6,41 billion

Source: UBEC, 2014

Table 5.5 shows the 70% UBEC funds that are shared to states on equal basis. Although the funds are equally shared among states yet the states have to meet the set criteria for accessing these funds (refer to chapter four for details). The table shows that each of the sampled state has accessed the total sum of 6.411 billion Naira from the scheme from 2005-2013. It was only in 2011 to 2012 that the two states accessed less than 1 billion naira from the scheme and the highest allocation received by these states was in 2007-2008 with the sum of 1,464,797,296 naira each. This money is meant to be spent on infrastructures, teacher's professional development and procurement of instructional materials on the basis of 70%, 15% and 15% respectively. Thus the two states are expected to utilize the total sum of N4, 487,000,000, N961, 500,000 and N961, 500,000 each on infrastructural development, teachers professional development and on the procurement of instructional materials respectively.

In addition to the UBEC Matching Grant, there was another source of funds for Basic Education that came in a form of community self- help project. The contributing partners are mostly International Donor Agencies in partnership with UBEC or SUBEB as the case may be and the community. The Donors in collaboration with UBEC/SUBEB identify schools within particular community and requested the schools to identify priority projects for the development of the school through the SBMC/PTA and come up with a cost for the projects for vetting and approval. It was after the approval the school SBME/PTA would mobilize 10% of the grant and the 90% would be financed by the Donors.

Table 5.6: Total Funds released for Community Assisted Self-Help Projects to Kaduna and Zamfara States from UBEC from 2006-2013 (N)

States	2006-2009	2010-2013	Total
Kaduna State	577 million	729 million	1,306 billion
Zamfara State	165 million	198 million	363 million

Source: UBEC, 2014.

Table 5.6 shows the total funds released for community, assisted self-help projects. Kaduna State has received a total sum of 1.306 billion Naira for Community Self-Help Project from 2006-2013. The state received 577 million from 2006 to 2009 and 729 million in between 2010 to 2013. Zamfara state on the other hand, got only the sum of 363 million Naira from the same programme; 165 million from 2006 to 2009 and 198 million from 2010 to 2013 as revealed from the table 5.6 above. This revealed that a lot of financial assistance was given to the two states under review for the delivery of the Basic Education programme.

However, it was the consensus opinion of the education managers and other stakeholders in the education industry interviewed that despite the UBE Matching Grants scheme, funding still posed a serious challenge in the delivery of basic education. The general opinion expressed was on the conditionalities associated with the release of the matching grants, slow utilization of the intervention funds by the states and late or non provision of counterpart funds by the states governments. Other issues raised were the delays in the

submission of action plans and problems of accountability and transparency of the grants accessed by the States and also Local Governments. This revealed that issues of enhanced funding are an exclusive business of the state government who access funds for and on behalf of the LGEA. The contention here is not on the funding structure or how the states access these funds but on the adequacy of the funds and how the funds were utilized by the state through SUBEB to support local government capacity in the provision of primary education.

MDGs Intervention on Infrastructural Capacity of the Local Government to Manage Primary Education

Information was sought on the number of infrastructural facilities provided by Kaduna and Zamfara SUBEBs over the period under study. Although we are unable to categorize the projects based on source of funds, however, we are able to know that most of these infrastructures were provided by SUBEBs from the Matching Grant released and other support grants from UBEC that come in a form of Community Self – Help Projects. The data from the Table 5.7 below indicate that achievements were made in these states with regards to infrastructural facilities considering the magnitude and the quantity of financial support received by the two states as discussed earlier. However, there exist some disparities between the states. Kaduna state achieved more in the construction of classrooms (1,866), classroom renovation (186), procurement of school furniture and laboratory equipment (178) whereas Zamfara state, gave top priorities on construction of toilets (1,519), procurement of Computer and ICT facilities (40), school perimeter fence (08) and provision of boreholes/wells (178). Furthermore, the information indicated that Zamfara state did not provide school uniforms, whereas Kaduna state did, by providing uniforms to 317,006 numbers of pupils in primary school under the reference periods.

Table 5.7: Number of Infrastructural Facilities Provided by SUBEB from UBEC Matching Grants and Community Self-Help Projects (2005- 2013)

Projects	Kaduna state			Zamfara state		
	2005/09	2010/13	**Total**	2005/09	2010/13	**Total**
Construction of classrooms	1,555	311	**1,866**	353	235	**588**
Renovation of classrooms	121	65	**186**	97	58	**155**
Computer & Information Communication & Technology (ICT) facilities	2	3	**5**	31	9	**40**
Construction of toilets	1042	209	**1,251**	918	601	**1,519**
Procurement of school furniture	38,831	7,766	**46,597**	17,508	10,827	**28,335**
School perimeter fence	2	0	**2**	8	0	**08**
Boreholes/wells Dug	81	38	**119**	130	48	**178**
Laboratory equipment	46	0	**46**	12	3	**15**
Others (provision of school uniform)	317,006	0	**317,006**	0	0	**0**

Source: KDSUBEB; ZSUBEB, UBEC and JICA various Reports from 2005-2013.

However, certain conclusions could be drawn from this information; first, the two states seem to have achieved more between 2005 to 2009 than 2010 to 2013 fiscal periods, perhaps because the amount between 2005- 2009 was greater (i.e. Over 60% of the total amount received as shown in the Table 5.7 above). Second, the priorities of the two states seem to be on construction of classrooms and toilets, renovation of classroom and procurement of school furniture as well as sinking of boreholes in schools. Third, there was a very wide disparity between the two states in the number of infrastructural facilities provided despite the fact that the two states virtually received the same amount of financial support. It was partly because either Zamfara state government had utilized these amounts to other equally important projects, or that the cost of the contracts awarded were much higher in Zamfara state than in Kaduna state. But notwithstanding, Kaduna state seems to be performing better than Zamfara state in the provision of infrastructural school facilities as per the quantity of infrastructure provided. We have also observed that the furniture provided was two-setter types rather than the usual students' desk and chair and the teachers' table was constructed like pupils' desk, a small type with no drawer attached. The toilets were not

separated as such there were no separate toilets for girls which were a serious setback for the attainment of the Girl-Child Education.

In the area of textbooks and other instructional materials procured for primary schools by the SUBEBs from the two states within the period under study, the story is not different. As can be seen from the Tables 5.8 below, the instructional materials provided were restricted only to four core subject areas (English, Math, Primary science and Social studies) and for these subjects the distribution was not on equal bases. Mathematics and English were given priorities than the other two subjects; perhaps because of their importance. All the same, the difference seems very wide. Again the disparity between the two states was also very pronounced with Zamfara state at disadvantaged. It was further observed that some of the assorted instructional materials like pupils writing materials and other playing materials were not provided at all at the periods under review in Zamfara State.

To ascertain the level of impact these facilities has on the local government capacity for the provision of primary education, we have to examine certain factors; first the mode of distribution of these facilities to LGEAs and further down to school in order to ascertain the level of spread to facilities access and secondly, the adequacy of these facilities to accommodate the growing school age population.

The table below gave us an idea of the distribution pattern of the infrastructural facilities provided and instructional materials procured by the SUBEB for and on behalf of the LGEAs. Although we could not get the statistics of the infrastructural school facilities provided to the LGEAs, however the text books distribution criteria might give us an idea into the state distribution pattern. 58,615 copies of English and 63,153 copies of mathematics text books were supplied to Kaduna North, representing 19.4% each of the total copies of these books supplied by the Kaduna SUBEB. While, Lere LGEA received 21,141 and 22,787 copies of English and Maths textbooks representing 7% each of the total copies supplied by

the state, where as Sanga a typical rural LGEA received 11,471 and 32,553 copies of English and mathematics text books representing only 3% each of the total text books supplied by the state. In the other two subjects' Primary science and Social studies the percentage dropped to 15%, 5% and 2% each for Kaduna North, Lere and Sanga LGEAs respectively. The same disparity is seen in Zamfara state where Gusau LGEA received 37% and 30% each of the entire textbooks supplied by the state (in the 4 core subject areas).

Table 5.8: Distribution Pattern of Textbooks Provided by SUBEBs (2005- 2013)

Text Books supplied	Kaduna state			Zamfara state		
	K/North L G E A	Lere L G E A	Sanga L G E A	Gusau L G E A	K/Namoda L G E A	Bakura L G E A
English	58,615 (19.4%)	21,141 (7%)	11,471 (3.9%)	87,619 (37%)	23,680 (10%)	18,945 (18%)
Mathematics	63,153 (19.4%)	22,787 (7%)	32,553 (3.9%)	83,080 (37%)	22,454 (10%)	40,417 (18%)
Primary science	25,124 (15%)	8,375 (5%)	3,350 (2%)	41,275 (30%)	6,879 (5%)	15,134 (11%)
Social studies	17,951 (15%)	5,984 (5%)	2,393 (2%)	27,429 (30%)	4,572 (5%)	10,057 (11%)

Source: KDSUBEB and ZSUBEB Records, 2005-2013.

However, we noticed that Bakura LGEA although a rural LGA seems to have benefited more than Karen Namoda a semi urban LGA. The reason is not far from the fact that the former Governor of the state and the political kingmaker of the state is from Bakura LGA and even the current Chairman of Zamfara SUBEB is also from Bakura LGA. This is because other LGAs that are more rural than Bakura, LGA like Birnin Magaji received far lower than Kauran Namoda LGA. Thus, despite equal contribution made by the Local Governments into the state counterpart account yet the distribution of the school projects and facilities was uneven and in favour of urban LGA. This might limit the impact of the funds generally and even undermine the capacity of the rural LGA.

It was also observed that there were no lead-down criteria for the distribution of the instructional materials to LGEAs in the two states under review. The distribution was mostly

influenced by political consideration and the location of the school (proximity to the center). And because of the inadequacy of the materials, five to ten pupils had to share one textbook during a particular class and none was allowed to take the book home in case of assignment. No wonder the responses of some school managers interviewed on whether school uniform and text books intervention has facilitated enrollment and retention of pupils in school revealed the opposite. Again, the perception of the PTAs and the SBMCs that were engaged in the focus group interview was that the quantity of the materials procured and distributed were insufficient and often those procured teachers' copies were not provided and some of the text books did not cover all the school curriculum and syllabus. All the same, they appreciate these materials given to their school and acknowledged that these instructional materials would go a long way at improving teaching and learning even though they have not yet recorded a significant change or improvement in the academic performance of their pupils as lamented.

To determine the adequacy or otherwise of the infrastructural support and the impact it has on the capacity of the LGEA to provide primary education we look at the summary of basic primary school infrastructures from the two states over a period of 6 years

Table 5.9: Summary of Basic Education Statistics (Primary Level)

Items	2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara
No of schools	3,489	1,209	3,714	1,276	3,821	1,347	3,879	1,371	4,026	1,314	4,026	1,568
No of c/rooms	10,836	4,227	13,836	4,395	15,467	5,167	19,855	5024	24,365	6,056	28,753	6,513
Enrollment	988,810	330,372	918,804	341,547	955,129	369,521	972,985	411,594	1,048,688	283,639	1,067,275	415,082
Ratio: c/room	92:1	79:1	67:1	78:1	62:1	72:1	49:1	82: 1	43:1	47:1	37:1	64:1

Source: SUBEB Annual Statistics 2007-2013 (Kaduna and Zamfara States).

Table 5.9 above revealed basic school infrastructural facilities available in the two states over a period of 6 years. The table shows that Kaduna SUBEB in 2007/08 school

session had 3,489 number of primary schools with10, 836 numbers of classrooms within the 23 LGEAs in the state. While, Zamfara SUBEB had 1,209 primary schools with 4,227 existing classrooms spread across the 14 LGEAs in the state in the same year. In the preceding year (2008/09), the number of the schools rose to 3,714 and 1,276 for Kaduna and Zamfara state respectively while, the number of classrooms increased by 28% and 3.8% for Kaduna and Zamfara state respectively. By 2012/13, the number of schools stood at 4,026 and 1,568 for Kaduna and Zamfara state respectively, which represent 13.3% and 22.9% increased over the period of 6 years in Kaduna and Zamfara States respectively. The table also shows that in terms of number of schools, Kaduna state recorded an increase of 13.3% over the period of 6 years while Zamfara state recorded an increase of 22.9% over the same period. In relation to the number of classrooms, Kaduna state recorded a 62.3 % increase whereas Zamfara state recorded a 35.1 % increase. This indicates that the new primary schools constructed in Zamfara state seems more while in terms of classrooms constructed Kaduna state is far ahead of Zamfara state. This was partly because Zamfara state is a rural state with large communities living in sparsely and scattered villages while, Kaduna is an urban state with large people living in a densely populated cities and semi urban centers. Thus, in such situations more schools are required in rural areas for access to basic education and in the case of urban centers more classrooms are required for large number of pupils within metropolitan cities.

The table also, revealed the enrollment over the period of 6 years. Kaduna state recorded an enrollment figure of 988,810 in 2007/08 which slightly drop by 7.1% in the year (2008/09) and then increased by 3.8% in 2009/10 and 7.2% by 2011/12 and further stood at 1,067,275 by 2012/13. Perhaps, the 7.2% increase recorded might have been connected to the introduction of free school uniform and midday meal programme in selected schools throughout the state in 2010. This was an effort to increase access to basic education. In the

same vein, Zamfara state was able to maintain a steady increase of 3.3% in 2008/09 from its initial enrollment figure of 330,372 in 2007/08 and 10.2% increase in 2009/10, but in the year 2011/2012, the state witnessed a drastic decrease of 31.1% in its enrollment figure. However, it was confirmed through the interview we conducted that due to the intervention of the traditional leaders as instructed by the state government to carry out village to village and school to school sensitization visit the primary school enrollment figures increased by 31.7% in 2012/13.

Despite the steady increase in number of schools, classrooms and enrollment, the ratio of pupil to classrooms for the two states in 2007/08 to2010/11 was far below the UBE set standard of 40 pupils to one classroom. For instance, Kaduna state recorded a ratio of 92:1 and Zamfara state 79:1 classroom in 2007/08. Even though every year the number slightly improved, yet it has not reached the approved standard. It was only in 2011/12 Kaduna state recorded a ratio of 43 pupils to 1 classroom and Zamfara state registered a ratio of 47 pupils to 1 classroom; which was closely to minimum standard. In the subsequent years, Kaduna state record, a ratio a little below the set standard which is appreciable (37:1) were as Zamfara state moved from the ratio of 47:1 to 64:1which was also disappointing. This clearly means that the MDGs infrastructural supports are grossly inadequate. We therefore conclude that the number of classrooms in the two states for the period under study was inadequate to meet the growing population (enrollment) of school going pupils which simply means the infrastructure required for the management of the basic education fall short in the LGEAs of these sampled states.

When the responses of adequacy of school facilities were compared across the sampled local governments in the two states under study, the frequency showed a significant agreement that the numbers of the schools are not adequate enough to accommodate the existing pupil population (47.4% for Kaduna state and 59.6% for Zamfara state) as shown in

table 5.10. This response did confirm the earlier position the study has made. For classroom, the opinion is between not available as ascertained by 42.4% and 57.9% responses from Kaduna and Zamfara states respectively and fairly available as maintained by 44.3% and 39.5% responses from Kaduna and Zamfara states accordingly. Instructional materials like blackboard, notice board, charts and the like, 70% of the total responses from Kaduna state and 76.3% of the total responses from Zamfara state confirmed that these facilities were never adequate. As regard to condition and adequacy of school furniture for both pupils and teacher, the results revealed and further affirmed to the bad condition and absence of furniture in the schools. 68% and 76.3% of the total responses from Kaduna and Zamfara states respectively, strongly hold on to the conviction that the school furniture are in bad condition and are also grossly inadequate.

Table 5.10: Opinion of State Respondents on Availability of UBE Facilities

S/N	Items	State	Level of responses				Total
			Undecided	Not available	Fairly available	Available	
1	Number of Primary schools	Kaduna	6 (3.1%)	92 (47.4%)	84 (43.3%)	12 (6.2%)	194 (100%)
		Zamfara	6 (2.6%)	136 (59.6%)	82 (36.0%)	4 (1.8%)	228 (100%)
2	Adequacy of classrooms	Kaduna	14 (7.2%)	82 (42.4%)	86 (44.3%)	12 (6.2%)	194 (100%)
		Zamfara	2 (.9%)	132 (57.9%)	90 (39.5%)	4 (1.8%)	228 (100%)
3	Instructional materials	Kaduna	10 (5.2%)	86 (44.3%)	96 (49.5%)	2 (1.0%)	194 (100%)
		Zamfara	14 (6.1%)	144 (63.2%)	70 (30.7%)		228 (100%)
4	School furniture	Kaduna	24 (12.4%)	132 (68.0%)	38 (19.6%)	-	194 (100%)
		Zamfara	14 (6.1%)	140 (61.4%)	74 (32.5%)	-	228 (100%)
5	Toilet facilities	Kaduna	12 (6.2%)	108 (55.7%)	74 (38.1%)	-	194 (100%)
		Zamfara	6 (2.6%)	150 (65.8%)	68 (29.8%)	4 (1.8%)	228 (100%)

Source: Survey Research, 2013.

In respect of toilet facilities, 55.7% and 65.8% of the total responses from Kaduna and Zamfara states agreed that the facilities were both inadequate and in bad condition. We further observed from our inspection of these facilities that most of them are grossly inadequate and in dilapidated condition. Infact some of the rural schools visited did not have a single toilet and resolved to the use of bush as convenience. Some classrooms do not have even wooden blackboards and no single furniture in the classroom. We also observed that the roofing, doors and windows of some classrooms were removed and not being replaced for long which implies that during the raining or very hot season such facilities could not be accessible and readily available for learning. Based on the above responses, the average mean of the results indicated that availability of basic school facilities was very low cut across all the sampled Local Governments in the two states under study.

On comparative bases, Kaduna state seems to be doing better than Zamfara state in provision of infrastructural facilities. Despite the fact that both states received almost equal amount from UBEC. Many reasons could be associated with this development, such as, difference in state priority, mode of allocation of contact and the like. We are also reliably informed that substantial amount of the grant accessed were set aside as state dedicated projects and such funds are transferred to state ministry of finance to be utilized in other state projects that might or not have direct bearing on basic education. For instance, in 2012 a substantial amount of money meant for Girl-Child education campaign and infrastructure was diverted by Zamfara state government to the construction of two General Hospitals (one in Maru and the other in Bakura LGA). Perhaps this further explains why Kaduna state is pairing better than Zamfara state in term of provision of infrastructure.

Generally, the MDGs intervention initiative on infrastructures and assorted school materials contributed marginally to LGEA capacity to manage public primary school partly because of their inadequacies, uneven distribution pattern and other “Nigerian factors”.

However, it is important to note that according to the UBE Matching grant structure, the provision of these school infrastructure is the responsibilities of the SUBEB not the LGEA. However these facilities are meant to enhance the capacity of the LGEA in the provision of primary education, thus the more adequate they are the better.

MDGs Intervention on Human Capacity of the Local Government to Manage Primary Education

The study further examined MDGs intervention on human capacity. Table 5.11 indicated the number of UBE Federal Teachers Scheme (FTS) allocated to the two states under study. The FTS was a Federal Government programme that started in 2006. The programme was aimed at assisting States to reduce shortage of teacher's requirement for the success of the UBE programme. The programme recruited unemployed NCE graduates in the States and post them to LGEAs to be further deployed to primary schools in the Local Governments to teach. The information from the Table 5.11 reveals that a total of 2,792 and 2,200 of these teachers were allocated to Kaduna and Zamfara state respectively from 2006 to 2011. It's important to note that the scheme provides that the FTS teachers be posted to LGEAs based on need, particularly rural LGEAs where they have serious shortage of qualified primary school teachers. However, the reverse was the case, as many FTS teachers don't like rural schools and thus they were posted to urban schools. Evidence has shown that 2,012 out of the 2,792 FTS teachers of Kaduna state were posted to urban schools within Kaduna metropolis. More than 50% of the FTS teachers in Zamfara state were posted to Gusau LGEA to be assigned schools.

Table 5.11: Number of Federal Teachers Scheme (FTS) Allocation for Kaduna and Zamfara States

Set	Kaduna state	Zamfara state
First set : 2006 – 2008	1,200	1,000
Second set: 2009 – 2011	1,592	1,200
Total	**2,792**	**2,200**

Source: UBEC Annual Reports 2006-2011.

However, some of the short coming witnessed by this scheme was first the delay in payment of intern's allowances by the SUBEB that made some to leave. This problem was overcomed by instigating an e-payment system. Consequently, States and Local Governments authorities find it difficult to monitor the performance of the interns. Again, retention of the interns also proved difficult. Despite the fact that internship offered employment and the prospect of a permanent job, many recruits absconded. Partly because of the inability of the LGEA to absorbed the interns after the expiration of their contract terms coupled with the fact that the internship is not a permanent and pensionable appointment.

To further confirm the above, our respondents (Education managers, PTAs and SBMCs) under our sampled focus groups interviewed reveal to us that most of these FTS teachers recruited did not stay when posted to rural schools and even those posted to urban schools were not performing to maximum expectations due to poor monitoring. The LGEAs inspectors were supposed to monitor them but since their payment were made by the Federal Government, the report of the LGEAs inspectors was of limited use and as such could hardly imposed compliance. It was also felt that with their limited numbers, the FTS teachers could not make any significant impact in raising the teaching staff strength of the LGEAs.

To further ascertain the impact of the FTS initiatives on the human capacity of the LGEA across the two states under study. We examined the adequacy and quality of human resources available.

Table 5.12: Summary of Basic Education Statistics (Primary Level)

Items	2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara	Kaduna	Zamfara
Enrollment	988,810	330,372	918,804	341,547	955,129	369,521	972,985	411,594	1,048,688	283,639	1,067,275	415,082
No of teachers	13,025	4,425	17,532	5,533	16,253	7,900	20,951	10,081	22,641	8,635	24,331	8,660
No of qualified	5,470 (42%)	1,239 (28%)	7,714 (44%)	1,660 (30%)	7,476 (46%)	2,607 (33%)	10,056 (48%)	3,528 (35%)	11,094 (49.5%)	3,113 (36%)	12,409 (51%)	4,144 (48%)
Ratio: qualified teacher/pupil.	183:1	267:1	119:1	206:1	128:1	141:1	97:1	136:1	95:1	91:1	86:1	100:1

Source: UBEC Education statistics 2007-2012, SUBEB Annual statistics 2007-2013 (Kaduna and Zamfara States).

Table 5.12 is a summary of some basic education statistics of the two states over a period of 6 years. We have earlier on analyzed the enrollment figures of the two states. These figures are also used to ascertain the staff and pupils ratio. The record shows that a total of 13,025 and 4,425 teachers in Kaduna and Zamfara state respectively, out of these number only 5,470 and1,239 are qualified (i.e possess NCE and above) in the year 2007/08. Meaning that 58% and 72% of these teachers in Kaduna and Zamfara state are not qualified to teach in primary schools going by TRCN and UBEC standard. For 2011/12 Kaduna state has a total of 22,641 teachers out of which 49.5% are qualified while, Zamfara state has 8,635 number of teachers of which 36% are qualified. The number of teachers as well as, the percentage of those qualified steadily increased to 24,331 in 2012/13 out of which 12,409 representing 51% of the total number are qualified in Kaduna state. Zamfara state recorded a steady increase of 8,660 numbers of teachers in the same year, out of which 48% are qualified. Although both states have recorded a slight decrease in the number of teachers at one point in time within the period of 6 years but on a whole the percentage of increase recorded by the two states over the period of 6years is appreciable. One of the reasons advanced for the slight decrease recorded by Kaduna state in 2008/09 was the retrenchment exercise of teachers with fake

certificates carried out in 2009 as a fall out of the State Education Summit of 2008. Zamfara state registered a decrease of 14.3% in the total number of teachers in 2011 as a result of the none implementation of the Teachers Salary Structure (TSS) by the Abdul-Aziz Yari administration in 2010 that led to a long strike action embarked upon by the State NUT as a result of the State Government policy of no work no pay on the striking teachers. This forced many to leave the job due to none payment of salary and none implementation of the agreement by the State Government.

However, despite the steady increase in the number of teachers, the teachers and pupil's ratio over a period of 6 years is below the approved standard of 40:1. In 2007/08 for instance, the ratio of qualified teachers is 183:1 for Kaduna state and 267:1 for Zamfara state, it dropped to 119:1 for Kaduna state and 206:1 for Zamfara state in 2008/09. It rose to 128:1 for Kaduna state in 2009/10. Zamfara state had witnessed the same thing in 2012/13 when the ratio slightly rose to 100 from 91:1 in 2011/12. Although, the overall statistics tends to show slight improvement in the ratio of teachers/pupils in the two states over the period of 6 years yet the ratio is by per below the approved UBE standard. This means that the efforts of the SUBEB in strengthening and enhancing the adequacy and often the quality of primary school teachers in the respective LGEAs in the two states under study fall short of expectation.

MDGs Intervention on Managerial Capacity of the Local Government to Manage Primary Education

However, in an effort to boost the quality and proficiency of the primary school teachers and managers of schools, the UBE intervention has identified teacher's professional development programme as part of the strategy.

Table 5.13: Staff Professional Development Programmes Organized by SUBEB for Primary School Teachers and Inspectors / Number of Beneficiaries (2007- 2013)

	Items	**Kaduna state**	**Zamfara state**
1	Strategies for effective implementation of the 9-year UBE Curriculum	3,345	1,769
2	Techniques of school management and record keeping	4,010	3,100
3	Methods of teaching the core subjects	5,509	3,700
4	Quality Assurance for Inspectors and supervisors	1,731	950
5	Improvisation of instructional materials for teachers	4,821	3,712
6	Training on ICT, Library,	809	210
	Total	**20,225**	**13,441**

Source: KDSUBEB; ZSUBEB, UBEC and SMASE

The information from Table 5.13 indicated that the primary school teachers and school inspectors from the two states under study had received quite a number of training in different field organized by SUBEB from 2007-2013. A total of 20,225 and 13,441 teachers from the 23 LGEAs in Kaduna and 14 LGEAs in Zamfara states respectively have attended numerous training programmes within the period under review. The most widely organized in which many teachers attended were strategies for effective implementation of the 9 years UBE Curriculum (3,345 and 1,769 beneficiaries from Kaduna and Zamfara state), techniques of school management and record keeping (4,010 and 3,100 for Kaduna and Zamfara), methods of teaching the core subjects (5,509 and 3,700 for Kaduna and Zamfara) and improvisation of instructional materials for teachers (4,821 and 3,712 for Kaduna and Zamfara respectively). The other training programmes that teachers have also received were in the area of Quality Assurance for inspectors/supervisors and the use of ICT/Library. Almost all the two states have attended all the training programmes but the number of attendance differs from one state with another, with many teachers benefitting from Kaduna state than Zamfara state. Although we don't have the LGEA statistics but the entire trainees were drawn from the LGEAs in the two states under study.

However, the perception of our state respondents on the impact of these development programmes on the managerial capacity of the LGEA staff was very elusive and negative. Our further inquiry has shown that the mode of the selection of both the trainers and trainees was based on political consideration rather on merit. Trainer maintained that participants often turned up late and missed parts of the course and a times, the nominated people were not teachers or education manager. Thus, the training amount to waste of resource. The trainees on their own part faulted the content of the training manual. The results of our focus group interview with the SBMC and PTA further reveal that most teachers attended these workshops for the allowances given. As a result of this information, we obtained from the managers at the LGEA level, the programmes did not make greater contribution in improving the managerial capacity of the teachers and the education managers at the local level.

To further ascertain the level of impact these intervention has on the managerial capacity of the LGEA, we examined the planning, coordinating and monitoring capacity of the LGEA. Table 5.14 summarizes the opinion of state respondents on the managerial capacity of LGEA's staff in the delivery of primary education. The table reveals that the management of the LGEA lacks the innovative ideas for primary education delivery. All the respondents (100%) from Kaduna state and 89.6% respondents from Zamfara state attested to this claim. Innovative ideas are the will, focus, and the ability to develop, design and create programmes and activities for the smooth running and delivery of basic education.

Managerial capacity of LGEA staff can also be measured in terms of the frequency and quality of planning. 38.9% and 61.1% of the total respondents from Kaduna state and 13.8% and 75.9% of the total respondents from Zamfara state strongly agreed and agreed respectively that the frequency and quality of planning at local government was relatively low and often very poor. This position was further confirmed by the opinions of the stakeholders in education from our personal interview.

Table 5.14: Opinion of State Respondents on the Managerial Capacity of Local Governments

S/N	Items	State	Level of responses					Total
			S/A	A	U	D	S/D	
1	The frequency and quality of planning at LGEA level is low and very poor.	Kaduna	14 (38.9%)	22 (61.1%)	-	-	-	36 (100%)
		Zamfara	8 (13.8%)	44 (75.9%)	4 (6.9%)	2 (3.4%)	-	58 (100%)
2	The nature and frequency of monitoring of school programmes by the LGEA staff and politicians are haphazardly done and often irregular.	Kaduna	6 (16.7%)	30 (83.3%)	-	-	-	36 (100%)
		Zamfara	14 (24.1%)	42 (72.4%)	-	2 (3.4%)	-	58 (100%)
3	The coordinating ability of the LGEA is very weak and often not observed.	Kaduna	8 (22.2%)	28 (77.8%)	-	-	-	36 (100%)
		Zamfara	20 (34.5%)	2 (3.4%)	10 (17.2%)	-	26 (44.8%)	58 (100%)

Source: Survey Research, 2013

Also, central to managerial capacity for LGEA is their coordinating ability. Coordination is the act of making people work together for a common goal. It ensures that things are done in accordance with set standards and approved procedures, schedule and responsibility, rules and regulations are strictly adhered to, chain of command and hierarchy of authority are duly respected. Based on the responses, 100% of the respondents from Kaduna state and 79.3% from Zamfara state expressed their opinions that the coordinating ability of the LGEA was weak. Partly because Local Governments role in primary education was reduced to the bearest level as argued by some LGA legislature in our interview and partly because of the low quality of the LGEA managers.

Again, table 5.14 shows that a total of 100% responses from Kaduna state and 96.5% of the total responses from Zamfara state held the opinion that the nature and frequency of schools monitoring by the school inspectors was haphazardly done and often irregular. We noticed that the pattern of internal school supervision by Head teachers and the mode of external school inspection carried out by school inspectors for quality assurance were not regular and thorough. It has been documented that monitoring and evaluation are major tools in determining not only the success of a given policy programme but the quality of the

programme as well. This implies that since the teaching and learning activities were not regularly and thoroughly monitored, it is likely to affect not only the quality of instruction but that of learning outcome, thereby lowering the standard of the basic education system.

To be fair to the primary school teachers, the issue of motivation is not taken seriously by the authority concerned. Although the local government has very limited roles in determining the mode and frequency of payment of teachers' salaries and allowance because deduction were made at source and amount remitted to SUBEB for payment to teachers at the LGEA. All the same, the LGA has to capture the amount required in its budgetary estimate. Again the LGA is fully responsible for the payment of teachers' promotion and yearly increase which they have to also make provision in their budget estimate. 100% of the total responses from education sector in Kaduna state and 96.6% of the total responses from Zamfara state agreed that the motivational system at the local government level was very poor to facilitate staff performance on the job. It has been established that staff performance and productivity is further enhanced by promoting staff welfare, frequent payment of salaries and staff promotion. Observations have shown that primary schools teachers were not paid their salaries as and when due throughout the state. Infact their secondary school counterpart always received their salaries a week or two before them. Again, the primary school teachers owed three months new salary implementation arrears which are yet to be upset. Also, Lere and Sanga Local Governments in Kaduna State and the entire Local Governments in Zamfara State are yet to implement the yearly promotion of the primary teacher under them.

Test of Hypothesis One

The multiple regression analysis was used to determine the impact of the MDGs intervention on education (independent variable) on the capacity of the local government to provide primary education (dependent variable). As stated earlier, the measures of MDGs intervention are financial, infrastructural and human supports while infrastructural, human

and managerial capacities were used as proxy for local government capacity. The responses of our respondents on these issues were sorted, coded and run using SPSS.16.0 and the result presented below.

Table 5.15, 5.16 and 5.17 shows the results of multiple regression analysis of the impact MDGs intervention effort in education has on the Local Governments capacity in managing primary education.

Table 5.15: Model Summary of the Multiple Regression Result

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.101 [a]	201	.301	3.46663	.051	3.674	3	207	.013

a. Predictors: (Constant), Tech_Support, Fin_support, infrast_support

Source: Survey Research, 2013

Table 5.16: Analysis of Variance (ANOVA)

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	132.454	3	44.151	1.674	613[b]
	Residual	2487.631	207	12.018		
	Total	2620.085	210			

a. Dependent Variable: MANAGERIAL_CAPACITY

b. Predictors: (Constant), Tech_Support, Fin_support, infrast_support

Source: Survey Research, 2013

Table 5.17: Multiple Regression Standard Coefficients Result

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	33.649	1.988		16.928	.000
	Fin_support	-.352	.135	-.181	-2.616	.510
	infrast_support	-.117	.092	-.092	-1.268	.206
	Tech_Support	-.054	.150	-.026	-.357	.722

a. Dependent Variable: MANAGERIAL_CAPACITY

Source: Survey Research, 2013

The overall result of the Regression statistics showed that MDGS intervention effort in education has not significantly impacted on the capacity of the local government to manage primary education. This is because the calculated regression p value of .510 (financial), .206 (infrastructural), .722 (technical) respectively are higher than the 0.05 alpha level of significance. Furthermore, the calculated R value, R square and adjusted R of 0.101, 0.201 and 0.301 respectively were each lower than the standard R value of 0.4000. This implies that the relationship between the dependent variable (local government capacity) and the independent variables (MDGs interventions in finance, infrastructure and technical) are very weak. Consequently, the null hypothesis which states that MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education, is hereby accepted and retained.

Decision

In conclusion the multiple regression analysis result in table 5.16 has an F value of 1. 674, significant at .613 which is even greater than 0.05% and the calculated regression p

value of the entire independent variables are higher than the 0.05 alpha level of significance. Therefore the null hypothesis (Ho) is accepted and the alternate rejected meaning the MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education.

5.4: Research Hypothesis Two

The research hypothesis is stated in a null form that the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in education. Three aspects of local government capacities were examined (i.e infrastructural, human and managerial capacities) in our earlier discussions on the MDGs intervention efforts and the impact it has on the local government capacity to provide primary education. We will now investigate the extent to which the capacity has enhanced or undermined the attainment of MDGs targets in education. Using variables like pattern of enrollment, retention, transition and completion to explain attainment of MDGs targets in basic education or as a measure of obtaining basic education. Where enrollment for the purpose of this study, is taken to mean a process whereby a school going age child is admitted into the formal primary school system. Retention on the other hand is the ability to keep the child in school while transition is the upward movement of the child from one grade to another within the same school system or from one lower to another higher school system (i.e. primary to junior secondary school). Completion is the final passing out or graduation from the formal school system either at primary level.

We have seen from our secondary data the consistent and continued increased in the enrollment pattern since 2007 to date. However, when we compare the enrollment figure of 439,885 for Zamfara state and 1,169,516 for Kaduna state for both pre primary and primary school enrollment (as shown in table 5.19) with the school age population of 1,055,126 for Zamfara state and 2,907,483 for Kaduna state, the enrollment figure account for only 41.7%

and 40.2% for Zamfara and Kaduna state respectively, as against the set target of 100% enrollment.

Again, for enrollment to be a very good measure of attainment of basic education, the issue of attendance, retention, completion and transition must be addressed. This is because, attainment of basic education goes beyond enrolling a child in school, to keeping that child to school to complete primary school and further transit to, retain in and complete the basic education circle of 9 years.

On the other hand, the retention rate of primary school pupils is calculated by the rate of school dropout. Using the enrollment figure for 2013 as a benchmark and applying the Education Sector Analysis (2008) internal efficiency of 77.7% completion rate for primary school education in Nigeria will mean that out of 320,183 and 123,416 new primary school intake from Kaduna and Zamfara state respectively, only 248,782 and 95,894 pupils from Kaduna and Zamfara state accordingly could complete the 6 year primary education cycle. This means that a significant proportion of 71,401 and 27,522 primary school pupils from Kaduna and Zamfara state will be drop out of school half way before graduation. Thus, if the issue of drop-out was not addressed, it means that every year a substantial percentage of the new rate in-take (i.e 22.3% of primary pupils) stand the risk of dropping half way to their completion. This position was further collaborated by the opinion of the state respondents in table 5.18 where 87.6% and 90.3% of the total responses from Kaduna and Zamfara state respectively agreed that the retention rate of pupils in the basic education sector was generally low. To validate the above response, the rate of school dropout was also labeled fairly high and high with a valid percentage of 82.5 and 78.1 from Kaduna and Zamfara state respectively.

Although we have not established at what level of the primary school the rate was high, it was no doubt a serious problem because, the danger in dropping out is that a child

will leave schooling without mastering the basic knowledge and skills meant for the completion of the basic education. This also amount to waste of resources from the economic point of view, because, resources being spent on pupils (i.e teacher salary, infrastructures, overhead etc.) are considered wasted.

Table 5.18: Opinion of State Respondents on Enrollment, Retention and Transition rates in Basic Education in Kaduna and Zamfara States

S/N	Items	State	Level of responses					Total
			U/D	Very low	Low	Fairly high	High	
1	The enrollment index of the basic education sector	Kaduna	8 (4.1%)	4 (2.1%)	28 (14.4%)	56 (28.9%)	98 (50.5%)	194 (100%)
		Zamfara	-	6 (2.6%)	46 (20.2%)	88 (28.6%)	88 (38.6%)	228 (100%)
2	The retention rate of pupils in the basic education sector	Kaduna	10 (5.2%)	60 (30.9%)	110 (56.7%)	14 (7.2%)	-	194 (100%)
		Zamfara	4 (1.8%)	96 (42.1%)	110 (48.2%)	18 (7.9%)	-	228 (100%)
3	Completion rate among pupils in primary schools	Kaduna	10 (5.2%)	62 (32.0%)	98 (50.5%)	20 (10.3%)	4 (2.1%)	194 (100%)
		Zamfara	14 (6.1%)	68 (29.8%)	124 (54.4%)	20 (8.8%)	2 (.9%)	228 (100%)
4	The rate of school drop out	Kaduna	4 (2.1%)	6 (3.1%)	24 (12.4%)	82 (42.3%)	78 (40.2%)	194 (100%)
		Zamfara	4 (1.8%)	18 (7.9%)	28 (12.3%)	98 (40.4%)	86 (37.7%)	228 (100%)

Source: Survey Research, 2013

The results of the completion rate among pupils in primary schools have not been very impressive since 1990 (MDGs baseline). From 58.0% in 1990, the primary school completion rate rose to 82.0% in 2004. In 2005, however, the completion rate decreased drastically to only 69.20%, and thereafter remained steady at 67.50% in both 2006 and 2007. The rate rose again to 70% in 2013 (MDGs 2013 Report). The mix progress of the completion rates of primary school underscored the capacity of the LGEA to attain the MDGs target of 100.0% completion rates by 2015. To make matter worst, there is wide variation between states and even within state (urban and rural). According to 2013 MDGs report, the primary school completion rates for Kaduna state was 70.7% while Zamfara state has as low

as 53%. In line with the above report, our respondents rated the primary school completion rate low (82.5% and 84.2% of the total respondents from Kaduna and Zamfara state). This goes to explain that since the pupils are hardly retained in school, the probability of their completing primary school was relatively very low.

Table 5.19: Out of School Population 2012/13

State	Level	School age population*			Enrollment **			Out of school population		
		M	F	T	M	F	T	M	F	T
Zamfara State	Pre-Primary	192922	176997	369919	14909	9894	24803	178013 (92%)	167103 (94.4%)	345116 (93%)
	Primary	353301	331906	685207	271273	143809	415082	82028 (23.6%)	188097 (56.7%)	270125 (39%)
Kaduna State	Pre-Primary	624,800	267,772	892,572	53,165	49,076	102,241	571,635 (91.5%)	218,696 (81.7%)	790,331 (89%)
	Primary	1,429,338	612,573	2,041,911	579,513	487,762	1,067,275	849,825 (59%)	124,811 (20.4%)	974,636 (48%)

Source: * National Bureau of Statistics, 2009. ** State Basic Education Boards (Kaduna and Zamfara States), 2013 Enrollment Figures.

Table 5.19 indicated the out of school population for both pre and primary school of the two states under study. To compute the out of school population, we compared the school age population based on the 2006 population census with 2012/2013 school enrollment for the two states. A total of 93% and 89% of pre- primary school age children were observed to be out of school in Zamfara and Kaduna state respectively. The proportion of pre-primary school children was tagged to be 90% by 2015. One year to the dateline and the proportion was only 7% for Zamfara state and 11% for Kaduna state which was far behind the expected set target. In the same table we also noticed disparities manifesting between gender with male recording the highest percentage of enrollment and higher proportion of out of school population in Kaduna state (91.5% pre- primary and 59% primary school population). Whereas, in Zamfara state the girl child has the highest proportion of out of school of 94.4% for pre-primary and 56.7% primary school. This negates policy and emphasizes geared for the promotion of Girl-Child Education.

Similarly, the proportion of primary school pupils that are out of school is 39% for Zamfara state and 48% for Kaduna state. This means that out of 685,207 primary school age populations in Zamfara state 415,082 children are enrolled into primary school (61% of the overall population), were as out of 2,041,911 primary school age population in Kaduna state 1,067,275 children are enrolled into primary school (52% of the total school age population). Overall, the proportion of both pre primary and primary school pupils that are out of school in Zamfara state is 615,241 representing 58.3% while that of Kaduna state was 764,967 representing 60.1% which is very disturbing. This shows that the two states are unlikely to meet the MDGs set target of zero percent out of school population by 2015. On comparative basis, Zamfara State seems to be faring better in terms of primary school population and Kaduna State is doing better in pre primary school population. By and large, the two states are far from the approved target of 90% for pre primary and 100% for primary enrollment by 2015.

Based on the analyses and statistics on enrollment, retention, completion rates and quality have all made us to believe that the attainment of the MDGs targets on basic education was undoubted and very difficult to achieve by 2015. However from the overall analysis, we can adduce that the MDG (UBE) intervention efforts in education fall far short of the overall impact on the capacity of the LGEA in managing primary education thereby undermining the attainment of the MDGs targets in education. To confirm or disprove the data presented and analyzed above, we subjected the primary data for statistical analysis using multiple regression analysis as the test instrument.

Test of Hypothesis Two

Ho: The enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in education.

Three aspects of local government capacities were examined (i.e human, infrastructural and managerial capacities) and regressed with the attainment of MDGs targets in education. Where variables like rate of enrolment, retention, and completion were used as proxy.

Table 5.20: Model Summary of the Multiple Regression Result

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.099[a]	.010	-.005	4.25101

a. Predictors: (Constant), Mgt. cap, Hum. cap, Infrst. Cap

Source: Survey Research, 2013

Tables 5.20, 5.21 and 5.22 show the result of the multiple regression analysis between the independent variable (local government capacity in managing primary education) and the dependent variable (attainment of MDGs target in education).

Table 5.21: Analysis of Variance (ANOVA)

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	37.085	3	12.362	.684	.563[a]
	Residual	3740.706	207	18.071		
	Total	3777.791	210			

a. Predictors: (Constant), Mgt. cap, Hum. cap, Infrst. cap

b. Dependent Variable: Attainment of MDGs

Source: Survey Research, 2013

Table 5.22: Multiple Regression Standard Coefficients Result

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	23.187	1.958		11.839	.000
	Human cap	.042	.537	.006	.078	.938
	Infrst. cap	-1.476	2.757	-.121	-.535	.593
	Mgt. cap	.250	2.634	.021	.095	.924

a. Dependent Variable: Attainment of MDGs

Source: Survey Research, 2013

The overall result of the Regression statistics shows that the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGS targets in Education. This is because the calculated regression p value as shown in table 5.22 of the entire independent variables of 0.938 (human), 0.593 (infrastructural) and 0.924 (management capacities) respectively are higher than the 0.05 alpha level of significance and thus appeared not significant at all. Also, the F-test (0.684, p >0.563) as shown in table 5.21 is not significant. This could be attributed to the insignificant p values of the independent variables and also the extent of the degree of the relationship amongst the variables as confirmed by the R value. Furthermore, the calculated R value, R square and adjusted R of 0.099, 0.010 and -0.005 respectively were each lower than the standard R value of 0.4000 and thus appeared insignificant. This implies that the strength of the relationship between the independent variable (LG capacity) and the dependent variable (Measure of MDGs attainment in education) is very weak. Consequently, the null hypothesis which state that enhanced capacity of the local government has not significantly impacted on the achievement of the MDGS targets in Education is hereby accepted and retained.

Decision

The result of the test instrument reveals that the F value in table 5.21 that assess the combined statistical significant of the results of the regression equation is 0.684 which is less than 2.60 and the P calculated of the entire independent variables are significantly higher than the .05 alpha level of significance. In conclusion therefore, the research null hypothesis (Ho) is hereby accepted and the alternate rejected. Meaning that the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in education.

5.5: Research Hypothesis Three

Research hypothesis three states that the MDGs intervention efforts in health has no significant impact on the capacity of the local government to manage primary health care. The independent variable is the MDGs Intervention for Health Related Services while the dependent variable is the Local Government capacity in managing primary health care.

The major intervention for health related MDGs targets in Nigeria comes from the MDGs Conditional Grant Scheme arrangement. This arrangement is similar to the UBE Matching Grant where funds are accessed on conditional grounds as part of which States Governments must provide counterpart funds equivalent to the total sum allocated before accessing the funds. In respect of MDGs – Local Government counterpart arrangement the benefitting LGA has to pay 40% of the total counterpart funds, while the State Government put in the remaining 60% to access the sum of one hundred million naira from the scheme. Here, we examined the funds accessed and the extent to which it utilization has strengthened the infrastructural/material, human and managerial capacity of the Local Government council in providing PHC services.

Table: 5.23: Number of Benefiting LGAs from the MDGs Conditional Grants Arrangement to Local Governments, 2011- 2013

State	2011	2012	2013	Total
Kaduna state	4 LGAs Ikara Brinin Gwari Kudan Sanga	4 LGAS Lere Giwa Kachia Kubau	6 LGAS Jaba Soba Kagarko Kajuru Igabi Chikun	14 LGAs
Zamfara state	3 LGAS Zurmi Maru Bukkuyum	4 LGAS Birnin Magaji Tsafe Bakura Anka	6 LGAs Bungudu Gumi Kauran Namoda Maradun Shinkafi Talatan Mafara	13 LGAs

Source: Documents from States MDGs offices form Kaduna and Zamfara 2013.

Table 5.23 has shown that a total of 14 LGAs from Kaduna state have benefited from the MDGs Conditional Grants arrangement while a total of 13 LGAs benefited from Zamfara state. The LGAs that have benefited from this arrangement based on the order of ranking in Kaduna state were Ikara, Birnin Gwari, Kudan, Sanga, Lere, Giwa, Kachia, Jaba, Soba, Kubau, Kajuru, Kagarko and Igabi LGAs; while Zurmi, Maru, Bukkuyum, Birnin Magaji, Tsafe, Bakura, Anka, Bungudu, Gummi, Kauran Namoda, Maradun, Shinkafi and Talatan Mafara LGAs in Zamfara state benefitted. Each of these Local Government Areas received the sum of 100,000,000 naira from the MDGs office plus an equivalent amount as counterpart funds to execute projects that were directed on specific MGDs targets. It was therefore assumed that Kaduna and Zamfara states have accessed a total of 1.4 billion and 1.3 billion naira respectively meant for Local Governments MDGs intervention in addition to the MDGs Conditional Grants arrangement to states. All these funds were with assumption that would

improve the capacity of the Local Governments in attaining MDGs set targets particularly the Health related targets.

It is important to note that the two states under study have received over 11 billion naira each from 2007 to 2011 as MDGs intervention grants and thus, expected to support the capacity of the LGA with these funds. Part of the MDGs intervention strategy is that 40-45% of the funds be spent on health, 35-40% on water and environment and the remaining 15-25% on economic activities (MDGs, 2012). Thus a substantial amount of money is to be sent on health care activities.

In addition to the MDGs grants, local governments are expected to compliment the efforts by beefing up their budgetary allocation in the MDG sectors particularly education and health. The MDGs programme emphasized the need for adequate budgetary allocations particularly to education and health care services. The UNESCO target for education is 26% while the WHO range is 34% of the total budgetary allocation of government (UNESCO, 2012 and WHO, 2008).

Table 5.24: Summary of Annual Estimates of selected Local Governments from Kaduna State in Health and Primary Education from 2010- 2012 (figures in Naira).

	Kaduna North LGA			**Lere LGA**			**Sanga LGA**		
Items	2010	2011	2012	2010	2011	2012	2010	2011	2012
Total estimate	2,152,638,855	2,848,352,838	3,767,787,896	2,072,883,107	2,594,789,775	4,346,054,196	1,543,529,115	1,887,001,425	2,537,540,917
Total Recurrent	1,756,046,596 (82%)	2,256,169,980 (79%)	2,971,853,979 (78.8%)	1,853,423,183 (89%)	2.358,557,120 (91%)	2,730,774,753 (63%)	1.107,572,282 (72%)	1,421,629,927 (75%)	1,743,385,667 (67.2%)
Total Capital	397,592,259 (18%)	691,872,948 (21%)	796,933,917 (21.2%)	219,450,924 (11%)	236,232,655 (8%)	1,615,279,443 (37%)	436,756,833 (28%)	465,371,498 (25%)	794,155,310 (32.8%)
Total estimates Health	64,363,500 (3%)	79,842,831 (2.8%)	98,897,219 (2.6%)	68,373,764 (3.3%)	85,100,000 (3.3%)	101,864,700 (2.3%)	54,947,840 (3.6%)	78,236,550 (4.1%)	93,450,000 (3.7%)
Total Education Estimates	53,495,381 (2.5%)	59,938,500 (2.1%)	69,000,000 (1.8%)	92,356,502 (4.5%)	107,137,021 (4.1%)	118,053,554 (2.7%)	71,644,741 (4.6%)	80,249,989 (4.3%)	85,788,500 (3.4%)

Source: Selected Local Governments Yearly Estimates, from 2010 – 2012 (State Ministry of Local Government)

This study has collected financial statistics of the sampled Local Governments in the two states. The summaries of the estimates (2010-2012) on primary education and health are presented in table 5.24 and 5.25. We also computed the percentage allocations to these sectors. It was generally observed that sampled Local Governments in Kaduna (i.e Kaduna North, Lere and Sanga LGA) and Zamfara states (i.e Gusau, Kauran Namoda and Bakura LGA) have, over the years not made any considerable effort in funding the Primary Health and Education sectors. As revealed from the summary of estimates for Health and Education from 2010 -2012 in Table 5.24 and 5.25, in 2010 Kaduna North, Lere and Sanga LGAs in Kaduna state allocated only 3%, 2.5%, 3.3% respectively for Primary Health Care and 4.5%, and 3.6% and 4.6% for Primary Education respectively in their budgetary estimates. For the subsequent years, the percentage decreased to 2.8% and 2.1% in 2011 and further to 2.6% and 1.8% in 2012 for Primary Health care and Education respectively for Kaduna North LGA. The same pattern of decrease applied too to Lere LGA in all the two sectors (Health and Education) only Sanga LGA experienced a fluctuating pattern in the Health sector from 3.6% in 2010, raised to 4.1% in 2011 and further felt to 3.7% in 2012. To make matters worse, 75% to 90% of the mega resources allocated to these sectors are for recurrent expenditures with insignificant amount set aside for capital expenditures. Although the budget estimates for these Local Governments sampled took the incremental pattern with a small percentage allocated for capital expenditure which most often took a decreasing pattern.

Table 5.25: Summary of Annual Estimates of Selected Local Governments from Zamfara State in Health and Primary Education from 2010- 2012 (Figures in Naira)

	Gusau LGA			**Kauran Namoda LGA**			**Bakura LGA**		
Items	2010	2011	2012	2010	2011	2012	2010	2011	2012
Total estimates	3,029,124,720	3,041,672,930	3,890,363,930	2,276,411,050	2,370,121,270	2,834,821,280	1,993,311,010	2,030,478,350	2,553,596,590
Total Recurrent	2,041,632,000 (67%)	2,036,339,030 (67%)	2,061,031,140 (53%)	1,094,049,960 (48.1%)	1,462,966,350 (62%)	1,614,500,040 (57%)	1.062,734,690 (53.3%)	1.139,688,080 (56.1%)	1,295,089,930 (51%)
Total Capital	987,492,720 (33%)	1,005,333,900 (33%)	1,829,332,790 (47%)	1,182,361,090 (51.9%)	908,154,920 (38%)	1,220,321,240 (43%)	930,576,320 (46.7%)	890,790,270 (43.9%)	1,258,506,660 (49%)
Total estimates Education	359,700,000 (11.9%)	253,100,235 (8.3%)	280,170,318 (7.2%)	183,354,431 (8.1%)	169,483,623 (7.2%)	162,533,751 (5.7%)	145,432,270 (7.3%)	149,126,277 (7.3%)	245,418,090 (9.6%)
Total Estimates Health	334,634,890 (11%)	523,734,642 (17.2%)	682,287,432 (17.5%)	257,812,405 (11.3%)	423,454,872 (17.9%)	533,780,530 (18.8%)	277,333,527 (13.9%)	264,386,690 (13%)	345,684,720 (13.5%)

Source: Selected Local Governments Yearly Estimates, from 2010 – 2012 (State Ministry of Local Government)

In the case of Zamfara state, the total capital expenditures allocations for the three Local Governments under study are by far higher than that of Kaduna state. In fact, for Kauran Namoda and Bakura LGAs, their capital expenditures went to the tune of 40 – 50% of the total expenditure over the period of the three years (2010-2012). Even in the sectoral allocation, Zamfara state seems to be faring better than Kaduna state. For instance Gusau LGA voted 11% of its total budgetary allocation to Primary Health Care and Education while Kaduna North from Kaduna state air marked only 3% to the Health sector and 2.5% to the Education sector in the same year (2010). Notwithstanding the three Local Governments from Zamfara state took the same decreasing and often fluctuating pattern just in similar pattern of Kaduna state as indicated from the same Tables 5.24 and 5.25. Again, going by the WHO standard of 34% of the total budgetary allocation to the Health sector and the UNESCO standard of 26% of the total budgetary estimates to the Education sector, the overall budgetary estimates made to Primary Health Care and Education units in all the six Local Governments sampled from the two states are per below the set standards. This therefore implies that these sectors fall short of the required financial capacity to effectively

and efficiently manage the delivery of Primary Health care and Education services at the Local Government levels. The perception of the respondents in education and health from our personal and focus group interviews maintain that most of these figures did not translate into actual spending by the LGAs. Some of the reasons put forward include; absence of political will and genuine commitment for service delivery from the top local bureaucrats and politicians, weak and often abused accountability mechanism of the local governments, undue state interference in the spending of the LGAs, weak IGR effort to compliment statutory allocation that is subject to dictate.

MDGs Intervention on Infrastructural Capacity of the Local Government to Manage Primary Health Care

Having looked at the MDGs support funds released and accessed by the two states and selected Local Governments within the two states. We now look at the utilization of these funds to ascertain its impact on the capacity of the Local Government in managing the Health related MDGs programmes. It should be borne in mind that Local Government is responsible for Primary Health Care delivery services which is the basic health care package for any one concerned with health delivery programme at grassroots levels.

Table 5.26: Number of Health Facilities (Infrastructural) Provided from MDGs Conditional Grants Funds to Local Government, 2011- 2013

Projects	Kaduna state		Zamfara state	
	Lere LGA	Sanga LGA	K/Namoda LGA	Bakura LGA
Construction of Health facility	2	2	1	1
Renovation of Health facility	11	11	15	15
Construction of toilets	5	5	-	-
Procurement of clinic furniture	11	11	10	10
Procurement of Basic Drugs	11	11	11	10
Health facility perimeter fence	-	-	3	3

Source: KDSPHCDA, ZSPHCDA, various Reports from 2007-2013.

Table 5.26 above provides the summary of the number of infrastructural health facilities provided from the MDGs accessed funds that have direct bearing to Primary Health

Care services. Information from the Table reveals that Lere and Sanga LGA from Kaduna state have constructed 2 health facilities each, renovated 11, constructed 4 toilets, procured furniture and drugs for 11 health facilities each from the MDGs grant received. While Kauran Namoda and Bakura LGAs from Zamfara state have constructed 1 health facility each, renovated 15, procured furniture for 10 and fenced 3 health facilities each within the same period. The only difference from the two states was that Kaduna has constructed toilets facilities and has not fenced any health facility while Zamfara state has fenced 3 health facilities and has not constructed any toilet. This disparity has to do with local priorities and state MDGs needs captured in the plan. Although Kaduna North and Gusau LGAs from the two states are yet to access the MDGs funds, nevertheless, the four LGAs that accessed the funds seem to be faring well.

On whether these infrastructural health facilities put in place have strengthened the capacity of the Local Governments to provide effective health care services. The responses of the District Health Committees (DHC) in our focus group interview reveals that these facilities provided were by far inadequate to make any significant impact on health care service delivery. Moreover, the location of the projects and distribution of the materials were in most cases politically influenced. This view collaborated with the responses of the women attending clinics who add that apart from being inadequate the health infrastructures were not in good conditions. They went further states that a time the few drugs and equipment sent were often diverted or cornered by some of the local health staff and bureaucrats. To further ascertain the impact of these efforts, we looked at the adequacy and distribution of the basic health facilities in the two states under study.

Tables 5.27 reveal the situation of primary health care facilities in the two states under study. The table shows the number of Primary Health Care facilities by category in comparison with political wards and units within the two states under study. The table

indicates that 255 PHC centres, 304 PHC clinics and 560 Health Posts are currently available in Kaduna state. While, in Zamfara state 34 PHC centres, 66 PHC clinics and 335 Health Post are available. It is important to note that the minimum standards for PHC delivery in Nigeria as prescribed by the National Primary Health Care Development Agency (NPHCDA) stipulated that PHC centres shall be located at each political ward to serve an estimated population of 10,000 -20,000 while PHC clinics shall be located in a village neighborhood or settlement of communities to serve an estimated population of 2,000- 5,000 people and a Health Post shall be located in a village or smaller settlement to serve an estimated population of 500 and below. It is on this ground that we use the political wards and polling units as a base to ascertain the adequacy or otherwise of these PHC facilities because political wards and polling units operate within the radius of 10,000 -20,000 (political ward) and 500 and below eligible voters (polling units) as specified by INEC. When we compare the number of wards with the PHC centres, we noticed that Kaduna state has a short fall of 100 PHC centres based on NPHCDA minimum standard. While, Zamfara state is short of 140 health centres because it has 174 political wards with only 34 PHC centres. Also, the number of Health post in each of the two states was grossly inadequate when compared with the number of polling units in each of the states. For instance, Kaduna state has 5,108 polling units with only 560 Health posts operating while Zamfara state has 2,410 polling units with only 335 available Health posts. It is also important to note that the Health post is the first primary health care referral point that provides basic health services to people and thus, are expected to be available and accessible to the people hence it is expected to be located in each settlement or neighbor hood to serve an estimated population of 500 and below.

Table 5.28: Number of Health Facilities Required and Number Available by Categories

State	PHC centres		PHC clinics		Health Post	
	Available	Required	Available	Required	Available	Required
Kaduna	155	255	305	510	560	5,108
Zamfara	34	174	66	241	335	2,410

Source: National Demographic and Health Survey: Fact Sheet, 2013.

To further, reveal the gross inadequacy and uneven distribution of the existing health facilities, table 5.29 shows the number of health facilities, the population figure and the ratio of the facilities to the population in the sampled Local Governments. Kaduna North LGA has 14 health facilities to serve a population of 364,575 going by the 2006 population census figure one facility is to 26,041 people. Thus, even if all the 14 facilities are PHC centres which they are not, and going by the maximum number a PHC centre can accommodate we still have shortage of 5. Sanga and Lere LGAs from Kaduna state, Gusau, Kauran Namoda and even Bakura LGAs from Zamfara state require more health facilities to accommodate their population even if these facilities were PHC centres or clinics. However, we observed that most of these health facilities are Health posts with a capacity to accommodate only 500 and below. Thus, when we divide the number of the available health facilities in these LGAs by their population, we noticed that these facilities could not cater for the given population. For instance, in Sanga LGA 46 health facilities are available within the ratio of 3,293:1and the 11 health facilities in Bakura LGA of Zamfara state with a ratio of 17,013:1 which is far inadequate to cater for the existing population in these LGAs.

The result of the questionnaire as presented in table 5.30 further reveals the inadequacy of health centres. 85.1% and 68.4% of the total responses from Kaduna and Zamfara state respectively were of the opinion that the PHC centres and clinics were inadequate. These stakeholders in health went further to maintain that the PHC personnel in

the health clinics and centres were also inadequate to effectively manage the existing health care facilities as indicated in table 5.30.

Table 5.29: Number of Health Facilities by Population in selected Local Governments in Kaduna and Zamfara State

Items	Kaduna North LGA	Sanga LGA	Lere LGA	Gusau LGA	Bakura LGA	Kauran Namoda LGA
No of health facilities	14	46	72	63	11	69
Population	364,575	151,485	339,740	383,712	187,141	285,363
Ratio	26,041:1	3,293:1	4,719:1	6.091:1	17,013:1	4,136:1

Source: PHC Departments from the Two States, Nov.2013

Health facilities also include health equipment, drugs and basic apparatus. The responses from table 5.30 revealed that basic health equipments in clinics and health centres were not available (75.4% and 75.5% of the total responses from Kaduna and Zamfara state). However, for Essential Drugs, the responses show fairly available (71.9% and 62.2% of the total responses from Kaduna and Zamfara state).

Table 5.30: Opinion of State Respondents on Adequacy of PHC Facilities

S/N	Items	State	Level of responses				Total
			Undecided	Not available	Fairy available	Available	
1	PHC Clinics/centres	Kaduna	4 (1.8%)	194 (85.1%)	30 (13.2%)	-	228 (100%)
		Zamfara	2 (1.0%)	134 (68.4%)	54 (27.6%)	6 (3.1%)	196 (100%)
2	Basic health equipments in clinics	Kaduna	2 (.9%)	172 (75.4%)	54 (23.7%)	-	228 (100%)
		Zamfara	-	148 (75.5%)	46 (23.5%)	2 (1.08%)	196 (100%)
3	Essential drugs in health clinics	Kaduna	-	24 (10.5%)	164 (71.9%)	40 (17.5%)	228 (100%)
		Zamfara	-	12 (6.1%)	62 (31.6%)	122 (62.2%)	196 (100%)
4	PHC personnel in health clinics	Kaduna	-	118 (51.8%)	104 (45.6%)	6 (2.6%)	228 (100%)
		Zamfara	-	116 (59.2%)	78 (39.8%)	2 (1.0%)	196 (100%)

Source: Survey Research, 2013

However, to ascertain the adequacy and condition of these facilities and equipments in some of the health facilities visited indicate that apart from Essential Drugs, other basic equipments required for the diagnosis and treatment of common diseases were not made available in many health centres; items like B.P. Apparatus, kidney dish, delivery beds, weighing scale and the like were observed and not found in most of the PHC clinics. In some cases even minor apparatus like tray, bandage and scissors were not supplied in some health clinics, most particularly rural health clinics. We also noticed that toilet facilities and source of good water supply were grossly inadequate and often absent in many of the health facilities visited. One particular episode worse sighting is the story of an outbreak of diarrhea epidemic in (Rimi) one of the villages visited in Bakura LGA. In the morning, we went to the Local Government secretariat and the PHC Director attached us with one of his staff to take us round the health facilities and Rimi being one of the health facility located at the out skate of the town cut our attention. Rimi is about 15 kilometers from the secretariat, on reaching the town, we noticed that something close to confusion, so we stopped to enquire and we were told that there was an outbreak of diarrhea epidemic two days ago and that an NGO had sent in medical team to assist in controlling the outbreak. So we quickly rushed to the only health facility in the village. On our way, we saw women and children carrying along with them jug of water, rubber bowel and mat moving toward the health facility. We wandered what they were going to do with those, but on reaching the clinic, we noticed that all were meant for the patient as there was no single toilet and water in the health clinic and the mat is the bed as there is no single bed not even examination bed and the clinic is looking big with several rooms, offices and a very big fence premises for a modern health centre but completely unfurnished in terms of equipment and facilities. This was a clear testimony of the poor state of health facilities in the Local Government Areas under this study particularly the rural Local Governments.

We have to also acknowledge the success story recorded by the provision of essential drugs supply in Nigeria as a result of the Bamako Initiative Programme (PTF, 1998). A programme that was more concerned with the revolving funds scheme through the District Committee System. Each health facility was expected to form a district health committee which would be responsible for the management of the drug funds and the subsequent sales and purchases of the essential drugs. The initiative was supported by NGOs and National Government. Also, from the result of the interview, we noticed that in addition to the drug revolving fund scheme, the Nation Health Insurance Policy played an important role in the success story of Essential Drug supply programme, most particularly in the PHC centres and General Hospitals.

However, all these did not seriously improve the basic infrastructural facilities required for the delivery of Primary health care programmes. The availability of infrastructures remained grossly inadequate. The perception of the women attending clinic in our focus group interview lamented that apart from the dilapidated structures in the health facilities, the inadequacy and often nonchalant attitude of the health providers and managers have seriously affected health care delivery.

MDGs Intervention on Human Capacity of the Local Government to Manage Primary Health Care

Another MDGs intervention programme was in the area of man power capacity and development. Part of the MDGs strategy is the introduction of the Federal Rural Nurses & Midwifes (FRN&M) scheme. The scheme was meant to strengthen the existing health workers strength at the local level particularly the rural health facilities. The scheme recruited and deployed qualified Nurses/midwives and Community Health Extension Workers (CHEW) to LGA to serve as primary health providers for a period of one year and it was expected that at the expiration of the one period, the LGA should absorb them. Table 5.31

shows the number and category of these health workers deployed to each state. In 2009, when the programme was introduced, a total of 96 Midwifes and 48 CHEW were deployed to Kaduna and Zamfara state respectively. After the expiration of their contracts, their contracts were renewed and their total number was raised to 144 for Midwife and 72 for CHEW in 2010 for each of the state. Due to the low absorbing capacity of the Local Governments, the contract of these set of health workers continued to be renewed up till the time our study was conducted in December, 2013.

Table 5.31: Number of Federal Rural Nurses & Midwife Employed under the Scheme Allocated to States 2009 - 2013

States	Category	2 009	2010	2011	2012	2013
Kaduna state	Mid-wife	96	144	144	144	144
	CHEW	48	72	72	72	72
Zamfara state	Mid-wife	96	144	144	144	144
	CHEW	48	72	72	72	72

Source: NPHCDA, 2013

Our further observation revealed that most of the health workers did not want to serve in rural areas where their services are highly needed. Even those posted to the urban health facility, we noticed hardly stayed and perhaps because of the cultural and often language barriers, some of them found it difficult to assimilate and integrate themselves with the people and as such the patients in most cases felt uncomfortable with their services as gathered from the responses of women attending clinics in our focus group interviewed. The views of our stakeholders in health in the interview conducted indicate that the Federal PHC Rural Nurse/Midwife scheme has not significantly boosted or strengthened the health related manpower requirement of the local governments. This implies that despite the recruitment of the PHC FRN&M deployed to LGAs within the states to serve their presence have not made any significant change in the PHC delivery services rendered to the local people. It was also felt that this has not improved the manpower capacity of the LGAs in that direction.

Table 5.32: Number and Categories of Health Workers in the Selected Local Governments in Kaduna and Zamfara State

Category of Health workers	Kaduna North LGA	Sanga LGA	Lere LGA	Gusau LGA	Bakura LGA	Kauran Namoda LGA
Doctors	-	-	-	-	-	-
Nurses/ Mid wife	34	5	26	12	2	10
CHO	8	8	1	5	-	2
Pharm. Tech/Asst.	5	2	3	1	-	1
CHEW	36	52	42	16	2	14
Medical Laboratory Scientists/Asst.		-	1	-	-	-
Environment & Pub HW	48	17	20	18	5	16
Food & Nutrition	-	-	2	1	-	2
JCHWE	24	17	22	20	4	16
Dentists	2	-	1	2	-	-
H/Attendant	169	118	180	188	111	147
Total	**326**	**219**	**308**	**263**	**124**	**208**

Source: PHC Departments of the Local Governments. Nov. 2013

The study has collected the health staff statistics of our sampled Local Governments. Table 5. 32 reveals the distribution of the health staff who are mostly none professionals such as; Health Attendants and Environmental Public Health Officers. Also, none of the LGA employed the services of a Medical Doctor. The situation was worst in Zamfara state where CHO, CHEW and JCHEW were grossly inadequate in the existing health facilities not to talk of Nurses/Midwives. For instance, Gusau LGA has 63 health facilities with only 41 PHC staff (5 CHO, 16 CHEW and 20 JCHEW), Bakura LGA has 11 health facilities with only 6 PHC staff and 2 Nurses/Midwife to cater for the entire health facilities while, Kauran Namoda has 10 Nurses/Midwife to serve the existing 69 health facilities with only 32 PHC staff (2 CHO, 14 CHEW and 16 JCHEW). We observed further that some of these health facilities, particularly those in the rural areas were managed by Environmental Health Officer and Health Attendant which was unusual and posed serious challenge to primary health care delivery.

Table 5.32 further reveals the uneven distribution of the health workers with great concentration in urban Local Governments; Kaduna North in Kaduna state and Gusau in Zamfara state, both urban Local Governments had 40.2% and 55.3% respectively of the total health workforce of the three Local Governments, followed by the semi- urban local governments with 37.6% and 36.6% (Lere and Kauran Namoda). While the rural Local Governments; Sanga in Kaduna state and Bakura in Zamfara state have only 21.5% and 8.1% respectively of the total workforce. This shows that there was serious shortage of health workers of all the categories in the rural Local Governments under study.

This inequality in distribution of health workers is greater in some category of workers like; CHO, Pharmacist and to some extent Nurses and Midwives, which goes contrary to the principle of PHC delivery (equitability of health services). Some of the factors responsible for the uneven distribution are financial and social difference among the Local Government Areas. In addition, most health workers prepared to work in urban centres. The overall results on human resources at local level depict uneven distribution of health workers between the rural and urban Local Government Areas within each state, as well as between the various types of health facilities within each Local Government Area. There were generally inadequate number of health workers in the two states under study, and the situations in the primary health post were more critical. The willingness of the policy makers to address these problems is also central in any discourse of PHC delivery at Local Government level.

In this respect, some writers (USAID, 2010 and World Bank, 2011) are of the view that human capacity of the local government also includes issues of political will of the political actors to harness and manage the limited resources available for development. The more the level of willingness, the better will be the capacity of the local government to provide services and vise - visa. On this note, respondents were asked to indicate the presence

or absence of political will as a measure of local government capacity for service delivery generally. The result of the responses as shown in table 5.33 below indicates that 100% and 65.5% of the total responses from Kaduna and Zamfara state respectively attested that the political will of the local political actors to mobilize resources and enforce effective service delivery at local government level was weak and often absent. Also, we further observed that most of the political actors at the local government level were not well educated, not socially exposed and politically focused, thus, lack direction and initiatives to bring about the needed development. Infact, the results of the interviews with some top local government staff and state officials attested that the non challent attitude, greed and non cooperative tendencies of the political actors were generally responsible for holding the operations of the local government to ransom, and undermining the capacity of the local government to provide basic services in the areas of primary education and health care. They further stated that appointment of local government staff by the Commission or Local Government was clouded with a lot of bias and political considerations thereby, compromising the human resource standard of the local government. Politicians often appoint their supporters and relatives irrespective of whether or not they possessed the requisite qualifications and requirements for appointment.

Table 5.33: Opinion of State Respondents on Human Capacity of the Local Governments

S/N	Items	State	Level of responses					Total
			U/D	S/D	D	A	S/A	
1	The local capacity for personnel development is weak	Kaduna	10 (27.8%)	24 (66.7%)	-	-	2 (5.6%)	36 (100%)
		Zamfara	28 (48.3%)	16 (27.6%)	-	14 (24.1%)	-	58 (100%)
2	The political will to mobilize and enforce effective service delivery at local level is weak	Kaduna	8 (22.2%)	28 (77.8%)	-	-	-	36 (100%)
		Zamfara	26 (44.8%)	12 (20.7%)	6 (10.3%)	14 (24.1%)	-	58 (100%)

Source: Survey Research, 2013

MDGs Intervention on Managerial Capacity of the Local Government to Manage Primary Health Care

The other strategy adapted by the MDGs to further enhance the managerial local capacity of health workers was through capacity development programmes. It is important to note that the health workers in the LGA enjoyed two kinds of capacity development programmes. One organized by the LGSC from the staff training funds and the other organized by the SPHCDA from state MDGs grants. These two programmes were meant to enhance the managerial skills and competencies of the health workers and managers. Table 5.34 and Table 5.35 below provide a synopsis of the types of training received by the PHC staff and number of beneficiaries in the two sampled states.

Table 5.34: Training Organized for PHC Staff by LGSC and Number of Beneficiaries from 2005-2013

Training organized and attended	Kaduna state		Zamfara state	
	2005-2009	2010-2013	2005-2009	2010-2013
Training on MDGs targets and intervention programmes	120	184	Nil	80
Training on Health Care Planning and budgeting	320	368	190	70
Training on financial management and Accounting procedures.	880	552	230	70
Training on ICT	850	460	370	140
Techniques of projects Monitoring and Evaluation	130	184	120	Nil
Training on specific disease diagnosis, treatment and prevention	Nil	92	70	Nil
Total	2,300	1,840	980	360

Source: Local Government Service Commission (LGSC), Kaduna and Zamfara State, 2013

Table 5.34 reveals the types of training organized by LGSC for PHC staff from 2005 – 2013. The information from the table shows that the LGSC of the two states have organized 6 types of workshops for PHC staff for the period under study. Total of 304 and 80 PHC staff respectively from Kaduna and Zamfara states were trained on MDGs targets and intervention programmes, whereas 688 and 260 were trained on Health Care Planning and Budgeting, 1,432 and 300 PHC staff were equally trained on Financial

Management and Accounting procedures, 1,310 and 510 PHC workers were trained on ICT, were as,314 and 120 PHC staff have received training on the techniques of project monitoring and evaluation and lastly,92 and 70 PHC staff received training on specific disease diagnosis, treatment and prevention from Kaduna and Zamfara state LGSCs respectively.

Information from the Table 5.34 shows some discrepancy in the number of beneficiaries and the type of training received in the two states. For instance, Kaduna state organized training for a total of 4,140 PHC staff while Zamfara state was only able to organize for a total of 1,340 staff. Again, Kaduna state has trained 120 PHC staff on MDGs targets and intervention programmes between 2005 -2009 while Zamfara state did not. Also, between 2010 – 2013 Kaduna state LGCS conducted a training workshop for 184 and 92 PHC staff on the techniques of project monitoring and evaluation and on specific disease diagnosis, treatment and prevention while Zamfara state has not. Although Zamfara state has between 2005-2009 organized training for 70 PHC staff on specific disease diagnosis, treatment and prevention while Kaduna state did not but notwithstanding Kaduna state LGSC performed far better on comparative basis than Zamfara state LGSC in organizing training programmes for PHC staff.

Table 5.35 Training Organized for PHC Staff and Community Health workers by National/State PHCDA and Number of Beneficiaries from 2009-2013

Training organized	Kaduna state	Zamfara state
	2009 – 2013	2009 – 2013
Training on MDGs targets and intervention programmes	976	280
Training on Community Development Committee System	1,300	1,030
New Techniques of Data Collection and Reporting system	322	480
Training on TB and HIV/AIDs surveillance system	530	320
Training on Drugs Management and administration	667	230
Training on specific disease diagnosis, treatment and prevention	2,065	940
Total	5,860	3,280

Source: NPHCDA/SPHCDAs, 2013

Table 5.35 also provides the summary of types of training organized for PHC providers by either the National or State PHCDA. The Agency was established in the States in 2009. The picture reveals that the training programmes were more specific and focus, directed at delivery of MDGs activities. These programmes include training of stakeholders on Community Development Committee system for effective management of the District Health Committees at each facility level. As a result of this training Kaduna state has trained 1,300 stakeholders, while Zamfara state trained 1,030 stakeholders. Other areas of training were on the new techniques of Data collection and Reporting, where the two states (Kaduna and Zamfara) have trained 322 and 480 respectively. Also, 530 PHC staff from Kaduna and 320 from Zamfara state were trained on TB and HIV/AIDs surveillance system and another 667 PHC providers from Kaduna and 230 from Zamfara state received training on Drugs management and administration. The bulk of the training received by the PHC providers was in the areas of disease diagnosis, treatment and prevention as revealed from the Table. In all Kaduna state had organized training for 5,860 PHC staff between 2009-2013, while Zamfara state had organized training for only 3,280 PHC providers. This goes to show the existing disparity between the two states. All the same time, large number of health providers and stakeholders from the two states have benefited in most of these short term courses and workshops. The extent to which these organized workshops and seminars has improved the technical and managerial capacity of the health workers and managers was also an issue widely discussed by our respondents.

However, from the opinions expressed by our respondents in table 5.33 shows that 94.5% of the total respondents from Kaduna state and 75.9% from Zamfara state the local capacity for personnel development was weak and often not regular. Only an insignificant 5.6% respondent from Kaduna state and 24.1% from Zamfara state did not agreed to the

claim. This clearly revealed that the issue of personnel development in the Local Governments under study was not given serious attention by the authority concern. In most cases training is the prerogative of the Local Government Service Commission/Board (LGSC/B) and or State Ministry of Local Government (SMOLG). However, Local Government can initiate and conduct training for some of its staff if need be and has the resources to do that after seeking for approval from the appropriate authority (LGSC or SMOLG). We noticed that local government did not exploit this opportunity, for none of the Local Government visited has organized a training programme for its staff.

The perception of our stakeholders from the focus groups interviews revealed that they are yet to see neither improvement in the managerial skills of the health managers nor a significant improvement in the managerial skills of the health workers. Information has shown that the supervisors and coordinator of PHC activities at local level do not live to expectation, Infact they are yet to practically demonstrate the managerial skills acquired from the series of training attended. By PHC managers we refer to Head of Department, 5 – 6 HOD Assistants, the District health supervisors and many other staff heading the various health facilities. Observation has shown that these PHC managers have not been supervising their field officers regularly not conducting periodic evaluation of PHC activities and also not on regular bases engaged in programme planning to set goals and determine work methods and procedures. They have also not made any significant effort to maintain inter sectoral collaboration in the other health related sectors that will ensure integrated health delivery. Local survey has also shown that the PHC providers in the respective health facilities have not demonstrated evidence of application of training received in their daily clinical activities and services. On our visitation to some of the health facilities, we observed the nonchalant attitude and unprofessional ethics of

most of the health providers. Some came to work very late and the few that were punctual found them busy chatting rather than attending to patients. We were reliably informed that a handful of these health providers engaged in numerous private practices in nearby clinics and medicine stores as such come to work after attending to their private patients. Even though many of them have attended training workshops on MDGs activities its surprising to note that very few know what the programme is all about talk less of the health related targets sets and their attainment. This therefore implied that the training has little impact on the managerial capacity of the PHC managers and staff in our sampled Local Governments.

Test of Hypothesis Three

Ho: MDGs intervention effort in health has no significant impact on the capacity of the local government to manage primary health care.

Variables like financial, infrastructural, and human/technical supports were used to measure MDGs intervention efforts in health whereas, variables such as, infrastructural, human and managerial capacities were used as proxy for local government capacity to provide primary health care.

Table 5.36: Model summary of the Multiple Regression Result

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.114[a]	.013	.001	3.59966	.013	.919	3	208	.433

a. Predictors: (Constant), Mgt support , Fin_Support, Tech_support

Source: Survey Research, 2013

Table 5.36, 5.37 and 5.38 reveal the results of multiple regression analysis between MDGs effort in health (independent variable) and local government capacity in providing primary health care services (dependent variable).

Table 5.37: Analysis of variance (ANOVA)

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	35.706	3	11.902	.919	.433[b]
	Residual	2695.176	208	12.958		
	Total	2730.882	211			

a. Dependent Variable: LG_CAPACITY in health

b. Predictors: (Constant), MDGD_efforts_in_health, Fin_Support, Tech_support

Source: Survey Research, 2013

Table 5.37: Multiple Regression Standard Coefficients Result

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	21.872	1.715		12.750	.000
	Fin_Support	-.068	.161	-.036	-.421	.674
	Tech_support	-.146	.196	-.087	-.748	.455
	Mgt support	.119	.084	.186	1.412	.160

a. Dependent Variable: LG_CAPACITY (HEALTH)

Source: Survey Research, 2013

Result of the Regression statistics showed that MDGS intervention effort in Health has no significant impact on the capacity of the local government to manage primary Health care. This is because the calculated regression p value in table 38 above of .674 (financial), .455 (technical) and .160 (managerial supports) respectively are higher than the 0.05 alpha

level of significance. Furthermore, the calculated R value, R square and adjusted R of 0.114, 0.013 and 0.001 respectively were each lower than the standard R value of 0.4000. This implies that the strength of the relationship between the dependent variable (local government capacity) and the independent variable MDGS efforts in health (financial, technical and infrastructural supports) are very weak. Consequently, the null hypothesis which states that MDGS intervention effort in health has no significant impact on the capacity of the local government to manage primary Health, is hereby accepted and retained.

Decision

The multiple regression result in table 5.37 is having an F value of .919 which less than 2.60 and also significant at .433 which is higher less than .05 (.000) in addition to the fact that the calculated regression p value of the entire independent variables are higher than 0.05 alpha level of significance. Thus by this result we therefore, accept the research null hypothesis (Ho) and reject the alternate hypothesis (H1) that MDGs intervention efforts in primary health care has no significant impact on the capacity of the local government to manage primary health care.

5.6: Research Hypothesis Four

Ho: The enhanced capacity of the local government in providing primary health care has not significantly impacted on the achievement of the MDGs targets in health.

Three aspects of local government capacities were examined (i.e infrastructural, human and managerial capacities) in our earlier discussions on the MDGs intervention efforts and the impact it has on the local government capacity to provide primary health care. We have seen the insignificant impact the MDGs intervention efforts has made on the capacity of the local government to manage primary health care. This certainly are drawbacks to the attainment of the MDGs targets in health. Although there are no statistics to show how local governments are pairing in the attainment of the health

related MDGs targets. The available state records revealed that all the two states are lagging behind in almost all the health indicators. For instance, Zamfara state has the lowest percentage (22.4%) of women receiving antenatal care, with an infant and maternal mortality rate of 217 and 800 respectively in 2013. Kaduna state recorded 60% of women received antenatal care, with 215 and 705 child and maternal mortality rate in the same year. These indicators are by far below the set standard of 90% of women received antenatal and 34 and 25 per 1000 live birth of child and maternal mortality rates by 2015 (National Demographic Survey, 2013). Thus many if not all of these draw back are as a result of Capacity gap of the LGA. The gap was as a result of insufficient and bad condition of infrastructural health facilities, inadequate and low quality of human resource requirement coupled with weak managerial competencies and skills of health managers and staff.

Another serious drawback that was responsible for the capacity gap was the non adherence to the community participation aspect of the MDGs-CGS guideline. The implementation manual advocates the use of participatory approach where communities are involved in every stage of the project (planning, implementation, monitoring and evaluation). The results of our interviews with opinion leaders and our stakeholders revealed the contrary. They maintained that the five representative of the community in the sixteen member local government MDGs planning committee are not really involved in the MDGs plan, nor are they consultants on matters affecting project location, implementation and monitoring. But often, they are called upon to witness the commissioning of a particular project. This certainly questioned the acceptability, utility and of course sustainability of the MDGs intervention projects. No wander you find communities not giving the MDGs intervention efforts the attention it deserves. We have seen in one village in Zamfara state were a health clinic was converted into a vigilante

group office and in Kaduna state an underutilized completed sole water project. All these are due to misplacement of priority as a result of non involvement of communities. Again, another very fundamental problem is the issue of community ownership of the MDGs intervention project, which is the backbone of project sustainability. Many of the MDGs intervention projects are not owned by the community even where such projects are used by the community, people don't see them as their own and as a result, the projects are not protected nor maintained by the community.

However, we noticed that there are some institutional intervention provided by other International Donor Agencies or State Government in partnership with Local or Federal Government that have bearing to enhance the capacity of the LGA in providing primary health care services. Some of these interventions were briefly discussed in this study.

Table 5.39: Opinions of State Respondents on MDGs Interventions to PHC Services

S/N	Items	State	Level of responses					Total
			U/D	S/D	D	A	S/A	
1	The Safe Motherhood Initiatives of the MDGs has supported the maternal and child health care programme for pregnant women locally	Kaduna	-	110 (48.2%)	104 (45.6%)	10 (4.4%)	4 (1.8%)	228 (100%)
		Zamfara	2 (1.0%)	120 (61.2%)	32 (16.3%)	26 (13.3%)	16 (8.2%)	196 (100%)
2	The Essential Drugs Initiatives have strengthen the local health facility drugs supply scheme	Kaduna	20 (8.8%)	146 (64.0%)	2 (.9%)	28 (12.3%)	32 (14.0%)	228 (100%)
		Zamfara	7 (7.1%)	28 (14.3%)	2 (1.0%)	134 (68.4%)	18 (9.2%)	196 (100%)
3	The procurement and distribution of treated mosquito nets under the Rollback Malaria Initiatives of the MDGs have supported the Local Government in its fight against malaria	Kaduna	-	12 (5.3%)	34 (14.9%)	104 (45.6%)	72 (34.2%)	228 (100%)
		Zamfara	-	32 (16.3%)	46 (23.5%)	88 (44.9%)	30 (15.3%)	196 (100%)
4	The MDGs has supported the house to house local Immunization programmes against child killer diseases	Kaduna	56 (24.6%)	26 (11.4%)	-	100 (43.9%)	46 (20.2%)	228 (100%)
		Zamfara	30 (15.3%)	28 (14.3%)	-	94 (48.0%)	44 (22.4%)	196 (100%)

Source: Survey Research, 2013

I. Safe motherhood initiatives was a programme designed in 2007 to enhance the Maternal and Child Health (M&CH) delivery services by providing free Maternal and Child Health care package to mothers and children in selected PHC centres and clinics within the Local Government Areas. Although the programme is a National programme, it relied heavily on State/ Local Governments and Donor agencies' support. In Kaduna state 112 HC facilities were enrolled into the scheme at the onset (2007) and the state government released an average of 75 million naira monthly for the programme. The key sources of funding were the state and LGA through co-financing arrangement. Although the state government has stopped funding the programme in the 112 PHC facilities due to the introduction of the MDGs Conditional Grant arrangement to LGA, notwithstanding substantial amount of money was put into the programme. In Zamfara state, the programme was called Integrated Maternal & Child Health care programme and was funded completely by the State Ministry of Health (SMOH) in conjunction with the State Ministry of Local Government (SMOLG). Our monitoring to some of the selected PHC facilities for the Safe Motherhood programme suggest that clients were bypassing their nearest health facilities and targeting the free MCH facilities in preference. This was as a result of the free drugs and treatment received in the MCH centres. This implied that the MCH facilities seem to have supported the delivery of M&CH care programme locally. However, the responses from the questionnaire disagreed with this position as reflected in Table 5.39 in which a combined responses of 93.8% and 77.5% of the total responses from Kaduna and Zamfara state respectively held the opinion that the safe mother hood initiative of the MDGs did not impact on the maternal and child health care programme for pregnant women and children locally. Perhaps the likely reason for their responses was the inadequate number of these MCH facilities in the

local areas and the insufficient number of support facilities in the MCH centres. We further observed that the free drugs were limited in number, such given on the basis of first come first serve and thereby making the centre very congested and operation very difficult. We were also informed from the women attending clinic that some local government personnel got the drugs without taking their patients to the centres and many of the drugs or test instruments to their private clinics. Also, since many of these facilities were concentrated in the urban centres as against the rural Local Governments, only few mothers and children benefitted. This therefore implied that although the initiatives had a good intention but suffered implementation gap which to some extent has limited its impact at strengthening the existing maternal and child health care programme run by the PHC facilities in the Local Government Areas.

II. The Roll Back Malaria Initiatives was a follow-up of the kick-out malaria initiatives supported by Support for National Malaria Programme (SUNMAP). It was aimed at mobilizing and assisting communities in the prevention and treatment of malaria cases. The Roll back malaria programme provided free drugs and test kits for malaria diagnosis. In addition, safe treated mosquito nets were provided to mothers and children who were identified as the vulnerable group likely to be victims of malaria attacks. 15 and 9 PHC centres in each of the 23 and 14 LGAs in Kaduna and Zamfara state respectively were selected for the programme. Over 2million treated mosquito nets were distributed to mothers and children in each of these states and mothers and children received free malaria test diagnosis in these selected PHC centres. The intention therefore was to support LGA via the PHC centres to prevent cases of malaria infection particularly among women and children. This programme received overwhelming support by our respondents (stakeholders in health) from the questionnaires; with combined responses of 79.8% and 60.2% of the total responses

from Kaduna and Zamfara state respectively, as shown in table 5.39 above. However the perception of some of the women attending clinic from our focus group interviews revealed that the mosquito nets distributed were insufficient and only few mothers were given. Again due to limited sensitization on how to use the nets, many women complained that the odor of the material was offensive, thereby limiting its usage. Notwithstanding there was a great appreciation over the free malaria test kits and drugs supplied to mothers.

III. Sustainable Drugs Supply System (SDSS) was an improvement of the Drugs Revolving Funds (DRF) scheme initiatives designed for the delivery of free and fee-based drugs at the facility level across the states. Its aim was to revitalize the DRF scheme by ensuring more community involvement in running the DRF and more robust financial management system within the facilities. The programme was initiated in 2007 and by 2008 13 PHC facilities were capitalized (i.e received first stock of the drugs) and in 2009 48 additional PHC facilities were capitalized. Due to capital intensive nature of the programme, only limited number of PHC facilities were capitalized out of the 255 PHC facilities selected for the programme (i.e one from each political ward). However, Zamfara state still maintained the earlier DRF scheme initiatives in which PHC facilities had received take up grants in a form of drugs and also the proceed from the sale of the drugs as revolving funds for the re-purchase of additional drugs. The programme was based on the District Health Committee system which should be solely controlled by the communities. Using the committee system as a guide and module of operation. Each PHC centre at ward level in Zamfara state was involved in this scheme and because of the community driven approach, the scheme seem to be doing well in many of the PHC facilities we inspected. However, for Kaduna state because of the free MCH initiatives introduced with the free drugs to

clients, have limited the coverage and outreach of the DRF scheme at PHC levels across the state. Our respondents have further confirmed this.

IV. The Immunization programme was a UNICEF supported activity aimed at fighting and eradicating the six child killer diseases (i.e tuberculosis, diphtheria, whooping cough, tetanus, measles and poliomyelitis). In line with this, a lot of resources and energies have been committed to the programme by all tiers of governments in collaboration with other donor agencies. Millions of naira worth of vaccines was procured, transportation facilities and logistics were provided and quite a number of training programmes were organized for technical staff and EPI managers in such areas of vaccine management and administration. PHC centres all over the federation were expected to observe routine Immunization services on selected days each week. The programme has to some extent supported the Local Governments in their fight against the child killer diseases. From our respondents in table 5.39, it was generally agreed that immunization programme was a success story. Combined responses of 64.1% and 70.4% of the total responses from Kaduna and Zamfara state respectively agreed to the statement that the immunization programmes have supported the PHC centres in their fight against the child killer diseases. However, the perception of the senior health managers interviewed has shown that the programme was facing serious challenges of irregular and often shortage of vaccine supply, lack of logistics at local level and too many round-of the immunization programmes which ended off in overstretching the scarce resources and tiring up the time of health providers and managers. We however observed that even the Routine immunization was often confused with polio eradication campaign as such some mothers seem to be afraid of taken their children. We also noticed that non- compliance continued to be a problem as communities still held on to their traditional, religious and often mis-guided beliefs

of the programme only aimed at ensuring birth control, psychological enslavement or causing general physical weakness among others.

From the foregone analysis on the MDGs interventions on health, we can deduce that although the intervention efforts are very much appreciated by local communities, it has limited impact on the capacity of the local health workers and the health facilities thereby undermining the overall attainment of the MDGs targets in health. Many factors come to bear in determining the limited impact of the MDGs efforts as gathered from the results of our interviews with MDGs focal persons and zonal coordinator. Some of the reasons advanced includes; untimely released of funds from the MDGs office, too much conditionality that slow the process of accessing and disbursement of the funds, lack of counterpart funds delays and often prevent states from accessing the funds and often inadequacy of the disbursed funds. We further noticed that the law absorbing capacity of states and local government is another factor that can undermined the impact of the MDGs efforts. Many of the LGAs lacks qualified programme and project managers that can design and packet a good proposal that can attract support. Even when support, is given the technical and professional staff that can effectively see to the implementation of the projects are often lacking. We are meant to understand that the state MDGs office was the one that put up the entire proposal for the benefitting LGAs in all the two states under study. This certainly undermined the planning, organizing and mobilizing capacity of the LGA managers and staff to manage MDGs interventions.

Test of Hypothesis Four

The multiple regression results we obtained from the tables 5.40, 5.41 and 5.42 revealed that the regression equation with the predictor's local government capacities were statistically insignificant.

Table 5.40: Model Summary of the Multiple Regression Result

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.182[a]	.033	.019	.41400

a. Predictors: (Constant), Mgt. cap, Infrast. cap, Hum. cap

Source: Survey Research, 2013

Table 5.41: Analysis of Variance (ANOVA)

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1.225	3	.408	2.382	.071[a]
	Residual	35.651	208	.171		
	Total	36.876	211			

a. Predictors: (Constant), Mgt. cap, Infrast. cap, Hum. cap

b. Dependent Variable: MDGs Attainment

Source: Survey Research, 2013

Table 5.42: Multiple Regression Standard Coefficients Result

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.289	.344		9.554	.000
	Infrast. cap	.196	.112	.123	1.758	.080
	Hum. cap	-.194	.110	-.280	-1.766	.079
	Mgt. cap	.127	.112	.182	1.136	.257

a. Dependent Variable: MDGs Attainment

Source: Survey Research, 2013

The overall result of the Regression statistics in table 5.42 showed that the calculated regression p value of the entire independent variables of .080 (infrastructural capacity), .079 (human capacity) and .257 (management capacity) respectively are all higher than the 0.05 alpha level of significance. Furthermore, the calculated R value, R square and adjusted R of 0.182, 0.033 and 0.019 respectively in table 5.40 were each lower than the standard R value of 0.4000. This implies that the strength of the relationship between the dependent variable

(Attainment of MDGs in Health) and the independent variable (LG capacity) is very weak. Consequently, the null hypothesis which state that enhanced capacity of the local government has not significantly impacted on the achievement of the MDGS targets in health is hereby accepted and retained.

Decision

The F value in table 5.41 in the regression equation is 2.383 which is by lower than 2.60 and significant at 0.071 and the enter independent variables are significantly higher than .05 alpha level of significance. Conclusively therefore, the research null hypothesis (Ho) is accepted and the alternate hypothesis (H1) is hereby rejected. Meaning that the enhanced capacity of the local government in providing primary health care has not significantly impacted on the achievement of the MDGs targets in health.

5.7: Summary of the Hypotheses Test

The results of the four hypotheses tested reveal the following conclusions:

i. MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education.
ii. MDGs intervention effort in health has no significant impact on the capacity of the local government to manage primary health care.
iii. The enhanced capacity of the local government in providing primary education has not significantly impacted on the achievement of the MDGs targets in education.
iv. The enhanced capacity of the local government in providing primary health care has not significantly impacted on the achievement of the MDGs targets in health.

5.8: Theoretical Implication of the Accountability Model

The theoretical implication of the model used for this study implies that the "compact mechanism" of the MDGs intervention is weak to ensure significant impact on the

Local Government capacity. This is so because the local government had limited control over the MDGs intervention funds because it is the state that accesses the funds for and on behalf of the LGA even were the counterpart funds are jointly paid. Again, the SUBEB and the SPHCDA that received procured and distributed the MDGs intervention facilities to the LGEA and the PHC departments of the LGA are not effective. We noticed that some of the materials procured and constructions carried out are of low standard and quality and even the distribution pattern is clouded by too many political considerations. The frequency and quality of monitoring and coordination of the activities of the LGEA and PHC department by these state bodies is weak and often absent. No wonder the FTS teachers and the FN&MW programmes have not yielded the desired results as discussed earlier.

Another feature of the "compact mechanism" is the monitoring and coordinating aspect of the LGEA and the PHC department. These too are weak. We have seen that LGEA school inspectors and health care supervisors of the LGA do not pay regular visit to primary schools and health clinics in order to monitor and coordinate the activities of the primary school teachers and health workers. No wonder the quality of instruction, learning out come and health services are far from attainment of the MDGs set targets in education and health.

More so the "voice mechanism" that is to be explored by the PTA/SBMC and the DHC is virtually non functional. These groups are expected to monitor the activities of the SUBEB and SPHCDA on the one hand and that of LGEA and PHC Department of the LGA on the other hand. So as to ensure that the MDGs intervention facilities are brought to and utilized by the primary schools and health clinics within the LGA. We observed that the PTA and the DHC were not involved in the procurement nor consulted in the distribution of the MDGs intervention materials. And even where their participation is a pre condition, as in the case of self- help projects, the local officials' side-line the committees in the actual implementation of the project. More so the PTA/SBMC and the DHC are expected to use the

enforceability features (as shown in the model) to report the performance of the teachers and health workers to the appropriate authorities to enforce correction and encourage good performance. This opportunity has not been explored.

In conclusion, this chapter has presented the empirical results, analyzed and tested the four hypotheses for this study. The findings from the data collected, presented and analyzed showed acceptance of all the four hypotheses for this study. In general, MDGs intervention efforts in education and health has not impacted significantly on the local government capacities thereby, undermining the attainment of the MDGs targets in education and health.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1: Introduction

The MDGs time frame is 2000 to 2015 and we are two years to the date line, thus many scholars are pessimistic as to whether Nigeria can meet the MDGs date line considering the level of progress made so far in the attainment of Education and Health related MDGs targets. Although a lot of energy and resources are committed to the attainment of these targets but strictly speaking, a lot need to be done to ensure the attainment of the MDGs targets in Education and Health care especially at the Local Government level. Regardless of the efforts made so far, there is no outstanding improvement in the capacity of the Local Governments in managing the MGDs programmes in Primary Education and Health care. The study examines the MDGs intervention efforts and their impact on the capacity of the Local Governments in managing the Education and Health related MDGs programmes as well as, the extent to which the capacity has enhanced or undermined the attainment of MDGs targets in education and health in selected Local Governments in Kaduna and Zamfara states. The objectives of the study are; first, to review the philosophy, origin and strategies of the MDGs programme. Second, to assess the capacity enhancement efforts of the MDGs programme on Local Governments. Third, to determine the extent to which the MDGs intervention has impacted on the capacity of the local government to provide primary education and health care services. Finally, to ascertain the extent of attainment of the MDGs targets in education and health at the local level.

To fully explore the major issues in this study, four hypotheses were formulated in a null form. The first hypothesis states that the MDGs intervention effort in education has no significant impact on the capacity of the local government to manage primary education. The

second hypothesis states that the MDGs intervention effort in health has no significant impact on the capacity of the local government to manage primary education. The third hypothesis states that the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in education. The fourth hypothesis maintains that the enhanced capacity of the local government has not significantly impacted on the achievement of the MDGs targets in the health sector.

6.2: Summary of Findings

In this section the study presents a brief and concise statement and discussion of findings deduced from the course of study. The analysis is in parts.

MDGs Intervention for Basic Education and the Capacity of the Local Government in Managing Primary Education

The study identifies that the major intervention for basic education in Nigeria comes from the UBEC matching grant which is 2% of the Federal Consolidated Revenue Funds (CRF) that were further consolidated by the MDG Debt Relief Funds. The funds were made available to states on conditional arrangement basis to be utilized in the provision and procurement of basic school infrastructure and materials, staff procurement, training and capacity building to enhance the managerial skills and competences of the staff and managers of the basic education. However, the statistics reveal that the huge amount of money given to support state and LGEAs capacities in the provision of basic education are said to be insufficient and grossly inadequate considering the funding gaps of the LGEAs in terms of infrastructure and services gaps.

The study noted that the absorption capacity of the local government is weak as a result of lack of qualified technical staff to design good proposal that can attract support and even where support grants are given, they lack the coordinating skills to manage the support

grants. Although the funds were utilized for the provision of basic infrastructure, procurement of materials, training and retraining of providers and managers of the basic education and in some instances direct recruitment of teachers and school managers, yet the capacity requirement fell short of the required standard in virtually all areas. This is because the targets are universal in nature and thus, became very impossible for developing countries to measure to those targets because of the poor economy, infrastructure, ecology, level of education and other development index.

The study reveals that Kaduna state has recorded an increase of 62.3% in the number of classrooms constructed over the period of six years (2007-2013) while, Zamfara state recorded an increase of only 35%. Notwithstanding, the pupils-classroom ratio for Kaduna state stood at 92:1 to 47:1 and Zamfara maintained a ratio of between 79:1 to 64:1 over the same period which are all below the UBE set standard of 40:1.

The study further established that schools' furniture and other infrastructural materials are grossly inadequate and often in bad condition across the two states under review. We noticed also that there is no separate toilets facilities for girls in all the schools visited across the two states which is a serious setback for the attainment of the girl child education. In all, there is infrastructural capacity gap in the basic education sector despite the MDGs intervention in education.

The study also finds out that Kaduna state has recorded an increase of 55.9% in the number of qualified teachers teaching in primary school within the LGEAs over the period of six years (2007-2013). Zamfara state has registered an impressive increase of 70% in the number of qualified primary school teachers within the same period. Yet the ratio of qualified teachers to pupils for Kaduna state stood at 183:1 to 86:1 while that of Zamfara state is between 267:1 to 100:1 over the same period. Thus, the two states have fallen short of the

required standard of 40:1. Hence, in terms of manpower capacity also, the two states are yet to meet up the approved set standard.

The study has also established that the planning, coordinating and monitoring capacity of the LGEA is weak and often absent thereby, undermining the managerial capacity of the LGEA staff in managing the basic education delivery locally. We noticed that school monitoring and inspection were haphazardly done and often irregular. Teacher's motivation was also not taken seriously by the authorities concerned thereby, affecting teacher's morale and in turn quality of instruction and learning out come.

The study reveals that the annual budgetary allocation made to the education and health sectors in all the six LGAs in Kaduna and Zamfara state within the period under study is between 2.5% to 18% which is lower and far below the UNESCO and WHO standard of 26% of the total budgetary allocation to education and 34% to the health sector. This certainly undermines the capacity of the LGAs in managing the MDGs activities in these sectors.

In respect to the attainment of the MDGs targets in education, the study established the following:

i. The two states (Kaduna and Zamfara) registered an increase in their enrollment index of 7.4% and 20.4% over the period under review but it only account for 40.2% and 41.7% of the enrollment index for Kaduna and Zamfara state respectively which is far below the set target of 100% enrollment target.
ii. The proportion of enrollment pre primary school children was 7% for Zamfara and 11% for Kaduna state which was far behind the expected set target of 90% per primary enrollment by 2015.

iii. Also, the retention rate of primary school children for Zamfara was 61% and 52% for Kaduna state respectively which are all below the MDGs set target of 100% primary school retention rate.

iv. Again, the overall completion rate for Kaduna state is 70.7% and Zamfara state has 53% both are far lower than the set target of 100% completion rate by 2015.

v. There is also, a disparity manifesting between gender with the girl child recording the highest proportion of out of school population of 94.4% and 56.7% for pre primary and primary school population respectively in Zamfara state which negates the policy geared towards the promotion of girl child education.

vi. We also observed a very wide disparity between the two states and even within the state in favour of urban areas. Despite the fact that both states under review accessed the same amount of money from the MGDs/UBE scheme; yet Kaduna state seem to be faring better than Zamfara state. Some of the factors responsible for this include; the mode and nature of awarding contract, state priority (soft or hard projects), presence of technical staff and most importantly, the so called state dedicated projects. Where huge amount of money were pulled out from the grant and used on other state projects that may or not have direct bearing on the provision of primary education.

In all, the study established that the states are lagging behind in the attainment of the virtually all the MDGs set targets in education.

MDGs Intervention for Primary Health Care and the Capacity of the Local Government in Managing Primary Health Care

We identified that the major intervention in this direction comes from the MDGs Conditional Grant Scheme. The funds are made available to states and local governments on conditional grounds (i.e. provision of counterpart funds among others). As it applied to basic education the funds are to support in strengthening the financial, material, human and managerial capacities of the local government in the provision of primary health care service.

The study established that the funds are inadequate considering the health services and infrastructural gap of the states under review. Also, the release of funds is often untimely and there is cumbersome bureaucratic procedure attached to the MDGs funds which slows down and often delays project implementation. We also noticed that there is a problem in the funding structure, the 60%- 40% counterpart arrangement between state and local government is not strictly adhered to. Local Governments are often made to pay 60% into the counterpart account, which further drains the limited finances of the local governments. Again, the LGAs are made to pay equal amount of money into the counterpart account but the distribution of the facilities and projects is unevenly done.

Also, we noticed that the MDGs-CGS implementation process at local government levels is top down approach (institutional) rather than participatory approach as stipulated in the implementation manual. As a result, the community ownership aspect of many, if not all MDGs –CGS intervention initiative is uncertain. This is likely to undermine the sustainability of the MDGs-CGS intervention initiatives.

As a fall out of the MDGs intervention in the health sector, the study observes that the number of PHC center, PHC clinics and Health post in the two states are inadequate to cater for the existing and growing population. For instance, Kaduna state has 155, 305 and 560 but requires 255, 510 and 5,108 PHC centers, PHC clinics and Health post respectively. While, Zamfara state has 34, 66 and 335 but requires 174, 241 and 2,410 PHC centers, PHC

clinics and Health post respectively. The study also noticed that other basic health facilities and equipment required for health operation in health center and clinics are grossly inadequate and often in bad condition. This explains the poor state of health facilities in the LGAs particularly rural LGA.

Again, the health workforce fell short of the approved PHC standard. 70%- 80% of the health workforce in the LGAs under study are non professional (Environmental public health and Health Attendants). Only 20%-30% are qualified health staff of PHC standard (CHO, CHEW, JCHEW, and Nurse Etc). The study further observed that even the quantity of the health workforce is inadequate to manage the existing health facilities and population. There is also, uneven distribution of the health workforce in favour of urban LGA thereby depriving the rural communities' access to basic health care services.

The synopsis of the number and type of training received by the health workers and managers apart from being inadequate, the training has not significantly impacted on technical and managerial capacity of the health workers and managers. We also noticed that the selection process of both the trainers and the trainees are often politically influenced thereby limiting the effectiveness of the training programmes.

Another drawback that was responsible for the capacity gap was the non adherence to the community participation aspect of the MDGs-CGS implementation manual which insists that communities must be involved in every stage of the MDGs activity. The study discovered that many MDGs intervention projects are not owned by the communities even where such projects are used by the communities, people don't see them as their own. As such do not care to protect and maintain the projects.

The study have also examined other specific MDGs intervention initiatives put in place to improve on the human, managerial, material and often financial capacity of the Local

Governments in providing primary health care services. Some of these programmes are the safe motherhood initiatives, roll back malaria initiatives, sustainable drugs supply scheme and the immunization programme among others. Evidence from the study has shown that these support initiatives to some extent have enhanced the delivery of primary health care particularly the maternal and child health care delivery in the respective health facilities chosen for the support initiative. These intervention initiatives are able to make some impact because of their community based approach in the implementation process. However, the inadequate number of these support initiative, the negative attitudes of some of the local managers of the initiatives coupled with the local corruption has limited the utility and impact of these support initiatives at strengthening the existing primary health care delivery system.

Although, we do not have statistics to show how the LGAs are pairing in meeting the health targets, yet the states indicators reveal that the maternal and child mortality rates were on the increase, malaria and other common diseases are still prevalent and common among local communities across the two states particularly the rural communities. For instance, Zamfara state has the lowest percentage (22.4%) of women receiving antenatal care, with an infant and maternal mortality rate of 217 and 800 respectively in 2013. Kaduna state recorded .6% of women that received antenatal care, with 215 and 705 child and maternal mortality rate in the same year. These indicators are by far below the set standard of 90% of women received antenatal and 34 and 25 per 1000 live birth of child and maternal mortality rates by 2015 (National Demographic Survey, 2013). This goes to show that the local communities under study are seriously lagging behind in the attainment of health related MDGs targets.

6.3: Conclusion

This study examines the capacity of the Local Governments in managing the Education and Health related MDGs programmes in selected Local Governments in Kaduna and Zamfara states. The study has been able to examine the impact the MDGs intervention efforts has on the Local Government capacity in managing education and health care services and the extent to which the local government capacities has enhanced or undermined the attainment of MDGs targets in Primary Education and health care. The multiple regression analysis results show that the independent variable (MDGs efforts in education and health) has no significant impact on the local government capacity in managing primary education and health. Thus the first two null hypotheses were accepted.

Similarly, other results of the regression analysis reveal that the independent variable (the enhanced local government capacity) has not significantly impacted on the dependent variable (attainment of MDGs targets in education and health). Thereby suggesting that the enhanced local government capacity has not significantly impacted on the attainment of the MDGs targets in education and health hence the last two hypotheses were also retained.

The overall findings of this study have shown that MDGs intervention initiatives although very much appreciable is found to be insufficient in quality and quantity, the financing arrangement is often cumbersome and too technical thereby resulting in delay in disbursement and project implementation. The utilization of the intervention funds is politically motivated thereby; undermining its significance in boasting the capacity of the Local Government to providing primary education and health care services to the local people. These challenges consequently undermined the attainment of the MDGs targets in education and health sectors and are likely to jeopardize the attainment of the MDGs targets by 2015.

6.4: Recommendations

From the analysis of the survey results, discussions and inferences drawn, the following recommendations are made:

i. The MDGs intervention funds should be increased and the cumbersome structure should be relaxed to allow for quick access of the funds. Also, the sectoral allocation of the LGA budget should be beefed up to meet international standard.

ii. Efforts should be made by the LGA at recruiting, retaining and retraining of qualified technical and professional staff who are knowledgeable in project design, monitoring and implementation and capable of putting up a proposal that can attract support from donors.

iii. The counterpart arrangement should be retained to ensure accountability. However, the state should be allowed to access its funds in phases rather than to wait until it has the complete counterpart funds.

iv. Public Procurement Act guidelines for the award of contract should be strictly adhered to. Political considerations in the award of contracts should be removed and ensure timely completion of contracts.

v. The state should ensure even distribution of projects and facilities among LGA and within the LGA so as to ensure equal access. Also, the LGA should ensure accountability mechanism to make sure that budgetary figures translate into actual spending.

vi. The participatory approach as advocated in the MDGs-CGS implementation manual should be strictly adhered to, so as to ensure community ownership, which will go a long way to enhance sustainability of the MDGs project.

vii. Shortage of qualified teachers and health workers should be addressed to effectively enhance the delivery of primary education and health care services.

viii. Also, training and development programmes for teachers and health workers should be made more regular. Follow up programmes and quality assurance unit should be organized to make sure the teachers are implementing what they learnt from the training programmes.

ix. Adequate infrastructural facilities required for the effective performance of the LGEA and PHC staff should be made available, accessible and in good condition. Things like classrooms, toilets, health clinics, furniture and other basic education and health equipment.

x. Motivation of teachers and health workers should be given priority attention by the LGA because it has been established that motivation is one of the factors that undermines the delivery capacity of the LGEA and PHC staff.

xi. The use of the state dedicated project account should be discouraged to allow for maximum utilization of the MDGs grants meant for the provision of primary education and health care services. By so doing, it will also bridge the performance gap between the two states.

xii. The MDGs deadline and bench marks should be redesign to take into account the peculiarities of the developing Nations. Infact, we suggested that Nation States be allow to choice their priorities, set deadline and benchmarks for their attainment. So as to facilitate the attainment of the chosen MDGs targets and ensure their sustainability.

xiii. The study recommends the adoption of the "voice and compact" mechanism of the Accountability framework to scale up the performance of education and health managers and staff as well as ensure equitable distribution of the MDGs projects and facilities within schools and health clinics across local communities in the LGA. The enforceability features of the framework will also give the PTA/SBMC and the DHC members the opportunity to track down performance of the primary school teachers and health workers in order to enforce compliance to lead down procedures. The voice mechanism could also ensure adequate financing of the MDGs intervention efforts through lobby and advocate.

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APPENDIX A
QUESTIONNAIRE FOR LOCAL MANAGEMENT AND LEGISLATURE

Department of Local Government and Development Studies,
Institute of Administration,
A.B.U. Zaria.
2rd December, 2013

Dear Respondent,

I am undertaking a research titled "**Assessment of the capacity of Local Governments in managing the Education and the Health related Millennium Development Goals programmes in some selected Local Governments in Kaduna and Zamfara States,**" for a Ph.D. Dissertation in the Department of Local Government and Development Studies, ABU, Zaria. The study is only for the purpose of academic degree (PhD). I assure you the confidentiality of the data I would be collecting from you.

I hope you will kindly fill the questionnaire as objectively as possible.

Thank you.

Yours faithfully,

DALHATU MOHAMMED JUMARE

SECTION A: PERSONAL INFORMATION
STATE---------- L.G.A----------
DEPT.---------- RANK----------
YEARS IN SERVICE---------- SEX----------
QUALIFICATION----------

SECTION B
Instruction: Please answer all the questions by ticking (√) only one number or letter that best represents your opinion based on the following scales:
1. Strongly Agree
2. Agree
3. Undecided
4. Disagree
5. Strongly Disagree

A. MDGs EFFORT AND LOCAL GOVERNMENT CAPACITY

How would you rate the impact of the MDGs intervention efforts on the following?

		1	**2**	**3**	**4**	5
1.	Construction of schools/health clinics					
2.	Man power development and training					
3.	Construction of toilet facilities					
4.	Procurement of school/ clinics facilities					
5.	Managerial competencies of LGA staff					
6.	Planning ability of the LGA staff					

HUMAN AND FINANCIAL CAPACITY

Please respond to the following statements

		1	**2**	**3**	**4**	5
7.	The manpower capacity for the attainment of MDGs targets on basic education is inadequate and poor in quality.					
8.	The manpower requirement for the attainment of health related MDGs targets is weak in quality and inadequate in number.					
9.	The financial management capacity of the local government is weak and often very poor					
10.	The local accountability mechanism are weak and often openly abused					

MANAGERIAL CAPACITY

Please respond to the following statements

		1	2	3	4	5
11.	The local bureaucrats lack the initiatives for service delivery.					
12.	The frequency and quality of planning at local level is low and very poor.					
13	The coordinating ability of the local bureaucrats is very weak and often not observed					
14.	The nature and frequency of monitoring of projects and programmes by the local bureaucrats and politicians are haphazard and often irregular.					
15.	The mobilization and enforcing ability for service delivery of the local management is weak and often very loose.					
16.	The staff motivational package is very poor to facilitate staff performance on the job.					
17	In your opinion, the overall capacity of the local governments in managing the MDGs intervention activities in Education and Health care is low and often very weak					

B. ATTAINMENT OF MDGs TARGETS

MDGs TARGETS ON BASIC EDUCATION:

How would you assess the following?

		High	**Fairly high**	**Low**	**Very low**	**Undecided**
18.	The pattern of enrollment in the basic education sector					
19.	The retention rate of pupils in the basic education sector					
20.	The rate of school drop out					
21.	Completion rate among pupils in primary schools					
22.	The completion rate of the basic education circle					
23.	The transition rate to junior secondary school					
24.	The transition rate from one grade to another grade					

MDGs TARGETS ON HEALTH CARE

How would you rate the following incidence?

		High	**Fairly high**	**Low**	**Very low**	**Undecided**
25.	Under-five mortality rate					
26.	Maternal mortality rate					
27.	The spread of HIV/AIDS					
28.	Access to reproductive health services					
29.	Access to treatment of HIV/AIDS for all those who need it.					
30.	The incidence of malaria and other major diseases					
31.	Rate and coverage of immunization programmes					
32.	Access to treatment of TB for those that need it					

33. Please give suggestions on how to enhance the capacity of the local governments for Better service delivery in the area of Education and Health care services.

_____

_____

QUESTIONNAIRE FOR STAFF OF THE EDUCATION DEPARTMENT

Department of Local Government and Development Studies,
Institute of Administration,
A.B.U. Zaria.
2rd December, 2013

Dear Respondent,

I am undertaking a research titled "**Assessment of the capacity of Local Governments in managing the Education and the Health related Millennium Development Goals programmes in some selected Local Governments in Kaduna and Zamfara States,**" for a Ph.D. Dissertation in the Department of Local Government and Development Studies, ABU, Zaria. The study is only for the purpose of academic degree (PhD). I assure you the confidentiality of the data I would be collecting from you.

I hope you will kindly fill the questionnaire as objectively as possible.

Thank you.

Yours faithfully,

DALHATU MOHAMMED JUMARE

SECTION A: PERSONAL INFORMATION
STATE---------- L.G.A---------- DEPT.----------
RANK---------- YEARS IN SERVICE---------- SEX----------
QUALIFICATION----------

SECTION B
Instruction: Please answer all the questions by ticking (√) only one number or letter that best represents your opinion based on the following scales:

1.	Strongly Agree	A.	Very High
2.	Agree	B.	High
3.	Disagree	C.	Low
4.	Strongly Disagree	D.	Very Low
5.	Undecided	F.	Undecided

NOTE: Only MDGs focal persons at the local government level should answer Section C of this questionnaire.

A. LOCAL GOVERNMENT CAPACITY FOR SERVICE DELIVERY

MANAGERIAL CAPACITY OF LGEAs
Please respond to the following statements

		1	2	3	4	5
1.	The LGEA staff lacks the initiatives for basic education delivery.					
2.	The frequency and quality of basic education planning at local level is low and very poor.					
3.	The nature and frequency of monitoring of basic education projects and programmes by the LGEA and the local community is haphazardly done and often irregular.					
4.	The coordinating ability of the LGEA and the local community is very weak and often not observed					
5.	The mobilization and enforcing ability for basic education delivery of the local management is weak and often very loose.					
6.	The staff motivational package is very poor to facilitate staff performance on the job.					
7	In your opinion, the overall capacity of the local governments in managing the MDGs intervention activities in Basic Education is low and often very weak					

How would you assess the adequacy of the following intervention funds to state?

		Available	Fairly Available	Not Available	Undecided
7.	MDG intervention funds				
8.	UBE matching grants				

How would you describe the adequacy of the following facilities/personnel in your local government?

		Available	Fairly Available	Not Available	Undecided
9.	Primary schools				
10.	Conducive classrooms				
11.	School Furniture				
12.	Teaching and learning facilities				
13.	Qualified teachers				
14.	School inspectors and supervisors				
15.	Toilet facilities				
16.	Basic hygiene equipments				
17.	First Aids items				

How would you rate the impact of the following MDGS/UBE intervention efforts?

		High	Fairly high	Low	Very Low	Undecided
18.	Construction of classrooms/toilets					
19.	Procurement of teaching and learning materials					
20.	Man power development and training					

MDGs TARGETS ON BASIC EDUCATION

How could you assess the following?

		High	Fairly high	Low	Very Low	Undecided
21.	The pattern of enrollment in the basic education sector					
22.	The retention rate of pupils in the basic education sector					
23.	The rate of school drop out					
24.	Completion rate among pupils in primary schools					
25.	The completion rate of the basic education circle					
26.	The transition rate to junior secondary school					
27.	The transition rate from one grade to another grade					

C. <u>MDGs INTERVENTION TO LOCAL GOVERNMENT (for MDGs Local Focal Persons Only)</u>

Please respond to the following statements:

		1	**2**	**3**	**4**	5
28.	The UBE Conditional Grant scheme ensures availability infrastructural school facilities at LGEA levels.					
29.	The Federal Teachers Scheme (FTS) has strengthened the provision of teachers for the UBE programme.					
30.	The State Education Sector Project has supported the procurement and rehabilitation of school facilities in the basic education sector					
31.	The free school uniform supported programme have facilitated school enrollment and retention of pupils in schools					
32.	The MDGs has organized capacity building workshops for basic education teachers and education managers at local levels.					
33.	The training programme organized for teachers and supervisors has improved on the capacity of the LGEA staff to deliver.					
34**.**	The MDGs intervention initiative has enhanced LGEA staff capacity for service delivery generally.					

35. Please give suggestions on how to enhance the capacity of the local governments for

Better service delivery in the area of Education and Health care services.

QUESTIONNAIRE FOR HEALTH STAFF

Department of Local Government and Development Studies,
Institute of Administration,
A.B.U. Zaria.
2rd December, 2013

Dear Respondent,

I am undertaking a research titled "**Assessment of the capacity of Local Governments in Managing the Education and the Health Related Millennium Development Goals Programmes in Some Selected Local Governments in Kaduna and Zamfara States,**" for a Ph.D. Dissertation in the Department of Local Government and Development Studies, ABU, Zaria. The study is only for the purpose of academic degree (PhD). I assure you the confidentiality of the data I would be collecting from you.

I hope you will kindly fill the questionnaire as objectively as possible.

Thank you.

Yours faithfully,

DALHATU MOHAMMED JUMARE

SECTION A: PERSONAL INFORMATION
STATE---------- L.G.A----------
DEPT.---------- RANK----------
YEARS IN SERVICE---------- SEX----------
QUALIFICATION----------

SECTION B
Instruction: Please answer all the questions by ticking (√) only one number or letter that best represents your opinion based on the following scales:
1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree
5. Undecided

NOTE: Only MDGs focal persons at the local government level should answer Section C of this questionnaire.

A. LOCAL GOVERNMENT CAPACITY FOR SERVICE DELIVERY

MANAGERIAL CAPACITY

Please respond to the following statements

		1	**2**	**3**	**4**	5
1.	The local health bureaucrats lack the initiatives for service delivery.					
2	The frequency and quality of PHC planning at local level is low and very poor.					
3.	The nature and frequency of monitoring of PHC facilities programmes by the local health supervisors is irregular and often haphazardly done.					
4.	The coordinating ability of the local health bureaucrats is very weak and often not observed					
5.	The mobilization and enforcing ability for PHC delivery by the local health management staff is weak and often very loose.					
6.	In your opinion, the overall capacity of the local governments in managing the MDGs intervention activities in Primary Health Care services is low and often very weak					

How would you assess the adequacy of the following intervention funds to state?

		Available	**Fairly Available**	**Not Available**	**Undecided**
7.	MDG intervention funds to state				
8.	MDG intervention funds to LGA				

How would you describe the adequacy of the following facilities/personnel in your local government?

		Available	**Fairly Available**	**Not Available**	**Undecided**
9	PHC Centres/Clinics				
10.	Basic health equipments in clinics				
11.	Essential Drugs in health clinics				
12.	PHC personnel in health clinics				

How would you rate the impact of the following MDGs intervention efforts?

		High	**Fairly high**	**Low**	**Very low**	**Undecided**
13.	Construction of health facility					
14.	Procurement of drugs and basic apparatus					
15.	Man power development and training					

B. ATTAINMENT OF MDGs TARGETS ON PRIMARY HEALTH CARE SERVICES

MDGs TARGETS ON HEALTH CARE

How would you rate the following incidence?

		High	**Fairly high**	**Low**	**Very low**	**Undecided**
16.	Under-five mortality rate					
17.	Maternal mortality rate					
18.	The spread of HIV/AIDS					
19.	Access to reproductive health services					
20.	Access to treatment of HIV/AIDS for all those who need it.					
21.	The incidence of malaria and other major diseases					
22.	Rate and coverage of immunization programmes					
23.	Access to treatment of TB for those that need it					

C. <u>MDGs INTERVENTION TO LOCAL GOVERNMENT</u>

Please respond to the following statements

		1	**2**	**3**	**4**	5
24.	The MDGs has also provided logistics and financial support to local government on many PHC service delivery area					
25.	The Safe Motherhood Initiatives of the MDGs has supported the maternal and child health care programme for pregnant women locally					
26.	The Essential Drugs Initiatives have strengthen the local health facility drugs supply scheme					
27.	The procurement and distribution of treated mosquito nets under the Rollback Malaria Initiatives of the MDGs have supported the local government in its fight against malaria					
28.	The MDGs has supported the house to house local immunization programmes against child killer diseases					
29.	The National PHC rural Nurse/Midwife scheme has boosted the health manpower requirement of the local government					
30.	The MDGs has provided technical and managerial support to Local PHC managers and providers through organized seminars and workshops.					

31. Please give suggestions on how to enhance the capacity of the local governments for Better service delivery in the area of Education and Health care services.

APPENDIX B: CHECK LIST OF INTERVIEW SCHEDULES

A. FOCUS GROUP INTERVIEW SCHEDULE FOR WOMEN ATTENDING CLINIC

1. Are you aware of MDGs programmes and activities on Health?
2. Can you identify some of the MDGs services and activities you know or have received?
3. How would you describe the MDGs programme in terms of support to health facility?
4. How can you rate the level of utilization of PHC facility in terms of frequency of attendance and percentage of the target population using the facility?
5. How would you describe the perception of the community on MDGs support services?
6. How would you describe the impact of the MDGs support services on health?

B. FOCUS GROUP INTERVIEW SCHEDULE FOR PTA /SBMC OFFICIALS AND DHC OFFICIALS

1. Are you aware of MDGs support initiatives for education/health?
2. Can you identify some of the MDGs support activities you know or have received?
3. How functional are these associations/committees in terms of supporting and assisting the development of MDGs activities in basic education/health at the local levels?
4. Can you describe the impact of the intervention on the capacity of the LGEA/PHC
5. In your opinion does the enhanced LGEA/PHC capacity undermined the attainment of the MDGs set targets on education/health?
6. Would you suggest ways to scale up the attainment of the set target on education/health

C. INTERVIEW SCHEDULE FOR TOP MDGs OFFICIALS AT THE STATE AND FOCAL PERSONS AT THE LOCAL LEVELS

1. Would you identify some of the MDGs intervention activities carried out in the area of health and education (in ….. LGA).
2. Would you explain the nature of these activities and their location within the Local Government Area?
3. What are some of the problems associated with the MDGs intervention efforts?
4. How receptive are the communities to MDGs activities on education and health?
5. How would you describe the impact of the MDGs support initiatives in basic education and primary health care services?
6. In your opinion, are the local governments likely to attain the MDGs targets in basic education and primary health care services?
7. Please, give reason for your answer in above.

D. INTERVIEW SCHEDULE FOR OPINION LEADERS IN THE COMMUNITY

1. Are you aware of MDGs programmes/activities?
2. Can you identify some MDGs intervention services rendered on education and health care in your community?
3. How would you describe the intervention in terms of contribution to the promotion of primary education and health care?
4. How would you describe the attitude of the people towards the intervention in terms of contribution to the promotion of primary education and health care?
5. How would you describe the impact of the MDGs support services on basic education and primary health care?

APPENDIX C:

OBSERVATION CHECK LIST

1. Physical condition of MDG facilities

- Primary schools
- Classrooms building and facilities
- Toilet facilities
- Health centres building and facilities
- School premises and health centers

2. Attitude and perception of people on

- Girl-child education
- Family planning
- Utilization of government service
- Ownership and maintenance of government service
- Frequency of usage
- General maintenance culture

3. Services provided/deliverance

- Teachers in classroom
- Health worker at work
- Health centre arrangement
- Nature of patient attendance

4. Attitude of local government officials on MDG intervention services

- Planning
- Implementation
- Monitoring
- Intersect oral collaboration
- Community mobilization and involvement

APPENDIX D: LIST OF INTERVIEWEES

A. Personal Interview Zamfara State

S/N	NAME	POSITION	DATE INTERVIEWED
1	Rilwanu Zurmi	MDGs state focal person	11/6/2013
2	Ahmed S Zamfara	Director M&E, State MDGs	5/12/2013
3	Mohammed Mahmud	Director Statistics SPHCDA	20/6/2013
4	Bello Sani	Sarkin Bakura LGA	8/8/2013
5	Luba Lawal Ammani	Director Female Education Board, Gusau	13/6/2013
6	Sani Mailafiya Gusau	Director Statistics ZSUBEB	12/6/2013

B. Personal Interview Kaduna State

S/N	NAME	POSITION	DATE INTERVIEWED
1	Hassan Aliyu	State MDGs Focal Person	2/7/2013
2	Shuaibu Balarabe	PRO KSUBEB	23/10/2013
3	Ibrahim Adamu	ICT Officer KSPHCDA	27/11/2013
4	Ibrahim Lazuru	Dallatun Saminaka (Chairman Saminaka LGA	20/9/2013
5	Sani Mazawaje	Director Training, LGSC, Kaduna	20/11/2013
6	Yahaya Mahmuda	Agom Ayu, Sanga LGA	8/10/2013

C. Focus Group Interview Gusau LGA

S/N	NAME	POSITION	DATE INTERVIEWED
1	Kasimu Abubakar Mohammad Ahmed Kabir Salihu Garba Habibu Salima Alhaji	Head master Gusau LGEA. Chairman SBMC, Gusau LGEA. Member Member Member	9/6/2013
2	Bello Audu Bakura Alh. Umar Shinkafi Yahaya Moriki Tukur Dorawa Lawal Adamu Abdullahi Tsafe	Director PHC Gusau. Mai-Ung.Tankin Ruwa Tudun Wada, Gusau (Chairman DHC T/Wada). In-charge PHC Ung.Tankin Ruwa, T/Wada, Gusau. Member Member Treasurer	26/6/2013
3	Halima Bello Safiya Atiku Laure Attahiru Habiba Turaki Saliha Adamu Zainab Maradun	In-charge PHC Railway station, Gusau. Women Attending Clinic Women Attending Clinic Women Attending Clinic Women Attending Clinic Women Attending Clinic	27/6/2013

D. Focus Group Interview Bakura LGA

S/N	NAME	POSITION	DATE INTERVIEWED
1	Yahaya Tudu Tukur Aliyu Tudu Labaran Yarima Salihu Dan Alhaji Auta Ganduje Auwal Yusuf	Sarkin Sudan Bakura (Chairman SBMC LGEA Bakura). Member Member Member Member Education Secretary	6/8/2013
2	Lawal Sani Auta Attahiru Kofa Kabir Usman Dan Ali Yusuf Dina Lawal Dan Sadau Gambo Alkali Tsafe	Matawallen Bakura (Chairman DHC Malamawa PHC Bakura). Member Member Member Member In-charge, Malamawa PHC, Bakura	7/8/2013
3	Hassan Adamu Bungudu Talatu Bello Maimuna Dan Rimi Hajara Lawal Saude Dan Malam	In-charge, Rimi PHC, Bakura Women Attending Clinic Women Attending Clinic Women Attending Clinic Women Attending Clinic Women Attending Clinic	9/8/2013

E. Focus Group Interview Kauran Namoda LGA

S/N	NAME	POSITION	DATE INTERVIEWED
1	Zainab Aboki Kofa	H/Mistress, Girls Focal primary School, Kaura.	13/8/2013
	Sambo Kaura	Dan Morikin Kaura (Chairman PTA)	
	Saidu Guru	Member	
	Saudatu Aliyu	Member	
	Lawal Kasuwan Daji	Member	
	Gambo Dan Hajiya	Treasurer	
2	Mustapha Suleman	In-charge PHC Kasuwan Daji	14/8/2013
	Attahiru Zubiaru	Mai Ung. K/Daji (Chairman DHC)	
	Buhari Mu'azu	Member	
	Idris Usman	Member	
	Victoria John	Member (Nurse)	
	Bagoberi Auta	Treasurer	
3	Tanko Dogon Kande	In-charge Magami HC	16/8/2013
	Binta Barau	Women Attending Clinic	
	Talle Gidan Dusu	Women Attending Clinic	
	Gambo Yar Kwasau	Women Attending Clinic	
	Aishatu Sambo	Women Attending Clinic	

F. Focus Group Interview Kaduna North LGA

S/N	NAME	POSITION	DATE INTERVIEWED
1	Aliyu Badamasi	Head Master LGEA Kawo	3/7/2013
	Adamu Danbala	Ward Head Kawo (Chairman SBMC)	
	Bello Tukur	Member	
	Ahmed Lawal	Member	
	Ojo Ayuba	Member	
	Godiya David	Member (Teacher)	
	Mamman Tanimu	Treasurer	
2	Suwaiba Iliyasu	In-charge PHC T/Wada	23/7/2013
	Mansur Zakari	Ward Head (Chairman DHC)	
	Waziri Balarabe	Member	
	Ahmed Abdurrahman	Member	
	Lawal Shehu	Member	
	Sani Mijinyawa	Member	
	Talatu Dalhatu	Member	
	Nuhu Garba	Treasurer	
3	Ester Madaki	In-charge PHC Unguwar Rimi	12/7/2013
	Talatu Lawal	Women Attending Clinics	
	Safiya Dauda	Women Attending Clinics	
	Rifkatu Daniel	Women Attending Clinics	
	Martha Joshua	Women Attending Clinics	
	Zainab Kabir	Women Attending Clinics	

G. Focus Group Interview Lere LGA

S/N	NAME	POSITION	DATE INTERVIEWED
1	Yusuf Sunusi Sale Ramin Kura Shekaru Dan Baba Jatau Hadari Maigari Aboki	Head Master LGEA Ramin Kura District Head Ramin Kura (Chairman PTA) Member Member Treasurer	16/9/2013
2	Murtala Yusuf Abubakar Mamman Abdul-Aziz Shuaibu Abubakar Balarabe Halima Dan Bala Haruna Anaruwa Bala Auta	In-charge PHC Dan Alhaji Saminaka District Head, Dan Alhaji, Saminaka (Chairman DHC) Member Member Member Member Treasurer	18/9/2013
3	Fatima Aliyu Amina Mohammed Zainab Yusuf Ramatu Aminu Hafsatu Sani Hauwa'u Murtala	In charge Comprehensive HC Sabon Layi Saminaka Women Attending Clinics Women Attending Clinics Women Attending Clinics Women Attending Clinics Women Attending Clinics	19/9/2013

H. Focus Group Interview Sanga LGA

S/N	NAME	POSITION	DATE INTERVIEWED
1	Yuhana Auta Badamasi Jatau Samuel Amba Dauda Bahago Lydia Ayuba Adamu Tanko	Head Master Fadan Ayu LGEA Primary school. Ward head Fadan Ayu (Chairman) SBMC, Fadan Ayu Primary School. Member Member Member Treasurer	8/10/2013
2	Mary Johanna Ayu Bala Makama Talatu Duniya Doguwa Habila Salisu Bello	In charge MCH Center Gwauntu Tsaftan Gwauntu (Chairman DHC MCH Center Gwauntu) Member Member Treasurer	9/10/2013
3	Alheri Mijinyawa Godiya Ishaya Julia Jonathan Gladiya Kurah Maryam Auta	In charge HC Dogon Daji Women Attending Clinics Women Attending Clinics Women Attending Clinics Women Attending Clinics	10/10/2013

APPENDIX E: LETTER FROM THE EDITOR

Department of English
Faculty of Arts,
Ahmadu Bello University
Zaria.
29th July, 2015.

TO WHOM IT MAY CONCERN.

This letter serves to confirm that in 7h July, 2015, I did the proof reading and the language editing for the thesis of;

Dalhatu MOHAMMED Jumare

Ph.D/LG/ADMIN/15523/2007-08

Entitled **Local Government Capacity in Managing the Education and Health Related Millennium Development Goals Programmes in Kaduna and Zamfara States, Nigeria**

This document is being submitted in partial fulfillment of the requirements for the award of the Doctor of Philosophy (Ph.D) in Local Government and Development Studies, in the Department of Local Government and Development Studies, Faculty of Administration, Ahmadu Bello University, Zaria.

I have proofread and edited the whole work including the references and appendices. This editing principally involves proofreading, language, style and grammar editing; and also checking the text for clarity of meaning, sequence of thought and expression and tenses. I have also noted any inconsistencies in thought, style and logic, and any ambiguities of words and phrases, and have corrected those errors which creep into all writing. I have written the corrections on the hard copy and have returned the document to the author, who is responsible for inserting these.

Name: ----------

Sign: ----------

Date: ----------