Nigeria
Resource Tracking in Health in Nigeria
Volume I

March 26, 2018

HNP
OVERVIEW AND KEY FINDINGS

RESOURCE TRACKING IN PRIMARY HEALTH CARE IN NIGERIA: CASE STUDY FROM NIGER AND EKITI STATES

VOLUME I

March 26, 2018

GHN07

Karima Saleh, Bernard Gauthier, Obert Pimhidzai
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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral drug</td>
</tr>
<tr>
<td>CPETS</td>
<td>Continuous public expenditure tracking survey</td>
</tr>
<tr>
<td>DFID</td>
<td>UK Department of International Development</td>
</tr>
<tr>
<td>DPHC</td>
<td>Department of primary health care</td>
</tr>
<tr>
<td>DRF</td>
<td>Drug revolving fund</td>
</tr>
<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccine Initiative</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GHE</td>
<td>government health expenditure</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross National Income</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information systems</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>IGR</td>
<td>Internally generated revenue</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>LGA</td>
<td>Local government authorities</td>
</tr>
<tr>
<td>LLIN</td>
<td>Long lasting insecticide nets</td>
</tr>
<tr>
<td>LMIC</td>
<td>low middle-income country</td>
</tr>
<tr>
<td>MCH</td>
<td>maternal and child health</td>
</tr>
<tr>
<td>MDAs</td>
<td>Ministries, Departments and Agencies</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MTSS</td>
<td>Medium-term sector strategy</td>
</tr>
<tr>
<td>MTBF</td>
<td>medium term budget framework</td>
</tr>
<tr>
<td>NACA</td>
<td>National Agency for the Control of AIDS</td>
</tr>
<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
</tr>
<tr>
<td>NGOs</td>
<td>non-government organizations</td>
</tr>
<tr>
<td>NPHCDA</td>
<td>National Primary Health Care Development Agency</td>
</tr>
<tr>
<td>NSHDP</td>
<td>National Strategic Health Development Plan</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother to child transmission</td>
</tr>
<tr>
<td>RBF</td>
<td>results based financing</td>
</tr>
<tr>
<td>SDI</td>
<td>Service Delivery Indicators</td>
</tr>
<tr>
<td>SMOH</td>
<td>State Ministry of Health</td>
</tr>
<tr>
<td>SPHCDA</td>
<td>State Primary Health Care Development Agency</td>
</tr>
<tr>
<td>TB DOTS</td>
<td>Tuberculosis Directly observed treatment, short-course</td>
</tr>
<tr>
<td>THE</td>
<td>Total health expenditure</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nation Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United Stated Agency for International Development</td>
</tr>
<tr>
<td>VAT</td>
<td>value added taxes</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

In Nigeria, health care is devolved to the states and primary health care (PHC) is the responsibility of the local governments, but existing budget and capacity constraints impact delivery for an effective health program. To respond to this concern, the Federal Ministry of Health (FMOH) developed a National Strategic Health Development Plan (NSHDP, 2010-2015) prioritizing strengthening of PHC services. A partnership must be formed between the various administrative levels (federal, state and local government authorities) to support an effective delivery of PHC services. The implementation of the NSHDP requires ensuring sustainable financing, efficient use of resources as well as accountability of expenditure, for a functioning and results-oriented delivery system, and especially at the PHC level.

What is presently spent on PHC, and what are gaps in resources? Most revenue at the local government authority (LGA) level comes from the Joint Account, which is made up of statutory transfers from the Federation Account and allocation by the State Government. LGAs rely on both on- and off-budget resources through the various administrative levels and non-government sources (e.g. internally generated revenue [IGR]). The government of Nigeria has not been able to reliably track information from the various levels of governments and off-budget means on how much is spent on PHC services. This is partly due to (a) too broad classifications of expenditure in the health sector to capture such granular information, (b) the fragmented nature of these resource (both cash and in-kind) flows toward PHC services and (c) the absence of a system to aggregate and track them (including reporting and consolidating out of pocket payments) in the context of a highly-decentralized federation.

The need to devise alternative means of tracking income and expenditure in the health sector is much needed especially at the PHC level in Nigeria. One of the central issues identified by previous studies in Nigeria is governance challenges and the weakness of monitoring and accountability structures at the PHC facility and LGA levels. Given the existing reporting and monitoring constraints, a retrospective study could not capture all the desired information. A new approach of a continuous public expenditure tracking survey (CPETS) was developed to understand flows and leakages, and institutional and financial constraints for PHC. This report provides some of the findings of the study, which was conducted in Niger and Ekiti states of Nigeria, and provides its implications on policy considerations. The study summary findings are provided in this Volume I, while the indepth study report is Volume II.

Public resource allocation for PHC

The declining oil revenue in recent years, has severely affected budget flows and allocations in both Ekiti and Niger states. While government remains the major source of financing for PHC, IGR and external financing became the default sources of financing health operations. Health had in previous years also received low prioritization but in recent years (2015), allocations and expenditures were even lower, given: (a) low releases, and (b) low budget execution. Federal government allocations for PHC in the states of Ekiti and Niger are negligible. Among administrative levels, as health is devolved to LGA level, they finance the largest share of PHC expenditure. When budgets are reduced, personnel emoluments are given priority over all other budget items: 98-99% of LGA health budget goes towards personnel emoluments.
Budget execution for PHC

Federal level not only allocates limited resources for PHC, but they also face budget execution challenges that are worse than that faced by both state and LGA levels. Generally, salaries are paid off, while restrictions are imposed on non-salary recurrent and capital budgets. However, during the fiscal year (2015), Ekiti state faced severe liquidity constraints and which also affected releases for salary. Overall budget execution for PHC seems to be at around 60% of total PHC budget. While, almost 100% of personnel emoluments are released and executed, of the overheads and investment budgets, about 5% may be released. While about 40-45% of total health budgets (in Ekiti and Niger states) are allocated for PHC, eventually only half of this allocation is released for PHC (or about 20-25% of the health budget). However, of resources for operations, less than 1% of public budgeted resources arrives at PHC facilities.

Figure: Public Resources in the Health sector toward PHC services in percentage, by levels (2015)

Source: Authors, World Bank.
Public actual expenditures for PHC: how much is spent and where is it spent?

The per capita spending for PHC is low. The (actual) PHC spending was about $4 ($3 for Ekiti and $4 for Niger) in 2015. Less than 30% of PHC spending went towards operations. Of the PHC budget, only half of it is received by PHC facilities. Otherwise, most of it is kept at the district level for running public health programs, and for running other related activities. When human resources are excluded, the amount of public resources reaching PHC facilities is about 7 cents ($0.07) per capita in Ekiti state and 4 cents ($0.04) per capita in Niger state. This is a negligible amount and severely inadequate to respond to PHC operations needs.

Non-public spending for PHC: IGRs and external financing can be critical for PHC operations

PHC facilities rely heavily on non-government sources of financing for PHC facilities operations. While both states earn a very small amount through IGRs earned at PHC facilities: Niger state, as compared to Ekiti state, earn a higher per capita amount through IGRs ($0.41 versus $0.04). Ekiti state, as compared to Niger state, relies on on-budget donor support they receive from federal government. For operations budget, in per capita terms, user fees contribute $0.27 per capita across the two states, donors contribute about $0.06 per capita on average in both states, and government provides less than $0.01 per capita to PHC health centers. Public resources make less than 10% of the operations resources at PHC facilities (10% in Ekiti versus 2% in Niger). State specifics are provided in the Table below.

Table: Sources of financing (excluding salaries) for PHC, per capita, $, 2015-2016

<table>
<thead>
<tr>
<th>Sources of Financing at PHC</th>
<th>Ekiti</th>
<th>Niger</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>User fees</td>
<td>0.045</td>
<td>0.407</td>
<td>0.270</td>
</tr>
<tr>
<td>Donors</td>
<td>0.066</td>
<td>0.060</td>
<td>0.062</td>
</tr>
<tr>
<td>Government</td>
<td>0.012</td>
<td>0.008</td>
<td>0.009</td>
</tr>
<tr>
<td>Total, $</td>
<td>0.123</td>
<td>0.474</td>
<td>0.342</td>
</tr>
</tbody>
</table>

Source: Authors, World Bank.

Note: This includes resources allocated for PHC and towards LGAs and facilities. Note: Retrospective expenditure data was captured for state and federal level. Prospective survey was conducted for LGAs and PHC facilities between October 2015 and March 2016.

Total spending for PHC

PHC facilities receive limited resources. When all sources of financing are considered (public, private, in-cash and in-kind), the amount is no more than $4 per capita. Government overall finances about 92% of PHC spending. Government sources are the primary financing for PHC, but significant amounts are from LGAs and for personnel emoluments. On average, earning through user fees is about 7% and earnings through donors is about 1.5%. PHC receives negligible resources for health operations from government sources. Of operations spending share, government finances on average less than 5%, while user fees finances on average about two thirds. The balance comes from donors¹. So, public sources are the least relevant to finance PHC operations.

¹ Direct donor contributions are resources directly allocated by donors to PHC facilities reported by PHC facilities through the survey modules. Donors’ indirect contributions to PHCs are support provided by donors through federal
PHC facility revenue

Based on actual revenues from all sources, the resource envelop of PHC facilities is quite low, when considering the demands against these facilities. Resources at PHC facilities (wages and salaries included), range from $15 to $22 per user, based on prevailing exchange rates at the time. The amounts are much lower in per capita terms as the resources PHCs receive and generate amount to N 235 per capita in Ekiti and N 533 per capita in Niger, thus equivalent to between $1 – 2.5 per capita.

The amount of resources received per capita in Ekiti and Niger, indicates that only a small share of public spending on health reached PHC facilities and points to lack of prioritization of PHC. Public spending is either concentrated on curative rather than preventative care or a greater share of this spending is not devoted to frontline service provision. Excluding user charges and direct non-government support, shows that government supported public PHC facilities to the tune of NG 225 and NG 465 per capita in Ekiti and Niger respectively, that is equivalent range from $1 to $2 per capita. This pales in comparison to the estimate of $16 and $19 government per capita spending in Ekiti and Niger respectively.

Efficiency in PHC facility spending – drugs availability

Regardless of financing or procurement mechanisms applied, both states faced significant drug stock outs, as overall resources remained inadequate. Niger state public PHC facilities relied on IGR to procure drugs from the private sector. As a result, the study found that the public PHC facilities were able to get drug replenishments faster than at public PHC facilities in Ekiti state. Ekiti state public PHC facilities relied on budget to procure drugs form public central medical stores through the help of drug revolving fund. As a result, although drug replenishments are not as fast, the prices of these drugs are much cheaper than other modes used by Ekiti or Niger states. Thus, public procurement of drugs doesn’t seem to offer any particular advantages over private procurement, which instead seemed more responsive to drug stock outs.

Performance of PHC facilities

Performance of facilities in terms of inputs availability is primarily dependent on having discretionary financing. Receiving direct in-kind support was another determining factor. Thus, the best performers (of PHC facilities) were those facilities that raised more in IGR, received donor supplies of drugs, were in LGAs that delivered drugs or were lucky enough to get cash support from the government. Nonetheless, purchase of medical equipment and upgrading of facilities infrastructure are totally neglected, being neither financed from discretionary facility funds nor by the government.

Summary

The main message coming out of this study is that public resources allocated for PHC operations is dismal. While at budgetary levels, PHC may be budgeted a significant share of health budget, in reality, much of that is not released. Given the fragmentation in responsibilities and financing, and poor budget execution and reporting of what funds are released, to whom, and how is it spent, little is ever reported to the higher-level government leadership and authorities.

and state transfers, in particular cash and in-kind support by donors to FMOH vertical programs and SPHCDA for PHC services (for non-salary purposes).
For cash, PHC facilities rely on revenue generated through user fees charged for drugs (mostly) followed by consultation and laboratory charges. The patients are therefore their primary payer for non-salary recurrent budgets. These resources help replenish drugs and other such expenses required for operating PHC facilities.

In a country where out-of-pocket health spending is significant (around 70% of total health spending), and population receives limited financial protection, this finding explains why PHC service use is so very poor and why health outcomes in Nigeria remain below standard. Nigeria has not met many of its health-related millennium development goals.

There are three main areas to be considered for policy discussions: (a) user fees charges for PHC and revenue sources for PHC, (b) inefficiencies in allocations and spending: low budget execution, resource allocation (in favor of hospitals over PHC), and resources spent in favor of personnel and not for operations, procurement challenges, and finally (c) limited reporting and accountability and governance mechanisms to influence behavioral change at the PHC facility level.

**Main findings and policy options to consider**

*What should be the policy on user fees in public PHC facilities in Nigeria?*  At this point household’s have significant out of pocket health spending in Nigeria. Among the top policy priorities to consider is improving financial protection of households against illness costs. For a formal user fees exemption policy, it will be important for a policy and realization on improving resources allocation for PHC operations. Without the latter, a no user fees policy, could still result in informal payments.

*Fragmentation in the flow of funds.* As shown in the study, resources for PHC came from various channels and some in cash and some in kind. This made it difficult for any one entity to monitor the flows and its use and its accountability. Pooled financing would help consolidate resources and flows around needs, and would result in improved efficiency and transparency.

*One of the critical concerns raised in this study is the limited non-salary recurrent budget for the operations of PHC facilities.* This is a critical concern, coupled with the challenge of the low overall public resource allocation for health. Where does the answer lie? Among the steps to be considered is to enforce the Health Bill that supports PHC. A costed basic health package would help ensure such resources can be committed from the highest authority and a mechanism established to earmark or develop a basic health fund. Philippines has experimented on a purchaser provider compact under their Philippines Health Insurance Corporation and through a capitation payment mechanism with local government authorities. Ghana has experiment in a similar fashion. Such a payment mechanism was also applied in Nigeria through NHIA under the MDG program, and resources were transferred to PHC facilities (rather than LGAs) and provided them in-cash support for facility operation and for drugs purchase. The Nigeria millennium development goals (MDG) program ended in 2015. There is no evaluation of the program. There can be important lessons learnt for Nigeria through internal and international experiences.

*Human resources challenges have been highlighted as a concern especially in the Ekiti public PHC facilities.* The focus group discussions highlighted the challenges faced in frequent staff move from district to district, staff absenteeism, inadequately trained staff, and limited motivation. The study used a mechanism to motivate staff’s behavior through a reward system/social recognition. It proved to have some limited effect in Ekiti, that may have been facing more motivational challenges. It had no effect in Niger state. The World Bank financed projects are also experimenting through results based financing, and an
evaluation of project output on staff motivation and performance would be beneficial to consider options open to Nigeria.

**Drug stock outs is rampant at public PHC facilities in both states of Ekiti and Niger.** While Ekiti relies on drug revolving fund (DRF) managed by the central medical stores, and Niger relies on DRF managed by State Primary Health Care Development Agency (SPHCDA), the findings on drug stock outs are similar. However, Ekiti has benefited from economies of scale and purchase at lower drug prices through the central medical stores. Niger, however, did not rely upon the SPHCDA, but instead purchased most of its drugs through the private pharmacies. Further assessment would be helpful in understanding the challenges faced at the institutional level (central medical stores and SPHCDA) in procuring drugs through the DRF mechanisms. The good news is that drugs procurement is decentralized and facilities have the authority to purchase from outside the public system. However, drugs purchased through Ekiti central medical stores have on average been cheaper than that procured by SPHCDA or by the private sector. Is the problem in drug procurement a challenge of the procurement processes at central medical stores or at SPHCDA, or is it the challenge in the resource envelop? Indonesia has considered essential health drugs for PHC as part of the public health goods and responsibility of the federal governments. Essential drugs for PHC are procured by federal government and delivered to PHC facilities, and maintain low drug stock outs. Ghana on the other hand decentralized procurement of drugs to local levels and when drugs were not available in the public system, then facilities could procure through private sector. While drug stock outs reduced, the small procurement packages increased drugs prices. Nigeria has some lessons to learn in this area, and consider solutions for public financing of all essential drugs through some pooled mechanism and perhaps with accountability at the federal level, or to consider providing sufficient recurrent budget to LGAs and PHC facilities to procure through decentralized local public and private mechanisms.

**Despite low performance of the public PHC facilities in Ekiti, health outcomes of the population of Ekiti state was much better than those of the Niger state.** The one difference observed was that Ekiti was a smaller state with many private clinics. While the study did not capture the performance of the private sector, it may be an important consideration for future studies to capture the private sector through its assessment followed by policy considerations. In the Philippines, the government was able to increase TB DOTS coverage through a public-private partnership engagement.

**While Ekiti state public PHC facilities had bank accounts and maintained a record through it, the Niger PHC facilities were not required to do so.** There is therefore low knowledge and transparency of what in-cash resources were earned and what resources were used. Also, while some PHC facilities based in urban areas may be earning a better revenue, rural PHC facilities may not be benefitting through IGRs equally. An equalization or resource allocation mode through a policy on IGR retention and use may be beneficial. Tanzania has set up clear policies on use of IGRs. PHC facilities have set up bank accounts with clear governance structures for authorization, transparency and funds use. These bank accounts are used for the national health insurance program to transfer funds for PHC use, and for IGRs to be deposited. The reports are also shared with LGAs, states, and federal levels, and can be used for planning programs. Ekiti state of Nigeria has also set up a similar system, although no assessment is available of it, and the Niger state can learn from their experiences.

**LGAs faced several challenges and a problem in accountability.** One option to improve transparency at the LGA level is by providing citizens information that could lead to empowerment to hold LGA officials accountable and improve quality of PHC services. (Das Gupta, Gauri, and Khemani 2004).

**Some of the public financial management system challenges are systemic,** such as lack of or limited considerations given to a comprehensive public financial management system, including: chart of accounts,
enforcing reporting, auditing, reporting mechanisms and capacity building at PHC facilities. These mechanisms could strengthen public financial management system all the way to the facility level, and provision of the appropriate incentives would be extremely important to ensure the likelihood of reliable reporting of not only patient profile data but of both financial and non-financial reporting.
CHAPTER I: Introduction and Objectives

1.1. Background

Nigeria’s Primary Health Care (PHC) program faces significant challenges. The backbone of a well functioning health delivery system is its PHC program. In Nigeria, among the challenges faced by the existing public PHC program are equitable access and quality of care. The poor rely much on public facilities and services as their first point of entry for both prevention and curative care. Their access to health care is most affected when the PHC program suffers from delivering services equitably and in an efficient manner.

In Nigeria, health care is devolved to the states and PHC is the responsibility of the local governments, but existing budget and capacity constraints impact delivery for an effective health program. To respond to this concern, the Federal Ministry of Health (FMOH) developed a National Strategic Health Development Plan (NSHDP, 2010-2015) prioritizing strengthening of PHC services. A partnership must be formed between the various administrative levels (federal, state and local government authorities) to support an effective delivery of PHC services. The implementation of the NSHDP requires ensuring sustainable financing, efficient use of resources as well as accountability of expenditure, for a functioning and results-oriented delivery system, and especially at the PHC level.

What is presently the quality of care offered at PHC, and what are gaps? A recent survey of PHC facilities (Service Delivery Indicators survey, SDI 2013-14) indicated many challenges towards an effective delivery of PHC services. Among these are: drug stock outs, absenteeism and limited knowledge or staff performance concerns, missing basic equipment, and poor infrastructure. Service use has been dismal, and seen to be probably among the worst in all African countries (as compared to by similar surveys in other African countries). Among the Nigeria states, average PHC service use was about 1.5 patients per day, and only 45% of the essential drugs tracked were available at the PHC facilities (2013). Little reliable information could be sought on financing of PHC facilities from a retrospective study.

What is presently spent on PHC, and what are gaps in resources? Most revenue at the local government authority (LGA) level comes from the Joint Account, which is made up of statutory transfers from the Federation Account and allocation by the State Government. LGAs rely on both on- and off-budget resources through the various administrative levels and non-government sources (e.g. internally generated revenue [IGR]). The government of Nigeria has not been able to reliably track information from the various levels of governments and off-budget means on how much is spent on PHC services. This is partly due to (a) too broad classifications of expenditure in the health sector to capture such granular information, (b) the fragmented nature of these resource (both cash and in-kind) flows toward PHC services and (c) the absence of a system to aggregate and track them (including reporting and consolidating out of pocket payments) in the context of a highly-decentralized federation.

The need to devise alternative means of tracking income and expenditure in the health sector is much needed especially at the PHC level. One of the central issues identified by previous studies is governance challenges and the weakness of monitoring and accountability structures at the PHC facility and LGA

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levels. Given the existing reporting and monitoring constraints, a retrospective study could not capture all the desired information. A new approach of a continuous public expenditure tracking survey (CPETS) was developed to understand flows and leakages, and institutional and financial constraints. This report provides some of the findings of the study, which was conducted in Niger and Ekiti states of Nigeria, and provides its implications on policy considerations.

1.2. Country Context and study motivation

Nigeria’s health status does not compare well with the other countries of similar income and within the region. For example, the country has not met several health-related millennium development goals (MDGs) in 2015. Nigeria, now, lags far behind many of its comparator countries in several indicators: falling short by 48% of reducing infant mortality rate, and falling short by 28% of reducing under-five child mortality rate (MDG Report 2015). With only 2% of the world’s population, Nigeria has 10% of the world’s maternal deaths, 10% of the world’s under-five mortality and 25% of the world malaria burden.

Nigeria is one of the largest economies of Sub-saharan Africa, but with stagnating growth rates in recent times. Nigeria is a low middle-income country with a gross national income (GNI, Atlas method) per capita of $2,790 (2015). Its growth rate in the past 5-years was 5.7%. While expecting a positive near-term growth rate, projections are expected to be in the range of 4.8 to 5.3%, a consequence of the challenges Nigeria faces from low prices of oil globally. Nigeria is rich in mineral and oil resources and are exporters of these goods; however, its revenue was critically affected as international market oil prices declined. Most of Nigeria’s revenue is generated through oil and hydrocarbons, which on average represented 16.5% of GDP between 2006 and 2010. When it comes to diversification of the revenue base, Nigeria is the least diversified. Nigeria has a low tax revenue, at 1.6% of gross domestic product (GDP), and cannot rely on this source for its needs. Over time, the international monetary fund (IMF) projections suggest that oil revenue will make a smaller share of GDP in the medium term. Since the states revenue is heavily dependent on federal transfers, and much on own IGR, it has also been affected by the drop-in oil prices.

Health care in Nigeria is mostly financed by households. Nigeria’s household out of pocket spending for health as share of total health spending (THE) is over 70%, and is among the worst in the world. Furthermore, THE is 43% below African regional average ($216 (PPP) per capita versus $308 (PPP)), with government financing representing less than 25% of THE (in PPP) compared to close to 60% on average in the Africa region (National Health Accounts, 2016).

Public health expenditure in Nigeria remains much below what is observed in comparable countries, representing only 1% of the gross domestic product, less than one third of what is observed on average in other African and Lower-Middle-Income countries (LMIC). This is despite a significant increase of government health expenditure (GHE) to 8.2% of total government expenditure in 2014 from 5.9% in 2000.

In low resource settings, such as Nigeria, more efficient use of resources with strategic purchasing is a critical determinant of both quantity and quality of health care. However, Nigeria’s health system organization and financing are fragmented. Its funding originates from different sources and it flows through different channels ending up in different pools/pots. Furthermore, information systems for monitoring the funding and delivery of health services are weak, as studies undertaken in Nigeria in recent years have indicated (Couttolenc 2013, World Bank 2014). Poor and unreliable financial and non-financial information contribute to weak accountability of service providers to various levels of government and to society in general.
1.3. Development Background of study site: Niger and Ekiti states

Both Niger and Ekiti states had varying characteristics, and varying performances. While Ekiti state had better development outcomes, both Ekiti and Niger states showed mixed results for public sector delivery performance. Niger state, from the Central region, was established in 1976, and Ekiti state, from the western region, was established almost two decades later in 1996. Both states have lower GDP per capita compared to the national average. Relative to Ekiti state, Niger is a larger state, with larger land, larger population and larger income.

Niger state, compared to Ekiti state performs worse off in all development indicators. When it comes to development indicators, relative to Ekiti state, Niger state reports higher proportion of population living below poverty levels, higher illiteracy rate, and worse health and nutrition indicators. For example, in Niger state, DPT\(^3\) immunization coverage of children under-2, was less than one-third (23%) of what is reported by Ekiti state (which has universal immunization coverage). In fact, Ekiti state has achieved universal coverage in most basic indicators in health and education. It performs even better than the national average. The two selected states are at very different levels of development outcome and health service delivery performance. [Table 1].

Table 1: Socioeconomic and health indicators for Niger and Ekiti states as compared to Nigeria

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Nigeria</th>
<th>Niger State</th>
<th>Ekiti State</th>
<th>SSA/ Africa</th>
<th>Low-MIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP /capita (PPP USD, 2011)</td>
<td>2,300</td>
<td>1,518</td>
<td>1,187</td>
<td>2,251</td>
<td>3,833</td>
</tr>
<tr>
<td>Life expectancy at birth (in years)</td>
<td>53</td>
<td>NA</td>
<td>NA</td>
<td>56</td>
<td>66</td>
</tr>
<tr>
<td>Infant mortality (per 1,000 live births)</td>
<td>78</td>
<td>78</td>
<td>48</td>
<td>68</td>
<td>46</td>
</tr>
<tr>
<td>Under-5 mortality rate (per 1,000)</td>
<td>124</td>
<td>123</td>
<td>71</td>
<td>107</td>
<td>62</td>
</tr>
<tr>
<td>Maternal mortality (/100,000 births)*</td>
<td>630/1100</td>
<td>NA</td>
<td>NA</td>
<td>480/900</td>
<td>260/180</td>
</tr>
<tr>
<td>Communicable diseases mortality (/100,000)</td>
<td>964</td>
<td>NA</td>
<td>NA</td>
<td>978</td>
<td>125</td>
</tr>
<tr>
<td>Antenatal care coverage (4+ visits)</td>
<td>45%</td>
<td>44.0</td>
<td>95.4</td>
<td>43</td>
<td>47</td>
</tr>
<tr>
<td>Skilled attendance at delivery</td>
<td>34%</td>
<td>53.9</td>
<td>89.8</td>
<td>49</td>
<td>65</td>
</tr>
<tr>
<td>Tuberculosis immunization coverage</td>
<td>61.7%</td>
<td>41.8</td>
<td>96.3</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>DPT immunization coverage</td>
<td>47%</td>
<td>23.9</td>
<td>93.4</td>
<td>71</td>
<td>73</td>
</tr>
<tr>
<td>Measles immunization coverage</td>
<td>71%</td>
<td></td>
<td></td>
<td>75</td>
<td>78</td>
</tr>
<tr>
<td>Stunting prevalence (moderate/severe)</td>
<td>34.8%</td>
<td>46.6</td>
<td>13.6</td>
<td>41</td>
<td>36</td>
</tr>
<tr>
<td>Children under 5 sleeping under ITNs</td>
<td>29%</td>
<td>9.8</td>
<td>26.5</td>
<td>32</td>
<td>NA</td>
</tr>
<tr>
<td>Use of improved drinking water</td>
<td>61%</td>
<td>69.6</td>
<td>74.4</td>
<td>64</td>
<td>87</td>
</tr>
<tr>
<td>Use of improved sanitation facilities</td>
<td>31%</td>
<td>37.6</td>
<td>37.7</td>
<td>34</td>
<td>47</td>
</tr>
<tr>
<td>Female (15-24) literacy</td>
<td>65.6%</td>
<td>28.3</td>
<td>96.8</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>


\(^3\) DPT stands for Diptheria, Pertusis and Tetanus.
Both states reported mixed results on public PHC facility performance, although Ekiti state faced greater challenges with staffing. Patient caseload at public PHC facilities in Ekiti were lower than Niger state, and both states remained below national average. SDI (2013-14). Staff absenteeism at public PHC facilities were significant: Ekiti state reported higher than national average, and almost double of Niger state, which reported lower than national average. As expected, there was an inverse relationship between staff absenteeism and patient caseload. Diagnostic capabilities of PHC staff was overall quite weak, however, staff at Ekiti State PHC facilities, relative to Niger state, were worse off at adhering to guidelines, and to managing maternal and newborn child complications. Both states managed drug revolving funds (DRF): in Niger state, DRF was managed under the State PHC development agency (SPHCDA), while in Ekiti it was managed under the State Central Medical Stores. Both states, although, reported similar poor access to drugs at PHC (less than 50% of basic drugs were available). Ekiti state reported better infrastructure and better availability of basic equipment at their PHC facilities.

Specific characteristics between the states highlight the rampant private sector providers in the Ekiti state. In Ekiti state, about 50% of clinics were privately owned, while in Niger state only 18% of clinics were privately owned. Despite low performance of public sector PHC facilities in both states, Ekiti state had better health outcomes. The private sector may have some implications for better health outcomes in Ekiti state.

Information on public spending in health and particularly for PHC was difficult to gather from previous studies. To diagnose the reasons for poor inputs in PHC, further information was needed on financing of PHC. The earlier SDI survey, which is done on retrospective data, could not gather much information on revenue generation or expenditure patterns at PHC facility level. This was primarily resulting from PHC facilities not maintaining budget and spending books, nor providing such information to LGAs. This called for a study to explore further in this area.

1.4. Issues in tracking public expenditure in health in Nigeria

Data is a challenge in Nigeria and retrospective extraction of information proved to be unreliable. Data challenges were faced in both financial and non-financial information, and which tends to create difficulties in obtaining usable financial and non-financial information to assess performance of the health sector. Some examples are listed hereunder:

- Information is generally available among the several information systems in place, but suffer from weak standardization and systematization;

- Existing information is difficult to access and use; it is fragmented among the many Ministries, Departments and Agencies channeling resources to and within the health system and across government levels, as well as many parallel information systems, without any systematic effort at consolidation;

- There is no system in place to consolidate public expenditure on health, and therefore reliable estimates are lacking; even recent National Health Accounts have faced substantial difficulties and are not comprehensive or fully reliable;
• Information on service provision is recorded but not systematized or consolidated, with a few exceptions (such as the Hospital Management Board in Niger State); information is especially difficult to obtain on service provision at PHC facilities, for lack of systematic consolidation;

• Information is often available at a high level of aggregation (as for budget allocation, which includes only three major line items – Personnel, Overhead, and Capital);

• Information is often inconsistent and incomplete, with frequent missing data, and with large, unexplained variations in reported variables. Data is often difficult to interpret due to lack of standardization of categories and indicator/variable definition;

• Recording and reporting is often manual, and relies to a large extent to recording systems and forms developed locally and not systematized or standardized or extracted;

• Related information is often scattered across different systems; for example, staff numbers may be available at the facility level but the value of payroll is usually not, especially in the case of PHC facilities (salaries are paid directly by central departments to staff individual bank accounts with no aggregation by facility);

• Information on IGR is usually recorded at the facility level, but not systematically consolidated, and may not appear in budget or financial reports.

Because of these limitations, use of existing (retrospective) information requires substantial effort at gathering and extracting from multiple sources, systematically verifying and validating information, triangulate this information with other sources, and complementing it when missing by indirect estimation methods. The existence of frequent large variations requires that clarifications and additional confirmations and verifications are needed before the information is ready for analytical use. This preparatory work implies that simply collecting existing data through a classical (retrospective) one-time public expenditure tracking survey approach is not likely to provide comprehensive and reliable information for analysis.

1.5. Study objective

This study’s overall objective is to examine the financing, performance, accountability and monitoring systems of PHC activities to help the country produce an effective PHC delivery system and ultimately to improve health outcomes. More specifically, the main objectives of the study are:

(i) To better understand the financing flows and identify bottlenecks in transferring and receiving resources through the health administrative system down to the PHC facility level;

(ii) To assess the level of resources allocated toward PHC services and that which is reaching these PHC facilities, and to determine the level of resources available at PHC level by state, including from IGR.

The CPETS study also aims to assess if the system developed at the PHC facility to strengthen and monitor resource flows on a continuous basis is able to: (a) improve resource flow monitoring, (b) allow a better understanding of where resources are spent, and (c) demonstrate who benefits from these resources. See Annex 1.
CHAPTER II: Governance, Institutional Arrangements and Resource Flows

2.1. Institutional arrangements

Health, according to the Nigerian Constitution, is a shared responsibility of the federal, state and local governments. Nigeria operates within a system of fiscal federalism characterized by extensive intergovernmental fiscal decentralization through fiscal autonomy and responsibility attributed to subnational (State and Local) governments. The federal, states and LGAs have independent revenue sources recognized by the constitution, and the states’ budget are not subject to federal control and scrutiny.

The decentralized health system in Nigeria is hampered by important challenges relating to governance and accountability in the use of resources and services. PHC services is the primary responsibility of LGAs, with federal and state administrations participating in some aspects of management and financing of these services, such as, public health goods, and special programs or interventions that may be financed or managed by them. This implies that the FMOH has no significant influence on funds allocated by subnational governments to secondary care and PHC. Similarly, state governments have limited control over how LGAs allocate resources toward PHC (even though the constitution gives the state supervisory role over the LGAs). Furthermore, there is minimal coordination between federal, state and local government for managing and financing PHC. These arrangements (or lack of) subsequently create difficulties in the coordination and management of health care policies as expenditure decisions of the three tiers of government are taken independently.

There is paucity of reliable data across the country on financing of the health system. This is a result of system fragmentation and poor information systems. There are no requirements for reporting public budget and expenditures to federal government or between administrative levels. There is no mechanisms or organization responsible for collecting health expenditure data across budget categories, tiers of government or types of services. Budgetary information is often not readily available, consolidated or comparable.

In the context of fiscal federalism and lack of adequate systems and accountability mechanisms, health financing sources (public and non-public), allocations and expenditures are not well informed. This creates difficulty in understanding bottlenecks, efficiency and equity considerations. First, budgets are not prepared according to international definitions and standards, and the local definitions and standards may not be standardized across the country. Second, the public budgets in Nigeria are structured under broad budgetary categories: personnel, overhead (or operations) and capital investment. Budget or expenditure details are not reported formally and are not consistently placed under each budget category. For example, some recurrent budgets could be in capital investment category. For one to understand spending specifics, follow up may be required with ministry and agency managing their own budgets. Third, there is an absence of mechanisms or organization responsible for collecting or collating health expenditure data across budget categories, tiers of government or types of services, and sources of financing (both public and non-public).
2.2. Public financing at state and LGA levels in Niger and Ekiti states

This section provides some information on sources of financing at state and LGA levels.

- States are highly dependent on statutory transfers from federal funds. Their internally generated revenues are a very small share (almost insignificant) of their overall revenue;
- Release of federal transfers are both cumbersome and procedural;
- State budget execution is low: while personnel emoluments are released, capital budgets are hardly released or spent, and especially in recent years;
- While some states have progressed on public budget management and framework, others have not. Ekiti state prepares medium term budget framework (MTBF), but this is not the case in Niger state;
- Some differences are noted in the governance structures and its autonomy as maintained by LGA administrations in the two states. While in Ekiti the approval of the LGA budgets are by the individual LGA councils, in contrast, in Niger, the approval of the LGA budget is not at the LGA level but by the state house of assembly.

Sources of financing at Niger and Ekiti states

*In Nigeria, generally, federal funds are transferred to states according to a state distribution formula that includes an “equality” dimension.* The state receives most of its resources through statutory allocations, followed by value added taxes (VAT) and excess crude oil. Other sources of financing include: internally generated revenue, grants and subventions and others. The statutory allocations to states are based on a formula as follows: some index on equality (40% share), population (30% share), landmass and terrain (10% share), social development factor (10% share), and internal revenue generation effort/IGR (10% share). The revenue collected from VAT are distributed between all administrative levels (federal level (15%), states (55%) and LGAs 30%), and the share of the state allocations are also based on a formula with some equity dimension: equity index (50%), population (30%), and derivation (20%) (Niger State PEMFAR 2009). [Box 1].

**Box 1: Funding for States come from several sources**

| (i) | Statutory transfers from the Federation Account to the state’s general budget; |
| (ii) | Federal transfers from the VAT fund, also channeled to the State’s general budget; |
| (iii) | Other sources channeled through the State Budget (Excess Crude Oil, and other receipts/Sundry revenues); |
| (iv) | Locally generated revenues (IGR) from general taxes; |
| (v) | Specific IGR collected at health facilities (from the General Revolving Fund and NHIS); |
| (vi) | In kind transfers related to disease-specific vertical programs, mostly funded through Development Partners but in part channeled through National Primary Health Care Development Agency [NPHCDA] and/or National Agency for the Control of AIDS [NACA] (eg. Global Fund through NACA and NPHCDA, and Global Alliance for Vaccine Initiative [GAVI] through NPHCDA); |
| (vii) | Transfers in kind (goods or services) from the FMOH and NPHCDA, for vaccines, training, monitoring and evaluation and supervision; |
| (viii) | Transfers in kinds from Development Partners; |
| (ix) | Federal budget funds for the federal hospital in the state. |
State governments are heavily dependent on statutory transfers from the Federation Account. Niger received at least 66% of its resources through the statutory transfers in 2010. Niger state operates two main financial accounts: the Consolidated Revenue Fund (for all non-capital revenue sources (Statutory Transfers, IGR)), and the Capital Development Fund. (Figure 1).

Figure 1: Financing sources for the government budget, Niger State, 2010

State budget preparation and allocations

There are some differences noted in the budget preparation processes between Ekiti and Niger states, as medium-term expenditure framework while applied in Ekiti is not applied in Niger. At the state level, budget preparation also goes through the same process as at the federal level with a budget preparation phase by the executive arm of government, its passage into an Appropriation Act by the Parliament and final accent by the Executive Governor (preparation and approval). In Ekiti, part of the budgeting process also includes the development of a three-year Medium-Term Sector Strategy (MTSS) and Medium-Term Budget Framework (MTBF) from which the budget for the year is derived. In Niger State, in contrast, the budget process does not include the development of MTSS or MTBF.

In much of Nigeria, budget classifications do not follow international rules and standards. Recurrent expenditure allocation is not consistent across years, probably due to different classification rules or forms of aggregation. To illustrate this, Niger state did not show one of the allocations to parastatals (of which the Hospital Board is the most important) in 2011-2012 budget, while it was shown in their 2009-2010 budget. It is likely that in the latter years it may have been consolidated under the budget category of “Personnel emoluments”. Similarly, capital expenditure is not at all shown because of its distorting effect: its budget allocation represents up to three times (in 2012) the budget for recurrent expenditure, but actual expenditure is much lower. (Figure 2).
The release of federal transfers is cumbersome and procedural. Resources are transferred from the Federation Account to the Ministries of Finance (MoF) in both states, which then grants Authority to Incur Expenditure (AIE). Furthermore, there is also the granting of clearance by the Due Process Office (DPO) and procurements of goods and services (including labour services) by font-line service providers, Ministries, Departments and Agencies (MDAs), LGAs and FCT (federal capital territories).

Official budgets typically have low implementation rates. Apart from personnel cost (for salaries and wages of employees), most expenditure components of the budget are hardly implemented, especially for capital projects whose execution are abysmally low. This could be in part explained by insufficient release of revenues accruing from the Federation Account in recent years as well as lower autonomous revenues.

Some specifics of LGA budget procedures and processes in Niger and Ekiti

As done for states, an equality dimension also influences federal and state allocation for local government authorities. These funds are transferred to LGAs through a Joint Account. The allocation formula is determined by several factors: population, land mass, terrain, local revenue, PHC enrollment and the number of hospitals, and an equality factor.

Just like the other tiers of government, LGAs prepare annual budgets, which contain the details of estimated revenues and proposed expenditures. The budget process, as for the federal and state levels, includes budget preparation by the executive arm of government, its passage into an Appropriation Act by the Parliament and ascent by the executive. The budget process typically starts in the last quarter of the outgoing year and ideally should have been completed by March of the following year. The budgeting process includes call for proposals to each department and consultation with the LGA stakeholders including traditional and community leaders.

While in Ekiti the approval of the LGA budgets are by the individual LGA councils, in contrast, in Niger the approval of the LGA budget is not at the LGA level but by the state house of assembly. In Ekiti, part of the budgeting process also includes the development of a three-year MTSS and MTBF – which was introduced in 2014-2016. Within the principle of separation of powers, while the executive arm of government prepares the budget estimates, approval of the budget of LGAs in Ekiti is the responsibility of the LGA Council made up of elected councillors. In contrast, the budgeting process in Niger does not include development of MTSS or MTBF and the approval of the budget is done by the State House of Assembly, rather than individual LGA councils. Although, Ekiti state was more advanced in development of its budgeting processes and governance structures, in the absence of elected councilors, LGA Budgets...
were approved by the State House of Assembly and experienced enormous delays. Hence, LGAs operated much of 2014 without approved budgets.

**Ekiti state has set limits for tighter control on LGA budget execution, as compared to Niger state.** Audited Financial Statements of LGAs in both states are not known to be prepared by the six months deadline given in the Fiscal Responsibility Act 2010 and to be published. However, in Ekiti state, the Ministry of Local Government and Community Development exerts control over the execution of LGA Budgets, with thresholds established for approval of expenditure payments.

**2.3. Allocations for health budget at state level**

**Similarities found in Niger and Ekiti state health budget preparation and allocations:**

- State health budget planning is centralized;
- State health budget is biased towards personnel emolument, and that too for hospital staff;
- State health budgets suffer from allocative inefficiencies: a very small share of the state health budget goes towards primary health care (less than 5% of state health budget);
- State health budgets prioritize fixed costs: overhead budgets must be collected by health facilities through their IGR processes. The burden therefore remains on the population.

**Unlike some other states, the budgeting process for health in Niger and Ekiti states are centralized, and facilities – both primary and secondary – do not have their own budget.** This is different from a few other states, such as Cross River (USAID 2012).

**Most Niger state budget in health goes towards personnel expenditure, and mostly for hospitals.** Over 97% of Niger State Government recurrent expenditure on health is for staff payroll (including Basic Salary and Allowances). Overhead Expenditure (non-personnel expenditure) is quite small and unable to meet the needs for supplies and services. It also fluctuates greatly year-to-year and between budget allocation and actual expenditure. Therefore, payroll allocation is a very good proxy for total budget expenditure allocation. Of the total payroll for 2012, 83% is allocated to hospital care, through the Hospital Management Board – which manages all state secondary hospitals – and the Ibrahim Badamasi Babangida (IBB) University Specialized Hospital (see Figure 3). Primary Care, mostly for supervision and support to LGA activities, received 4.5% of the total payroll. The remaining payroll is spent for state ministry of health (SMOH) itself (8.1%) and four state health professional training schools (4% altogether).

**Ekiti State budget is allocated mostly to hospital care.** Similar to Niger state, the state budget allocates little to primary care, as the payment of its facility staff is still the responsibility of the LGAs. Eighty one percent of the state health budget goes to the Hospital Management Board hospitals and the University
Hospital. The latter seems to consume an excessively high proportion of resources, 36% of the total against 45% for the 15 secondary hospitals in the state (Figure 4). The budget for the Federal Medical Center in Ido-Ekiti, of 4.15 billion Naira in 2012, equals the sum of the University Hospital and all General Hospitals combined, which indicates an important distortion in resource allocation in benefit of the highest level of the health delivery system. This is confirmed when data are combined from the budget and the State Health Accounts: 69% of funding by type of provider in the state goes to hospitals, and 41% to tertiary-level hospitals, while primary care receives only 25% of total funding (Figure 5).

The state health budget allocation pattern excludes a substantial part of facility-level expenditure. Most non-staff expenditure is to be covered by revenues (IGR) generated by the facilities themselves. The distribution of overhead is not available.

Many health facilities, such as, the Ekiti State University Teaching Hospital (EKSUTH) is largely dependent on non-budget sources for recurrent costs. This hospital, for example, obtains about two-thirds of the funding for its non-staff recurrent costs from IGR, specifically from NHIS transfers (74 million Naira in 2011) and user charges (146 million naira on average in 2011 and 2013). The rest comes from the state budget subvention. The exact proportion is unclear, as the subvention to parastatals – e.g. the EKSTH hospital – does not discriminate between recurrent and capital expenditures.

There is lack of transparency and accountability in how state health budgets are used. The Annual Financial Statements of State Governments and LGAs, though may be prepared on time (within six months of the year end), are not presented at the detailed level as per the State Budget, especially with regards to capital expenditure. This practice hinders transparency and accountability as well as informed decision making on PHC programmes.
2.4. Resource Flows towards PHC in Niger and Ekiti states

Resources in PHC in Niger and Ekiti states are fragmented in its flows and are complex. The flow of funds within the Nigerian health system is quite complex, due to the federal nature of the state and the existence of many horizontal (across Ministries, departments and agencies and organizations of same level) and vertical (across levels of government and facility levels) flows. Several parastatal agencies are responsible for coordinating and funding specific health services or programs, especially PHC, hospital care, and HIV/AIDS, at the federal and state levels.

While the constitutional arrangement assigns the responsibility of funding PHC to Local Government, federal and state governments also provide support to public health and PHC programs through federal and state budgets. Public health programs also receive external financing and which is mostly managed by federal government (e.g. FMOH, NACA, and others). They fund and run vertical PHC programs, often uncoordinated, to strengthen the PHC system in the country. These programs include Tuberculosis and Leprosy control, Malaria control, health education and environmental sanitation, HIV/AIDS programs, etc. [See Annex 2 for additional fund flow, including by programs].

Additional federal special funds are also set up to support public health and PHC services. Funds for a specific program such as the HCP (Health Coverage for the Poor, which focuses on Maternal and Child Health) was allocated from FMOH to national health insurance scheme (NHIS), and then as a pre-payment directly to public hospitals or PHC facilities. Other funds, originating from the Global Fund or Global Alliance for Vaccine Initiatives (GAVI), were channeled through National Agency for the control of AIDS (NACA) and the NPHCDA, where they were used to procure goods or services (e.g. vaccines, training) and transferred in kind to States and then to health facilities (see discussion on vertical programs). Finally, some PHC facilities receive funds in cash from Development Partners as support for certain activities (e.g. outreach activities). Complexity in resource flows and weaknesses in their recording and reporting imply that the national health accounts estimates do not reflect all financial flows in the health sector (Box 1).

Several vertical programs are funded by or through federal agencies that transfer in kind-resources to state (and sometimes local) governments. These resources are often transferred in kind rather than in cash. Several of these flows are channeled through the National PHC Development Agency (NPHCDA) (Box 2 and Table 2):
Box 2: Resource flows for vertical programs

(i) Global Fund funds for HIV/AIDS, Tuberculosis and Malaria are centralized by NACA (National AIDS Control Agency) which distributes them through two main channels: via NPHCDA to State Governments to public facilities in the states, and directly to private NGOs or Faith-Based Organizations (FBOs).

(ii) GAVI funds follow a similar pattern: they are channeled through NPHCDA to State Governments and public facilities.

(iii) The Polio Eradication Program is managed by World Health Organization (WHO) on behalf of NPHCDA, and distributed to state Governments.

(iv) Immunization vaccines are purchased centrally on behalf of NPHCDA by UNICEF and then distributed to State Governments.

(v) Federal activities related to Training, Monitoring & Evaluation and Supervision of public programs and facilities in the states are undertaken by NPHCDA and the Department of Hospital Services (for federal hospitals in the states), among others.

(vi) The Midwives Scheme (MSS) is a program run by NPHCDA to train and maintain a number of midwives in the states.

(vii) NHIS has been charged with managing enrollment to the Maternal and Child Program; public facilities in the states enroll pregnant women in the program, and are paid a per capita amount by the National Health Insurance Scheme (NHIS) through its accredited HMOs.

(viii) Finally, the Federal Government through NPHCDA and other MDAs, finance the construction or renovation of health facilities (PHCs for NPHCDA) and the procurement of larger or expensive equipment.

Many of these flows (including (i)-(v)) are in kind – goods or services – rather than cash. It is not clear at this point whether these transfers are systematically accounted for and valued in the State Governments’ accounting system; the NHIS maternal and child health (MCH) program clearly appears as IGR at the facility level but does not appear in the budget (see below in the next section).

<table>
<thead>
<tr>
<th>Name of MDA / Organization</th>
<th>Source of Fund and Area of intervention</th>
<th>Form of support –In-Kind or Cash</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Level Funding</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMoH: Vertical programs (Malaria Elimination Program, TB and Leprosy, HIV and Community Health Programs)</td>
<td>Budget provision: Procurement of treated bed nets, Establishment of 100 TB DOTS center, procurement of equipment and laboratory reagents and other consumables and support implementation of policy on leprosy. Procurement of antiretroviral (ARV) drugs test kits, provision and management and National health promotion program. Newborn care, Gender, Elderly, Adolescent’s, Hygiene, and development of guidelines, policy, and protocols, information/education/communication (IEC) materials, coordinating meetings and documentation and implementation on national nutrition program.</td>
<td>In-Kind support to facilities with long lasting impregnated nets (LLN), ARV drugs, Health promotion programs and production of IEC materials.</td>
</tr>
<tr>
<td><strong>NPHCDA: Immunization and Support for MSS</strong></td>
<td>Federal Budget: Promotion and Delivery of PHC services, immunization, and support to MSS</td>
<td>In-Kind support to facilities</td>
</tr>
<tr>
<td><strong>NHIS</strong></td>
<td>Budget provision: Payment to providers for formal sector beneficiaries – PHC service. Fee for services for hospitals and Capitation to PHC Facilities</td>
<td>CASH- procurement of services</td>
</tr>
<tr>
<td><strong>SURE-P:</strong></td>
<td>Federal Budget: Mother and child (MCH) Programs:  • Salaries of midwives, CHEWS</td>
<td>In-Kind Support to PHC facilities</td>
</tr>
<tr>
<td>Name of MDA / Organization</td>
<td>Source of Fund and Area of intervention</td>
<td>Form of support – In-Kind or Cash</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td></td>
<td><strong>MCH procurement of drugs and other consumables</strong>&lt;br&gt;<strong>infrastructural capital development and procurement of equipment</strong></td>
<td></td>
</tr>
<tr>
<td>NACA</td>
<td>Budget Provision/Presidency: HIV/AIDS testing counselling and treatment of HIV patients</td>
<td>In-Kind Support: HIV awareness campaign, HIV kits and ART.</td>
</tr>
<tr>
<td>NHIS-MDG Fund</td>
<td>Federal Budget Provision: Federal intervention fund for MDG- MCH Payment to providers for MCH beneficiaries – PHC service. Fee for services for hospitals and Capitation to PHC Facilities</td>
<td>CASH- procurement of MCH services</td>
</tr>
<tr>
<td><strong>State Level Funding</strong></td>
<td>Supply of ART drugs, nets and anti-malaria campaign. State Budget Provision: Procurement of equipment and laboratory reagents and other consumables and support implementation of policy on leprosy and TB, including TB DOTS kits</td>
<td>In-kind support to facilities</td>
</tr>
<tr>
<td>SMoH-DRF</td>
<td>State Budget Provision: Capitalization of state drug revolving fund managed by the Central Medical Store (CMS)</td>
<td>Cash support to CMS</td>
</tr>
<tr>
<td>SMoLG</td>
<td>Local Government Agency (LGA) Budget</td>
<td>Cash – Payment of Salaries of PHC staff</td>
</tr>
<tr>
<td>SACA</td>
<td>State Budget: HIV/AIDS</td>
<td>In-Kind Support to facilities</td>
</tr>
<tr>
<td><strong>Local Government Level Funding</strong></td>
<td>LGA Budget</td>
<td>Cash-imprest, In-Kind Equipment and supplies</td>
</tr>
<tr>
<td><strong>Facility Level Funding</strong></td>
<td>Generated from sale of cards, drugs, laboratory test etc</td>
<td>Cash support</td>
</tr>
<tr>
<td>Development Partners/unilateral and Multilateral Agencies, NGOs</td>
<td><strong>Primary Health Care Programs support:</strong> UNICEF; Global Fund; WHO, World Bank; USAID; DfID</td>
<td>Cash Support for logistics, transportation. In-kind support – drugs, equipment, infrastructure development etc.</td>
</tr>
</tbody>
</table>

*Source: World Bank.*

*In summary, resources for PHC came from multiple sources, including federal, state and local government, donors and internally generated revenue (IGR).* As represented, PHC facilities receive resources from (a) federal budget through federal ministry of health (FMOH) via national primary health care development agency (NPHCDA) to state primary health care development agency (SPHCDA), state ministry of health (SMOH) via SPHCDA and LGA DPHC, (b) vertical program grants e.g. millennium development goal (MDG) fund/Global Fund (via state MOH, or via LGA DPHC), and (c) internally generated revenue (National Health Insurance Scheme (NHIS), user fees).
Overall, PHC services in Nigeria are financed through three main sources: (i) public budgets at various government levels; (ii) international donors; (iii) private financing and internally generated funds within PHC facilities. The diagram below shows that a PHC facility could be receiving resources (in-cash and in-kind) from at least 6 direct official sources. Additional official financing flows could come indirectly. While, off-budget resource flows are not shown here. These multiple financing flows limit planning, coordination and monitoring [Boxes 3 and 4]. Additional programmatic financing flows are provided in Annex 2.

Box 3: Fund flow for primary health care

Source: World Bank
Box 4: Fund flow for primary health care

Allocation from Federation account (mineral and non-mineral revenues and VAT)

Federal Gov't

States Gov't

LGAs

Donor

Health

SGF

SMOH and its programs

SPHCD

Donor

SMOH Joint account

Salaries of LGA staff, statutory deductions

LGA net allocation = IGR

LGA Dept of Primary Health Care

PHC Facilities

Key:

<table>
<thead>
<tr>
<th>Fund flow</th>
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<tbody>
<tr>
<td>In-kind support</td>
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<tr>
<td>In-kind and cash support</td>
</tr>
</tbody>
</table>

Source: Authors, World Bank.
Insufficient funding is an important issue and contributes to many challenges in delivering effective PHC services, but is far from being the sole problem. Health care delivery in the states of Niger and Ekiti – and probably in Nigeria as a whole – suffer from a number of weaknesses and challenges ranging from governance to financing, resource planning and use, and management of service delivery, which directly contribute to the low effectiveness of the health system. Supporting systems in place are not enforced or used effectively, and in some cases are not designed in the most effective way. This is the case in particular of the planning and budgeting system and of information systems at large. While these issues have been broadly known for some time, through past assessments and recent surveys and reports, evidence is scarce on their relative magnitude, how these problems play out and impact on service delivery in actual facilities and programs, and on the relative merits of possible strategies to address them. In particular, consistent information is not available on how services are organized and resources managed and spent at the facility level, which prevents effective planning, budgeting, monitoring and evaluation of health services.”

Some of the specific areas of concern that contribute to the low effectiveness of the health system are:

- A conflictive pattern of deconcentration cum centralization of decision-making that reduces the cohesion of the health system;
- Fragmented and unreliable information systems, that prevent consistent and comprehensive information to be available when needed;
- Poor accountability mechanisms and a lack of focus on results and performance;
- Lack of adequate management tools and weak planning and budgeting systems, that prevent efficient resource management;
- Low credibility of the budget system due to its incompleteness, dissociation from planning or actual needs, delays in fund release and wide variations in budget allocations;
- Prioritization of capital expenditures in the public budget, coupled with an over-reliance on facility-level IGR for most non-staff recurrent expenditure;
- Generally low level of public funding for health in comparison with other African countries and Middle-Income Countries;
- Dissociation of resource allocation from the prevalent burden of diseases, with overemphasis on hospital services;
- Lack of uniform regulations and systems for management of user charges and other areas;
- Large variations in allocation and availability of human resources, which does not reflect actual needs;
- Fragmented and unreliable supply of drugs and other critical supplies;
- Weak and largely ineffective technical supervision of service provision.
Accountability and Information systems within PHC

Similarities in the systems maintained in LGAs and PHC facilities of Niger and Ekiti states

- Niger and Ekiti states maintain e-payroll systems, and salaries are transferred directly into government employee bank accounts;
- However, general budgeting and accounting at LGAs are manual, and faces challenges from inaccuracies and errors;
- PHC facilities in both states collect IGRs;
- While drugs received through federal governments are accounted for, in-kind items obtained from Development Partners, such as vaccines from UNICEF, and drugs, test kits, LLINs, and other medical equipment which are also captured as PHC financing sources, are not formally recorded.
- Furthermore, there is no regular reporting mechanism (financial reporting) established for PHC facilities reporting to LGAs and as such financial returns cannot easily be compiled on IGRs used for facility maintenance and cleaning;
- The only visible reliable information system working in the PHC facilities in both states was the HMIS which records services provided and utilization of vaccines, drugs, therapy kits (TB DOTS), LLINs (although not being reported).
- No system for recording in-kind resources inflows was observed. In Ekiti state, the PHC facilities attempted to record expenditure in a notebook but no revenues were recorded. At best facility kept quantity invoice of commodities supplied to facilities. Such records were kept in loose sheets, as no such information was ever requested for by LGAs or other agencies.

Differences observed in the systems maintained in LGAs and PHC facilities of Niger and Ekiti states

- Ekiti State uses an e-platform for budget preparation that is web-based, but they do not have a software for financial recordings. Niger state relies completely on a manual process for budgeting and financial recordings;
- Ekiti PHC facilities maintain 2 separate bank accounts (DRF, and other revenues), although this is not the case for Niger PHC facilities, which while maintaining a bank account for NHIS capitation transfers, does not maintain for any other type of IGRs earned (either through DRF or through other services). For Niger state it is not a matter of in-access to bank accounts, it is however more about limited governance and enforcement of such policies and reporting requirements;
- Ekiti state has a policy on what share of the IGRs can be maintained by the PHC facilities for its use, and what must be pooled through its facility bank accounts. Either this policy does not exist or not strictly enforced in Niger state PHC facilities;
- In Niger PHC facilities, while cash receipts are used, manual cash books are not maintained for recording of cash transactions, and neither for reconciliation of both cash and in-kind transactions. However, there is no regular reporting mechanism (financial reporting) established for PHC facilities.
- In Ekiti PHC facilities, cash Receipts ledgers and manual cash books are regularly maintained (except for periodic gaps in some instances) for recording of cash and banking transactions.
CHAPTER III. Public Spending for Primary Health Care

3.1. Public spending for PHC

Public resource allocation for PHC

- The declining oil revenue in recent years, has severely affected budget flows and allocations in both Ekiti and Niger states. The internally generated revenue became the default sources of financing health operations;

- Health had in previous years also received low prioritization but in recent years, allocations and expenditures were even lower, given: (a) low releases, and (b) low budget execution;

- Among administrative levels, as health is devolved to LGA level, they finance the largest share of PHC expenditures;

- When budgets are reduced, personnel emoluments are given priority over all other budget items;

- 98-99% of LGA health budget goes towards personnel emoluments;

The federal health budget faces low prioritization, and was coupled with recent declines in real terms, although, priority was given to PHC. For the two fiscal years (FY2015 and FY2016), examined in the study, the overall federal health budget remained stable in nominal terms at about 250 billion Naira; however, it decreased in real terms and in relative share within the federal budget (from 5.1% to 4.1% of total government expenditure). During the period, PHC budget (which includes programs run by FMOH, NPHCDA, and other agencies administering the vertical programs) remain a small share of the federal budget (8% in FY2016) although increased in nominal terms by close to one third (from N14.5 billion in 2015 to N20.4 billion in 2016).

Given significant dependence on federal statutory transfers, state budgets faced volatility due to falling oil revenue, although Ekiti state experienced a drastic reduction compared to Niger state. In face of decreasing oil revenue shares, the overall state budget in Ekiti decreased by about 17% between FY2015 and FY2016. The Ekiti state health budget in FY2015 had represented a relatively larger share of the overall state budget than in Niger (6.2% vs 3.1%). However, in FY2016, the Ekiti state health budget took a severe blow with a decline of 76% (between FY2015 and FY2016), dropping to a meager 0.7% of the overall state budget. In Niger, during the same period, the reverse situation was observed with the overall state budget decreasing by a mere 2%, while the state health budget increasing by a quarter, reaching about 4% of the state budget.

Mixed results are noted in shares of state health budget allocated for PHC in both Ekiti and Niger states. While Ekiti shows a very small share, Niger shows a significant share of the state health budget allocated for PHC. In Niger, the official PHC budget in FY2015 represented a stunning 43% of the state health budget. In Ekiti, the official PHC budget represented a mere 6.1% of the state health budget in FY2015 and increased to 16.6% in FY2016 in the context of a severely shrinking health budget. However, PHC budget in Ekiti state dropped by close to four-fifth compared to the previous year, from N131 billion in FY2015 to N34 billion in FY2016.
Local government authorities (LGAs) are the primary financiers of PHC. At the LGA level, where most of the funding for PHC activities is observed, the budget for LGA Health Departments, was much larger compared to the state level health budget, especially the one devoted to PHC activities (SPHCDA), by a factor of 17 to 1 in Ekiti, and of 9 to 1 in Niger (for the entire state health budget the share of LGA health budget over state health budget is at a ratio of 2.6 to 1 in both Ekiti and Niger, that is, consolidated LGA health budget is 2.6 times higher than state health budget).

Budget execution for PHC

- Federal level not only allocates limited resources for PHC, but they also face budget execution challenges that are worse than that faced by both state and LGA levels;
- Generally, salaries are paid off, while restrictions are imposed on non-salary recurrent and capital budgets. However, during the fiscal year, Ekiti state faced severe liquidity constraints and which also affected releases for salary;
- Overall budget execution for PHC seems to be at around 60% of total PHC budget;
- While, almost 100% of personnel emoluments are released and executed, of the overheads and investment budgets, about 5% may be released;
- While about 40-45% of total health budgets (in Ekiti and Niger states) are allocated for PHC, eventually only half of this allocation is released for PHC (or about 20-25% of the health budget).

Budget execution remains a challenge and the execution rate for PHC budget at the federal level is worse than both state and LGA levels. The PHC budget’s execution rate, in the context of decrease in revenues of oil production, was only about 60% of the budgeted envelope for FY2015. Ultimately, the actual spending for PHC services was hence about half the share of the officially allocated federal health budget during that year (3.1 % compared to 6.1%).

Low budget execution rates have been dominating the PHC health budget at the state level, and primarily a result of low and late releases. In both states, apart from personnel emoluments, most budget items were hardly released or spent.

- In both states but especially in Ekiti, the SPHCDA budgets have much lower execution rates than observed across the state budget. Indeed, the execution rate of the SPHCDA budget in Ekiti was only 10.8% of the official budget. For the first quarter of FY2016, execution rate was 3.9%.
- In Niger, higher execution rates were observed. Still, actual expenditures only represented about one-fifth for the health budget and one-third of the approved budget for PHC services put forward by SPHCDA.

These low execution rates observed in the health sectors in both states are likely due to very low release rates, especially of capital and overhead expenditures compared with other budget categories and sectors, as health agencies in both states reported spending all resources released by the Treasury.

LGAs too face budget execution challenges, especially for capital and overhead budgets. Personnel emoluments is given priority over all other budget items. A higher execution rate of the budget was observed across LGAs in both states compared to federal and state budgets. Still, the execution rate of the
PHC budget in FY2015 across LGAs was about 60% of approved budget (58% in Ekiti and 62% in Niger), with very low rate of actual expenditure of capital and overhead budgets (less than 5% in both states).

**Eventually, less than 50% of the budget is executed for PHC.** While budget allocation for PHC is about 45-50% of total health budget in Ekiti and Niger states, actual spending is about 20-25% of the health budget allocation. But, when considering non-salary recurrent spending, less than 5% is spent. However, less than 1% arrives at PHC facilities. [Figure 6].

**Figure 6: Public Resources in the Health sector toward PHC services in percentage, by levels (2015)**

Source: Authors. World Bank.
Public actual expenditures for PHC: how much is spent and where is it spent?

- The primary sources for financing PHC are coming from LGAs. Federal government allocations for PHC in the states of Ekiti and Niger are negligible;
- Total per capita (actual) health expenditure for PHC was about $6 for both Ekiti and Niger states;
- The per capita (actual) non-salary recurrent spending for PHC was however lower at $1.50 in Ekiti state and $1.80 in Niger state;
- Less than 30% of PHC spending goes towards operations;
- Of the PHC budget, only half of it is received by PHC facilities. Otherwise, most of it is kept at the district level for running public health programs, and for running other related activities;
- When human resources are excluded, the amount of public resources reaching PHC facilities is about 7 cents ($0.07) per capita in Ekiti state and 4 cents ($0.04) per capita in Niger state;
- Less than 2% of PHC public resource received at PHC facilities goes towards operations.

Public resources for health (including PHC) are available from all levels of government as well as international donors/NGOs, but federal government budgetary contributions are negligible. Of these public resources, about 98% (99% in Niger) comes from the LGAs and 2.3% from the state level in Ekiti (0.8% in Niger), while the federal level contribution is negligible.

Per capita spending for health in both Ekiti and Niger states are small and very limited public resources go towards financing operations. Official public health resource allocation per capita totaled $25.40 in Ekiti, and $18.30 in Niger. Actual public expenditure for health are lower, about $18 per capita in Ekiti and $15 per capita in Niger. When excluding human resources, actual expenditures for health represent about $2.2 per capita in Ekiti and $3.2 per capita in Niger. Less than 20% of actual spending in health goes towards operations.

Public expenditures for PHC are limited. Resources for PHC services are generally allocated to LGA as public health programs managed at district level are also financed by these resources. Total per capita (actual) health expenditure for PHC was about $6 for both states. The per capita (actual) non-salary recurrent spending for PHC was low at $1.5 in Ekiti state and $1.8 in Niger state. Less than 30% of PHC spending goes towards operations.

Public expenditures for operations at PHC facility level is negligible. Some of the PHC resources come to PHC facilities, while others are retained at the district level as they too are for larger public health programs. When human resources are accounted for, public resources made available at PHC facilities amounts to $3 per capita in Ekiti and $4 per capita in Niger. This is about 50-65% of total PHC resources available to LGAs. However, most (about 98-99%) of these resources go towards financing personnel emoluments. When human resources are excluded, the amount is about 7 cents ($0.07) per capita in Ekiti and 4 cents ($0.04) per capita in Niger. Less than 2% of PHC resource received at PHC facilities goes towards operations. [Figure 7].

Ekiti state, as compared to Niger state, received higher per capita resource allocations for health. However, when it came to PHC, on a per capita basis, both states received almost similar amounts. When personnel emoluments were excluded, Ekiti states received slightly lower per capita spending at PHC facilities than Niger states.
Eventually, the reception of operations resources for PHC at PHC facilities are negligible, as (a) resource allocation for PHC is low, (b) operations resources released to PHC facilities is low and (c) budget execution of these operations resources are low.

3.2. Non-public spending for PHC

- Funds for PHC staff personnel emoluments do not come from non-public spending;
- PHC facilities rely heavily on IGRs for PHC facilities operations;
- While both states earn a very small amount through IGRs earned at PHC facilities: Niger state, as compared to Ekiti state, earn a higher per capita amount through IGRs ($0.41 versus $0.04);
- Ekiti state, as compared to Niger state, relies on on-budget donor support they receive from federal government;
- For operations budget, in per capita terms, user fees contribute $0.27 across the two states, donors contribute about $0.06 per capita on average in both states, and government provides less than $0.01 per capita to PHC health centers.

Internally generated revenue plays a significant role for operations at PHC facilities. Given such low operations resource support from government sources, PHC facilities rely to a large part on IGR (user fees), especially in Niger, and off-budget donor contribution (especially in Ekiti) to finance their operations. Niger rely at 86% on user fees (41 cents of $0.41 per capita) to finance their non-wage expenditures, compared to around 37% in Ekiti (4 cents or $0.04 per capita).

Donors provide support for operations but not towards personnel emoluments. Donors contribute to 54% of non-wage revenues in Ekiti state compared to only 14% in Niger state. In per capita terms, user fees contribute 27 cents ($0.27) on average across the two states, donors contribute about 0.06 cent ($0.006) per capita on average in both states in direct and indirect support other than personnel emoluments, while government provides less than 1 cent ($0.01) per capita to PHC health centers.
Direct donor contribution to PHC facilities is very low. While Ekiti relies on donor contribution (mostly through on-budget), Niger is not as dependent on donor contributions.

3.3. Total spending for PHC

PHC receives limited resources for health. When all sources of financing are considered (public, private, in-cash and in-kind), the amount is no more than $4 per capita. Government overall finances about 92% of PHC spending. Government sources are the primary financing for PHC, but significant amounts are from LGAs and for personnel emoluments. Earning through user fees is about 7% and earnings through donors is about 1.5%

PHC receives negligible resources for health operations from government sources. Of operations spending share, government finances on average less than 5%, while user fees finances on average about two thirds. The balance comes from donors⁴. So, public sources are the least relevant to finance PHC operations. [Table 3].

⁴ Direct donor contributions are resources directly allocated by donors to PHC facilities reported by PHC facilities through the survey modules. Donors’ indirect contributions to PHCs are support provided by donors through federal and state transfers, in particular cash and in-kind support by donors to FMOH vertical programs and SPHCDA for PHC services (for non-salary purposes).
Table 3: Actual contributions to PHC operations (2015)

<table>
<thead>
<tr>
<th></th>
<th>Ekiti</th>
<th>Niger</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% of total revenues (excluding salaries)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>User fees</td>
<td>36.6</td>
<td>85.8</td>
<td>67.2</td>
</tr>
<tr>
<td>Donors - direct</td>
<td>3.0</td>
<td>5.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Donors - indirect</td>
<td>50.6</td>
<td>7.6</td>
<td>13.4</td>
</tr>
<tr>
<td>Government</td>
<td>9.8</td>
<td>1.7</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>% of total revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>User fees</td>
<td>1.4</td>
<td>8.9</td>
<td>6.1</td>
</tr>
<tr>
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<td>0.5</td>
<td>0.4</td>
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<tr>
<td>Donors - indirect</td>
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<td>0.8</td>
<td>1.1</td>
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<tr>
<td>Government</td>
<td>96.5</td>
<td>89.8</td>
<td>92.4</td>
</tr>
<tr>
<td><strong>Total revenues (excluding salaries) $ per capita (a)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>User fees</td>
<td>0.045</td>
<td>0.407</td>
<td>0.270</td>
</tr>
<tr>
<td>Donors - direct</td>
<td>0.004</td>
<td>0.024</td>
<td>0.016</td>
</tr>
<tr>
<td>Donors - indirect</td>
<td>0.062</td>
<td>0.036</td>
<td>0.046</td>
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<tr>
<td>Government</td>
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<td>0.009</td>
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<tr>
<td><strong>Total</strong></td>
<td>0.123</td>
<td>0.474</td>
<td>0.342</td>
</tr>
<tr>
<td><strong>Total revenues - $ per capita (a)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>User fees</td>
<td>0.045</td>
<td>0.407</td>
<td>0.270</td>
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<tr>
<td>Donors - direct</td>
<td>0.004</td>
<td>0.024</td>
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<tr>
<td>Donors - indirect</td>
<td>0.062</td>
<td>0.036</td>
<td>0.046</td>
</tr>
<tr>
<td>Government</td>
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<td>4.127</td>
<td>3.730</td>
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<tr>
<td><strong>Total</strong></td>
<td>3.183</td>
<td>4.593</td>
<td>4.063</td>
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</tbody>
</table>

Source: PETS NG 2016, module 1 and 2, as well as module 3 and 6 based on retrospective data collected from the single vertical programs at the Ministry of Health as well as the Ministry of Budget and Economic Planning and retrospective data by the state Ministry of LGAs in Niger and by the single LGAs in Ekiti. Note: Direct donors’ contributions refer to the revenues observed at the PHC level as coming directly from donors, while indirect contributions are imputed using information on transfers from donors to Federal, State and LGA level of government directly for PHC facilities to determine the share of government expenditure (excluding salaries) likely sourcing from donors. (a) A 12-month projection based on the 7 months covered from the PETS between October 2015 and April 2016 is used. Population projection based on the 2006 population census with annual population growth assessed at 3.1%; exchange rate: 1$=199N.

In summary, both states relied heavily on public sector to finance PHC, but mostly for personnel emoluments. On a per capita basis, Niger state received about $4.60 per capita for PHC, while Ekiti state received about $3.20 per capita (2015). Government financed most of these resources: for Niger state (90%), and for Ekiti state (96%). The balance of financing came from IGRs and external financing. Over 90% of resources were for personnel emoluments (90% in Niger and 96% in Ekiti).

PHC facilities in both states had very low amounts for covering operations costs, and they relied heavily on off-budget sources, example, IGRs. PHC facilities of Niger state relied heavily on user fees for non-wage recurrent spending (86%), while Ekiti state relied heavily on indirect (on-budget) contribution from donors (e.g. vaccines, drugs, and others) – 50% - followed by user fees (36%). While Niger state, on average, earned about $0.40 per capita from user fees, Ekiti state earned one tenth of that ($0.04). On average, Niger state received about $0.50 per capita from non-wage salary spending (this includes both in-cash and in-kind), compared to Ekiti state of $0.12 per capita. Government contribution was very small for non-wage salary: for Niger state it was 2%, while for Ekiti state it was 10% in FY2015. From public and

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5 Direct donor contributions are resources directly allocated by donors to PHC facilities reported by PHC facilities through the survey modules. Donors’ indirect contributions to PHCs are support provided by donors through federal and state transfers, in particular cash and in-kind support by donors to FMOH vertical programs and SPHCDCA for PHC services (for non-salary purposes).
external financing, about 85% resources are transferred as in-kind (drugs, vaccines, equipment, training). What in-cash resources are transferred, come from IGR, external financing, and from other donors and non-governmental organizations (NGOs).

### 3.4. Availability of Resources at PHC level

*The government is the most important source of resources for public primary health care facilities.* However, its support to facilities almost entirely comprises of wages and salaries. During the period of the survey, none of the facilities in the sample received cash from the government in Ekiti and only one percent received such support from the government in Niger. While, outside donor provided support through on-budget, however, government’s spending of its own resources to operations for PHC is very limited.

*The largest value of non-government support is made by international agencies and NGOs to the government instead, especially through vertical programs and other projects.* Adjusted for their contribution through government channels, donor support constitutes 12% and 9% of support to PHC facilities for Ekiti and Niger states, respectively. Donors – international agencies in particular - provide less of their support directly to facilities, which is reflected in such support accounting for less than 1% of PHC facilities’ resources. [Figure 8].

**Figure 8: Composition of PHC revenues by source**

(a) Unadjusted for indirect donor support  
(b) Adjusted for donor support to government

<table>
<thead>
<tr>
<th></th>
<th>Ekiti</th>
<th>Niger</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
<td>97</td>
<td>85</td>
</tr>
<tr>
<td><strong>Non-government</strong></td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td><strong>IGR</strong></td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: Authors, World Bank.

*Resources at PHC facilities are inadequate, and spending is less responsive to gaps in availability of drugs, medical equipment and infrastructure.* Although spending may be responsive to a combination of (a) a shortfall in non-wage spending and (b) a smaller share of government’s health budget is devoted to PHC. Facilities do not receive discretionary funding from the government. While, resources from non-government sources is negligible. PHC facilities therefore try to make up for the shortfall using IGR but this also is inadequate.
While user fees provide a relatively significant contribution in Niger, they have a much smaller importance in Ekiti. In the former, user fees accounted for 12% of resources, making them the second most important source of revenues at the facility level. However, they did not contribute much in Ekiti where they made up only 3% of revenues received.

Based on actual revenues from all sources, the resource envelop of PHC facilities is quite low, when considering the demands against these facilities. Resources at PHC facilities (wages and salaries included), range from $15 to $22 per user, based on prevailing exchange rates at the time. The amounts are much lower in per capita terms as the resources PHCs receive and generate amount to N 235 per capita in Ekiti and N 533 per capita in Niger, thus equivalent to between $1 – 2.5 per capita.

The amount of resources received per capita in Ekiti and Niger, indicates that only a small share of public spending on health reached PHC facilities and points to lack of prioritization of PHC. Public spending is either concentrated on curative rather than preventative care or a greater share of this spending is not devoted to frontline service provision. Excluding user charges and direct non-government support, shows that government supported public PHC facilities to the tune of NG 225 and NG 465 per capita in Ekiti and Niger respectively, that is equivalent range from $1 to $2 per capita. This pales in comparison to the estimate of $16 and $19 government per capita spending in Ekiti and Niger respectively.

Efficiency in PHC spending – drugs availability

- Niger state public PHC facilities relied on IGR to procure drugs from the private sector. As a result, we find that the public PHC facilities were able to get drug replenishments faster than at public PHC facilities in Ekiti state.
- Ekiti state public PHC facilities relied on budget to procure drugs form public central medical stores through the help of drug revolving fund. As a result, although drug replenishments are not as fast, the prices of these drugs are much cheaper than other modes used by Ekiti or Niger states.
- Regardless of financing or procurement mechanisms applied, both states faced significant drug stock outs, as overall resources remained inadequate.

Medicines

Decentralized drug procurement privileges have certain benefits, but budget constraints damper much of those privileges. There was a significant autonomy in drug procurement: more autonomy in Niger state than in Ekiti state. As PHC facilities used their own sources of financing, they procured from those places where they could maximize benefits (e.g. efficient procurement, and least cost option). Niger state relies on IGR for financing drugs procured (74%), and they mostly procure from private sector (74%). While Ekiti states relies on purchasing from DRF (60%), and also procures mostly from government sources (89%). Ekiti PHC facilities had lower amounts earned through off-budget sources (IGR and other donors), so they did not have the means to procure through any options (public and private).

Drugs procured through private sector also showed a more responsive and timely delivery. Private procurement, as experienced by Niger state, had a higher likelihood of being more timely in delivering drugs than public DRF procurement (as seen in Ekiti state). Niger state procured a higher proportion of their drugs through private sector as compared to Ekiti state. Drug replenishment seemed poorer in Ekiti for tracer drugs and availability of drugs was lower in Ekiti in all months of the survey. The study could
not validate the quality of drugs (in terms of counterfeits), although, the same brand names and volumes were compared.

**DRF managed by central medical stores, benefiting from economies of scale, were able to offer drugs at lower prices.** While private sector procurement in Niger resulted in timely delivery, it was certainly not true for drug prices. Ekiti state mostly procured from the public sector/DRF. DRF was able to provide drugs for much cheaper prices than (a) private sector prices in Ekiti and in Niger, and (b) public sector prices in Niger. Niger state, on the other hand, procured mostly from the private sector, and which offered credit\(^6\) to facilities, and on average, drug prices were offered at lower than the Niger public sector (where DRF was managed by SPHCDA).

*Regardless of financing or procurement mechanisms applied, both states faced significant drug stock outs, as overall resources remained inadequate.* Budget is still highly constrained, and with limited contribution from the government, the supply of drugs is inadequate, irrespective of how they are finally financed or procured. The share of tracer drugs available each month barely exceeded 20-25% in both states. There was little variability across months, partly reflecting a low replenishment rate. The share of out of stock drugs ever purchased or received was below 15% in both states, with more frequent likelihood of purchases in Niger state. Out of the 46 tracer drugs, stock was never maintained for over half of them for the duration of the survey (6-months). [Figure 9].

**Figure 9: PHC facilities: drugs financing and availability for Ekiti and Niger for study period.**

(a) Disaggregation of drugs value by procurement source  
(b) drug stock out rate

![Bar chart](chart.png)

**Source:** Authors, World Bank.

**Basic equipment and infrastructure**

*Lack of basic infrastructure, equipment and drugs at primary health facilities attests to the inadequacy of resources at Primary Health Care facilities.* On average, facilities only had 2 of the six basic medical equipment in the minimum equipment SDI indicator (sphygmonometer, thermometer, stethoscope, weighting scale, sterilizer and refrigerator). They had less than 5 percent of tracer drugs available and only

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\(^6\) While the study was unable to investigate further on the credit / microfinance access available to public PHC facilities from private drug sellers, adhoc information suggested that such practices may be existing, and offers some additional flexibility to Niger state public PHC facilities to procure drugs from private sources (despite their own budget constraints).
21% had the minimum infrastructure (electricity, improved water source and improved toilets). The lack of basic medical equipment was especially glaring.

Despite the poor availability of medical supplies and equipment, facilities barely received them from government or non-government sources. In both states, less than 3% received medical equipment of any kind. Regression results of aggregate input availability indicators show these to be significantly correlated with receipt of drugs from NGOs or directly from the government and amount of discretionary funding received by facilities, which is mostly internally generated revenues. This suggest, that as drug availability is a proxy indicator. If PHC facilities as able to mobilize additional operational resources (through IGR, or donors, or government) to stock drugs, they are also likely to get basic equipment.

Without direct cash support and with low government spending on non-wage health expenditures, out-of-pocket spending is the most important source of financing for drugs, medical supplies and other expenses. Facilities generated most of their internal revenues from selling drugs, representing up to 75% of IGRs in Ekiti and 85% in Niger.

Conclusion

In summary, government is the most important source of resources for public PHC facilities. However, its support to facilities almost entirely comprises of wages and salaries. Outside donor provided support, government’s spending of its own resources to PHC is limited. Among the reasons for inadequate non-salary recurrent resources are PHC include: a combination of the shortfall in non-wage spending and a smaller share of government’s health budget devoted to PHC. Thus, PHC spending is less responsive to gaps in availability of drugs, medical equipment and infrastructure. PHC facilities do not receive discretionary funding from government and non-government sources are negligible. PHC facilities, although, try to make up for the shortfall by using IGR, but this too is inadequate.

Performance of facilities in terms of inputs availability is primarily dependent on having discretionary financing. Receiving direct in-kind support was another determining factor. Thus, the best performers are those facilities that raised more in IGR, received donor supplies of drugs, were in LGA that delivered drugs or were lucky enough to get cash support from the government. Nonetheless, purchase of medical equipment and upgrading of facilities infrastructure are totally neglected, being neither financed from discretionary facility funds nor by the government.

IGRs were more crucial for financing drugs, though procurement channels differ. Niger, which relied more on private purchases of drugs, replenished out of stock drugs more often than Ekiti, which depended heavily on public procurement. The cost of drugs depended on the predominant method of procurement in each state, with procurement from private sector being cheaper in Niger, but more expensive in Ekiti. Despite the procurement channel, the prioritized therapeutic drugs were the same. Thus, public procurement of drugs doesn’t seem to offer any particular advantage over private procurement, which instead seemed more responsive to drug stock outs.
CHAPTER IV: Discussions

There are a few aspects of the study findings that lead us to discussions on policy implications.

4.1. Public finance management

Budgeting process

Little consideration is given to performance- or output-based planning and budgeting. Even if planning may have been done at decentralized levels, the budgets are not prepared on actual needs for implementation and for outputs. Governments continue to use a historical budgeting system, priority is given to personnel salary, and less to everything else. For example, planning starts at the facility level (bottom-up) but final planning and resource allocation decisions are centralized.

There is no programmatic budget. There is no clear understanding from the budget what is allocated for various programs or what is allocated for various levels of care, example, PHC. Budgets do not clearly identify priority programs, such as, PHC. The budget is distributed between three budget categories: recurrent (personnel, overheads) and capital investment. The latter includes capital and operational items. The rational used is that external financing is monitored closely as capital projects, and so are other key programs and actual capital investments. Just looking at the budget in its final form, it is difficult to really understand how much is budgeted for operations. Nigeria, though, is considering a new chart of accounts.

Budget classification

The current budget classification shows a large proportion of resources allocated to capital expenditures. However, a closer look at the detailed items categorized as such indicates that in many cases this classification is misleading. For example, nearly all allocations by NPHCDA to vertical programs are categorized as capital, when in fact a substantial part is for services (consultancy fees), drugs and supply kits, allowances, training, or vaccines. An exercise on chart of accounts and reclassifying recurrent from capital and development budgets would bring about some clarity.

Capital versus recurrent spending

There are wide deviations between budgeted estimates and actual spending (e.g. Niger PEMFAR 2009). But these large variations are mostly for capital expenditure rather than recurrent expenditures. Allocation patterns show a high proportion of capital expenditure; this is due to (i) much of non-staff recurrent expenditures being funded through non-budgetary sources, and (ii) misclassification of certain items as capital when they are not, especially for projects and vertical programs.

An analysis of budget documents and assessments for federal and state MDAs alike show several shortcomings.

Budgets and actual spending

Systematic biases are found in budget estimates versus actual allocations: actual revenue is consistently lower than budgeted for most years, leading to budget deficits against budgeted surpluses. There is a high
incidence of extra-budgetary spending in most MDAs, both in budgetary line items (especially in Transport and Travel and Miscellaneous) and because of the importance of non-budgetary funding (mostly from facility-generated IGR).

4.2. Strategic purchasing

Budget prioritization and allocations

Social sector allocation (Education and Health) showed large drops in relative share/reallocation of Government Expenditure between budget estimates and actual expenditure, in favor of economic sectors (Transport, Power).

There is low prioritization and low resource allocation of the public-sector budget for PHC, and this is at all levels of the government (federal, state and LGAs). Health is devolved to the state, and PHC is the responsibility of the LGAs. But, there is non-clarity on the roles of federal, state and LGAs in commitment for public health goods and services, and for PHC. LGAs lack capacity and face several constraints, including budgetary. From among federal and state levels, who is responsible for what, including in terms of resource envelop, allocation, monitoring and other technical and human resource support.

Public resource allocation is inefficient. Funding sources seem to be specialized: government budget finances personnel and capital, while non-personnel operational expenses are funded through IGR from user charges, the NHIS and donors. Funding is not pooled and highly fragmented. Funding allocation is heavily distorted and inefficient in face of the predominant burden of disease: resource allocation – and therefore health care delivery – prioritizes hospital care, and especially tertiary-level facilities; 68% of government expenditure on health in Ekiti State is allocated toward hospital care, and 41% toward the two tertiary hospitals; in Niger State 83% of the government payroll on health goes to hospitals in 2013.

Procurement of drugs

Procurement is fully decentralized to facilities of all sizes (with the exception of drugs), but this contributes to loss of scale economies and unstandardized and nontransparent procurement practices. Facilities are responsible for spending on goods and services but have no say in resource allocation.

Budget execution

Even though budgets suggest that resources are being committed to PHC, approved budgets or releases are low, and so is the execution of the budget. While, for the former, there is need to engage treasury and Ministries of Finance in discussions, for the latter, there is also need to engage the Ministries, Departments and Agencies (MDAs). As MDAs don’t prepare budgets with outputs in mind, and treasury has their own ceilings of what they can approve, much lower amounts actually reach the MDAs and often late in the FY. The late, infrequent and low amounts of release, coupled with poor capacity, limited planning and often cumbersome procurement procedures, effects the final execution of the budget. These capital investment projects (that include operations) have had a challenge to be executed.

Pooling

Even though the country has a NHIS, there is little benefit in terms of risk pooling. The NHIS manages limited risk pools (example, only formal civil servants or 5% of the population), and limited budgets (mostly they reimburse hospitals for civil servant use). There is little consolidated information on the state health
insurance schemes. There is however potential to consider pooling and purchasing mechanisms and consider the incentives it could consider for targeting and performance.

There is limited pooling or consolidated health budget. Various MDAs take on different responsibilities and funds (most in-kind) are allocated for PHC. There is little prior knowledge by PHC facilities on how much of what resources will come their way and by when. Also, the resources do not cover the entire costs of running the PHC facilities and even what is budgeted may not be released. NHIS had a MDG capitation fund, and while that program was not evaluated and was administered only in few states (and not during this study period), NHIS or state basic health fund could be a potential solution for this challenge.

**Low budget release and tracking**

Information on actual releases and spending are not easily available, while information on budgets are easily available. There is little tracking of where funds are spent. This challenge seemed to be far greater at federal level. Resources are diversified and controlled under various MDAs, and information is not consolidated under any agency. While actual spending by the three budget categories may be tractable, recording of actual spending by programs was difficult to gather. Little knowledge is available on off-budget revenue receipts. Data was not easily accessible to dive deeper into budgetary details.

This is another area that is of importance, to have electronic databases – chart of accounts for health expenditure. This will certainly also help government monitor expenditure data through national health accounts. Currently, information on actual financial receipts (including IGRs) and spending in health are limited and lacking in cases.

**Budget controls and recordings**

Multiple flows of these different kinds make up the basket of resources that is available for facility management, but there is no mechanism in place to consolidate these different sources, so it is presently impossible to measure the total funding for any given facility of type of facility (e.g. secondary hospitals or primary care facilities).

Facilities have little control and management over budget flows and resources, especially when they do not have their own budget allocation (as is the case for PHC facilities), as most of these purchases and payments are made centrally. Little information is recorded at the facility level except for staff numbers and stock management. Transfers in kind most often bypass the budget and are not systematically recorded at the facility level, except when goods are stocked at facility; even then, experience has shown that reliability of information varies substantially. IGR is the main source of funding for inputs, except vertical drugs and vaccines and small services such as utilities, rent, etc.

**Performance**

As most resources come for personnel salaries, and as it goes directly into personnel bank accounts, it may not reflect the actual presence of performance of staff and there is little control at MDAs itself. Compacts between administration and providers and/or performance based incentives and payments could have some influence. While absenteeism was noted at various public facilities, staff knowledge for better performance was a bigger challenge. While budget overheads are supposed to include staff training, these overheads do not seem to include much budget for training, including insufficient resources for supervision.

As most transfers are made in-kind from various administrative levels, there is need to have a clear understanding of these flows as well. While it was easier to know how much of the in-kind resources were
released at federal level, (for example, how many vaccines or drugs were distributed), little knowledge was available at federal level on how much went to each state or LGA, or how much went for PHC. The federal MDAs seem to track inputs such as receipt and releases or distribution rather than outputs, such as who has benefitted from it. At federal level, there is little knowledge by decentralized levels. Even when it came to the National Health Insurance Authority (NHIA), it was easier to get information on which private HMO was contracted and by how much, rather than who benefited, that is which states, LGAs, or facilities (hospitals, PHC) or population sub-groups received what reimbursements, etc.

The availability of appropriate clinical personnel and drugs are among the key indicators of quality for clinics as perceived by consumers. Many PHC facilities had unfilled posts for personnel. It is not clear whether these were unfilled resulting from limited budgets or unable to attract personnel to those posts. Further, public budgets were hardly available for drugs. Budgets also faced execution challenges for overheads and capital investment – two budget categories where drugs could be budgeted under. It is not clear from the study if appropriate plans and budgets were in place for PHC essential drug list. Such a drug list is available, and hence there is an easy way to certainly project budget requirements. Whose responsibility is it to finance these drugs, and to ensure their availability at the PHC facilities? Essential drugs are often not available at public PHC facilities. These could be a result of poor planning, low budgets, and low and late budget releases to allow for bulk procurement. There could also be an implicit incentive by the various levels of administration that facilities should generate their own revenues through copayments and use them to procure drugs (although drug procurement is generally not decentralized, but when central medical stores or drug revolving funds (DRF) cannot respond to requests, facilities are permitted to purchase their own drugs). One point to note however is that hospitals did not face as large a drug stock out as PHC clinics. The PHC essential drugs package is much cheaper than hospital packages. One explanation is that hospitals get larger volume of patients, and can earn a higher copay from them. Also, they have larger budgets, and an additional source of financing from NHIS.

Drugs stock outs were rampant in PHC facilities in both states, whether they relied on DRF or own purchase. There were insufficient funds, either through public sources, or even through private sources, to allow PHC facilities to maintain stock of essential medicines. This obviously affected patients from accessing these facilities. Patients either decided to go to private facilities or to bypass the public PHC facilities in favor of hospitals.

**Internally generated revenue**

Policies and practices for charging, recording and reporting user fees are not clear or not standardized, not only across states but also across similar facilities; different facilities appear to charge for different services. Retaining and use of IGR also varies by facility, which may allow local managers to prioritize critical needs, but may also allow for inefficient use of scarce resources. Even though it is submitted, information on IGR is not available in a consolidated manner. Financing patterns also vary significantly across facilities, as NHIS has implemented its different programs (Maternal and Child Health, community health insurance, civil servants scheme) in some states and some facilities but not in others; where it is in place, it constitutes a significant source of revenue (IGR) at the facility level.

Information on IGRs were not known by LGAs or by States. This is an important source of income for PHC. Bank accounts were not maintained by all PHC facilities in Niger, although were in Ekiti, and therefore there was no deposit made into a system, which could capture such information. Also, there is no financial reporting mechanism from PHC facilities to LGAs that require reporting of all financial information (revenue and expenditures), including for IGRs.
Verification

While financial records were expected to be maintained at the local government authority levels, data was not necessarily disaggregated and completed. Audit certificates were not necessarily available.

With regard to the Ekiti Local Government Authorities, the Medium-Term Budget Framework (MTBF) for the financial years 2014-2016 is their first involvement in that process. However, in the absence of elected councilors, LGA Budgets are approved by the State House of Assembly and have experienced enormous delays. Hence, LGAs have operated much of 2014 without approved budgets. For financial reporting purposes, MS Excel is being used at the LGAs to maintain accounting records and financial statements. Audited Financial Statements of LGAs are not known to be prepared by the six months deadline given in the Fiscal Responsibility Act 2010 and to be published. However, the Ministry of Local Government and Community Development exerts control over the execution of LGA Budgets, with thresholds established for approval of expenditure payments.

- With regards to the Niger LGA, MS Excel is also being used to maintain accounting records and financial statements at the LGA level. The Chanchaga LGA visited was able to produce General Purpose Financial Statements (GPFS) for financial year ended 31st December 2013 by 30th June 2014 (as stated), though audit certificate and date signed could not be obtained from the Financial Statements provided. The GPFS is cited as being prepared in compliance with the Finance (Control and Management) Act, 1958.

4.3. Policy and programmatic implications

The study points to the fact that there is need to strengthen public financial management systems at decentralized levels, including for LGAs. Facility based financial management systems also need to be systematized and strengthened. There is need to not only strengthen systems but also to apply bottom up and inclusive budgeting and planning processes. Such processes may exist in Nigeria, but not fully appreciated and not made use of. Community support could be beneficial to monitor and facilitate. This can have a significant influence in prioritization and re-allocation of resources in favor of PHC.

Payroll system

An e-payroll system is being used for payment of salaries with an e-platform for making those payments into the individual bank accounts of workers. The LGAs however do not report payroll by PHC facilities, and the difficulty of separating salary expenditures by facility is compounded by the mobility of personnel and the frequency of changes in posts as confirmed by some of the LGA Financial officers interviewed. Electronic databases are not maintained for all accounts at LGA levels. LGAs use manual systems backed by Microsoft Excel for budgeting and accounting.

IGRs

There is no regular reporting mechanism (financial reporting) established for PHC facilities reporting to LGAs and as such financial returns cannot be compiled on IGRs used for facility maintenance and cleaning. IGRs are a critical source of revenue collected at PHC facilities. Databases are therefore not consistently capturing the same data, and PHC facilities are not sending the same data onwards to LGAs. Consequently, states get inconsistent set of and missing information.

To assure the integrity of the financial resources (in-cash) at the LGA or State level it would be recommendable to capture IGR at the facility level. This would require the establishment of a periodic
report on IGRs collected in cash by the PHC Facilities from patient treatment fees, mark-up on drug sales, lab fees, scanning fees, birth certificates, etc. and to aggregate data by the LGAs.

**Bank accounts for PHC facilities**

Bank accounts are not always maintained by PHC facilities. For example, Ekiti state PHC facilities maintained three bank accounts (for DRF, NHIS, and other revenue), while Niger state PHC facilities did not generally maintain any bank accounts, except for when they were required to do so for NHIS. While urban areas in both state have banks, it is not clear whether all rural LGAs have easy access to banks. Also, the governance structure of bank accountholder and approvers are not clear. Enforcement of such a policy on maintaining bank accounts, establishing rules of revenue retention and use and accountabilities could be very beneficial to PHC facilities.

**Book-keeping skills needed at PHC facilities**

Furthermore, there is need to build capacity for book keeping and record keeping as well as develop appropriate book/record keeping instruments at the PHC facility levels. While little in-cash resources are being received by PHC facilities from the public sector, many of them do charge user fees and copayments for drugs. These resources are not necessarily being recorded in a manner that is easily accessible or shared. This was either a result of lack of standardized instruments (for book keeping), limited capacity (no appropriate training) and/or lack of supervision and accountability mechanisms.

There is inappropriate compilation of in-kind information. As resources are being transferred from public and some others (e.g. donors and nongovernment organizations) more in-kind than in-cash, especially for other than wages and salaries, it is important to figure out what precisely is being transferred and what are potential shortages and inefficiencies that can be addressed. Although, most transfers may be going through government administrative levels, and therefore there may be a process to compile that information as in-kind resources are transferred, there are some in-kind resources that came directly to PHC facilities bypassing the various government administrative levels, and these include direct transfers from various donors to PHC facilities, and those items that may be self-procured by the PHC facilities. Record keeping of non-cash transfers are as important as cash transfers. This was not always done or even if instruments are available, the results are not shared or analyzed for operation or decision-making purposes.

**Health Management Information Systems**

The National Health Management Information Systems (NHMIS) is supported by the District Health Information System (DHIS2) platform which has been implemented by the FMoH at the federal, state, LGA and tertiary and secondary hospital level across the country. The DHIS platform collects aggregated routine data, and by extension will have the capacity to receive in aggregated format routine health statistics from Electronic Health Records (EHR) systems being implemented in public and private hospitals in the country. The system supports the capture of data linked to the Federal, state, local government and health facilities through a web based platform. The data warehouse and the web based interface is managed by the Monitoring and Evaluation Division of the DHPRS/FMoH.

- Information gap – In spite of FMoH efforts made to integrate HMIS into the DHIS platform, disruptive parallel M&E efforts (e.g., Immunization by SPHCDA; Malaria LLINs report; SuNMaP; HIV/AIDS; etc.) are still observed. Efforts should concentrate at all levels in improving HMIS data quality rather that maintaining parallel inefficiencies and breakdown of data integrity. In HIV/AIDS each program area such as OVC, ART, and PMTCT has its own routine information system which respond primarily to the need of program funders.
• According the USAID-PMI\(^7\) in assessing Nigeria’s process of shifting from a parallel malaria information system to a harmonized HMIS, considers case reporting efforts through the HMIS at the present time remains poor. However, the same report acknowledges that the new harmonized HMIS is an opportunity to greatly improve the availability of consistent malaria information.

• The only visible reliable information system working in the PHC was the HMIS which records services provided and utilization of vaccines, drugs, therapy kits (TB DOTS), LLINs (although not being reported).

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The Health Management Information Systems (HMIS) is undergoing a standardization of all the registries across the country and the two states Ekiti and Niger are using those registries in all the facilities where the HMIS is being implemented including rural and urban (on a paper based), as well as some PHC and secondary level state hospital facilities and the LGAs on a web based application. These are not fully operational at all LGAs and all PHCs.

There is no culture for verification and technical audit, and where there is, it is narrowly defined. When it comes to recording patient information at PHC facilities, there was a clear gap in the information captured. While there seems to be a robust information system for vertical programs, there did not seem to be one for other programs. This was noted in several but not all facilities. This may also be a culprit for low utilization information reported by SDI. There is need to strengthen the PHC health management information system, and to also develop regular reporting and verification processes. A preliminary assessment of recording systems maintained at PHC facilities, also showed that many recording forms are not filled out in a timely manner, and many have missing information. There is clearly a lack of understanding, analysis and use of this information for decision making.

Table 4: PHC HMIS recording forms in public PHC facilities in Niger and Ekiti and its filling rate.

<table>
<thead>
<tr>
<th>State</th>
<th>HMIS Monthly Summary Form</th>
<th>Daily General Attendance Register</th>
<th>OPD Register</th>
<th>ANC Register</th>
<th>Immunization Register</th>
<th>TB/HIV Register</th>
<th>Family Planning Register</th>
<th>Treatment Book/Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ekiti</td>
<td>92%</td>
<td>83%</td>
<td>94%</td>
<td>85%</td>
<td>95%</td>
<td>83%</td>
<td>77%</td>
<td>62%</td>
</tr>
<tr>
<td>Niger</td>
<td>89%</td>
<td>76%</td>
<td>81%</td>
<td>61%</td>
<td>92%</td>
<td>83%</td>
<td>83%</td>
<td>72%</td>
</tr>
</tbody>
</table>

Source: Authors, World Bank.
Notes: A=recording forms available at PHC facilities; C=recording forms filled at PHC facilities.

The incentives for record filling remained low, and when such an incentive was introduced through the two experiments under this study, we found that quality of filling rates had improved, although, verification and reconciling with other sources of information did not. This was also compounded by the fact that there was close supervision under the study. The study results and the qualitative analysis suggested that particular characteristics of the incentive intervention, such as regular high-level feedback on performance, can be especially important – even at times more so than the final reward.

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\(^7\) FY2014 Nigeria Malaria Operational Plan - President's Malaria Initiative
One other important observation from the study suggested that specific governance structures and accountability mechanisms will have significant influence on how staff behave and what motivates them. The state-provider compact (in levels of supervision, financing, mechanisms in use for drug procurement) and the nature of citizen engagement at facility level was also an important influence to staff behavior. Community engagement and a strong citizen ‘voice’ can also result in the state government being much more engaged around PHC. There are some lessons learnt from the state of Niger. A preponderance of private drug enterprise and a credit regime created conditions for facility-community engagement that can enable responsiveness and a degree of accountability at community level but do not support resource tracking objectives at government level. The states and LGAs might start considering these issues of “compacts”. There can be lessons learnt from within other states of Nigeria, those that have applied the results based financing (RBF) modality and those that are starting to set up state based insurance and therefore contracts or compacts between purchaser and provider. Purchaser provider compacts do not exist. Nigeria is currently considering mechanisms to adopt to set up such a compact, either through their existing NHIS or through state health insurance schemes.

PHC level financial recording systems were designed under this study, including for consolidating information at LGA levels. With some modification, these tools can be adopted by the PHC facilities and LGAs.

4.4. Main findings and policy options to consider

What should be the policy on user fees in public PHC facilities in Nigeria? At this point household’s have significant out of pocket health spending in Nigeria. Among the top policy priorities to consider is improving financial protection of households against illness costs. For a formal user fees exemption policy, it will be important for a policy and realization on improving resources allocation for PHC operations. Without the latter, a no user fees policy, could still result in informal payments.

Fragmentation in the flow of funds. As shown in the study, resources for PHC came from various channels and some in cash and some in kind. This made it difficult for any one entity to monitor the flows and its use and its accountability. Pooled financing would help consolidate resources and flows around needs, and would result in improved efficiency and transparency.

One of the critical concerns raised in this study is the limited non-salary recurrent budget for the operations of PHC facilities. This is a critical concern, coupled with the challenge of the low overall public resource allocation for health. Where does the answer lie? Among the steps to be considered is to enforce the Health Bill that supports PHC. A costed basic health package would help ensure such resources can be committed from the highest authority and a mechanism established to earmark or develop a basic health fund. Philippines has experimented on a purchaser provider compact under their Philippines Health Insurance Corporation and through a capitation payment mechanism with local government authorities. Ghana has experiment in a similar fashion. Such a payment mechanism was also applied in Nigeria through NHIA under the MDG program, and resources were transferred to PHC facilities (rather than LGAs) and provided them in-cash support for facility operation and for drugs purchase. The Nigeria MDG program ended in 2015. There is no evaluation of the program. There can be important lessons learnt for Nigeria through internal and international experiences.

Drug stock outs is rampant at public PHC facilities in both states of Ekiti and Niger. While Ekiti relies on DRF managed by the central medical stores, and Niger relies on DRG managed by SPHCDA, the
findings on drug stock outs are similar. However, Ekiti has benefited from economies of scale and purchase at lower drug prices through the central medical stores. Niger, however, did not rely upon the SPHCDA, but instead purchased most of its drugs through the private pharmacies. Further assessment would be helpful in understanding the challenges faced at the institutional level (central medical stores and SPHCDA) in procuring drugs through the DRF mechanisms. The good news is that drugs procurement is decentralized and facilities have the authority to purchase from outside the public system. However, drugs purchased through Ekiti central medical stores have on average been cheaper than that procured by SPHCDA or by the private sector. Is the problem in drug procurement a challenge of the procurement processes at central medical stores or at SPHCDA, or in the challenge in the resource envelop? Indonesia has considered essential health drugs for PHC as part of the public health goods and responsibility of the federal governments. Essential drugs for PHC are procured by federal government and delivered to PHC facilities, and maintain low drug stock outs. Ghana on the other hand decentralized procurement of drugs to local levels and when drugs were not available in the public system, then facilities could procure through private sector. While drug stock outs reduced, the small procurement packages increased drugs prices. Nigeria has some lessons to learn in this area, and consider solutions for public financing of all essential drugs through some pooled mechanism and perhaps with accountability at the federal level, or to consider providing sufficient recurrent budget to LGAs and PHC facilities to procure through decentralized local public and private mechanisms.

**Human resources challenges have been highlighted as a concern especially in the Ekiti public PHC facilities.** The focus group discussions highlighted the challenges faced in frequent staff move from district to district, staff absenteeism, inadequately trained staff, and limited motivation. The study used a mechanism to motivate staff’s behavior through a reward system/social recognition. It proved to have some limited effect in Ekiti, that may have been facing more motivational challenges. It had no effect in Niger state. The World Bank financed projects are also experimenting through results based financing, and an evaluation of project output on staff motivation and performance would be beneficial to consider options open to Nigeria.

**Despite low performance of the public PHC facilities in Ekiti, health outcomes of the population of Ekiti state was much better than those of the Niger state.** The one difference observed was that Ekiti was a smaller state with many private clinics. While the study did not capture the performance of the private sector, it may be an important consideration for future studies to capture the private sector through its assessment followed by policy considerations. In the Philippines, the government was able to increase TB DOTS coverage through a public-private partnership engagement.

**While Ekiti state public PHC facilities had bank accounts and maintained a record through it, the Niger PHC facilities were not required to do so.** There is therefore low knowledge and transparency of what in-cash resources were earned and what resources were used. Also, while some PHC facilities based in urban areas may be earning a better revenue, rural PHC facilities may not be benefitting through IGRs equally. An equalization or resource allocation mode through a policy on IGR retention and use may be beneficial. Tanzania has set up clear policies on use of IGRs. PHC facilities have set up bank accounts with clear governance structures for authorization, transparency and funds use. These bank accounts are used for the national health insurance program to transfer funds for PHC use, and for IGRs to be deposited. The reports are also shared with LGAs, states, and federal levels, and can be used for planning programs. Ekiti state of Nigeria has also set up a similar system, although no assessment is available of it, and the Niger state can learn from their experiences.
LGAs faced several challenges and a problem in accountability. One option to improve transparency at the LGA level is by providing citizens information that could lead to empowerment to hold LGA officials accountable and improve quality of PHC services. (Das Gupta, Gauri, and Khemani 2004).

Some of the public financial management system challenges are systemic, such as lack of or limited considerations given to a comprehensive public financial management system, including: chart of accounts, enforcing reporting, auditing, reporting mechanisms and capacity building at PHC facilities. These mechanisms could strengthen public financial management system all the way to the facility level, and provision of the appropriate incentives would be extremely important to ensure the likelihood of reliable reporting of not only patient profile data but of both financial and non-financial reporting.
Annex 1 - The continuous public expenditure tracking survey approach – a new methodology

In the context of Nigeria, knowledge on resource envelop, allocation and utilization in the PHC system is lacking. Closing this knowledge gap was the primary focus of the study, and drove its methodological design. For this study on resource tracking, the decision was taken to use a continuous public expenditure tracking survey (continuous PETS or CPETS) at LGA and public PHC facility level. This study focuses mainly at resources for PHC services. In selecting the methodology for the CPETS, key decisions had to be made on which budgetary items should be assessed, depending on the data gaps and key policy questions that need to be addressed. It was decided to focus on non-salary recurrent spending.

The study objective was to understand PHC spending. This was done by gathering information to assess the following (a) sources of financing for PHC, the shares that went for PHC (as share of overall health budget and non-budget, i.e. Internally generated revenue [IGR]), (c) per capita spending for PHC, and (d) efficiency of how PHC resources were used. As PHC facilities receive resources, both in cash and in kind, for this study, information was needed on flows for PHC in cash and in kind, and in how PHC facilities spent their resources.

The CPETS was therefore used to address the challenge of assessing resource envelop, allocation, and utilization in a sector dominated by in-kind supplies or highly irregular cash transactions with no accountability requirements. This CPETS approach sought to collect information on resources and activities on a prospective, real time basis, instead of retrospectively. It entailed tracking public expenditure through the various layers of the healthcare system toward PHC services and implementing real time information recording and reporting tools and capacity building at the PHC and Local Government Administration (LGA) levels, to allow continuous data recording and verification to assess resource flows from the various layers of governments and vertical health programs to the PHC units.

The CPETS approach developed in Nigeria is in the context of weak governance environment and poor data recording and reporting, especially at the PHC level. This has entailed implementing a program of information recording and reporting at the PHC and Local Government Administration (LGA) levels, allowing continuous data recording and verification.
Annex 2 – Funds Flow Chart for Primary Health Care

Some findings based on a fund flow analysis conducted through a rapid assessment of personnel of various administrative levels from Niger and Ekiti states (Gonima et. Al, 2014), the following findings are reported.


PHC Program

NIGER STATE - PHC Flow Mapping: 2013 Expenditures

Primary Health Care Expenditures – FY 2013


EKITI STATE - PHC Flow Mapping: 2013 Expenditures

Primary Health Care Expenditures – FY 2013

Immunization Program

NIGER STATE - Flow Mapping: Immunization & In-kind Vaccines (Est.)

Resource Allocation criteria/rules
- MTFF/NHIDP
- Annual Budget NPHCDA
- Vaccine Procurement and Logistics
- State allocation/ population targets (SMT)


EKITI STATE - Flow Mapping: Immunization & In-kind Vaccines (Est.)

Resource Allocation criteria/rules
- MTFF/NHIDP
- Annual Budget NPHCDA
- Vaccine Procurement and Logistics
- State allocation/ population targets (SMT)

Annex 3 – Rapid assessment of personnel functions and capacity of various administrative levels: Niger and Ekiti States

Some findings based on a qualitative study conducted through focus groups in 2013 through a rapid assessment of personnel of various administrative levels from Niger and Ekiti states (Couttolenc, B. 2013. Resource Tracking Study, World Bank), the following findings are reported.

**Figure A3.1: Main issues reported in Governance and Accountability**

![Figure A3.1: Main issues in Governance and Accountability](image)

*Source: World Bank.*

**Figure A3.2: Main issues in Planning and Budgeting**

![Figure A3.2: Main issues in Planning and Budgeting](image)

*Source: World Bank.*
Figure A3.3: Main issues in financing and expenditure

![Bar chart showing the main issues in financing and expenditure]


Figure A3.4: Main problems relating to procurement

![Bar chart showing the main problems relating to procurement]


Note: CMS is central medical stores.
Figure A3.5: Main problems in the area of human resources


Figure A.3.6: Main problems in Service Delivery and Quality Assurance


Note: PHC is primary health care.
Summary of findings from the workshop

The rapid assessment workshop confirmed some findings obtained from interviews with stakeholders and raised additional issues. Important findings include:

- Facilities face different challenges depending on several factors, which are reflected in significant differences in response patterns; varying perceptions may be at play, but also significantly different realities.
- A major factor contributing to this is the lack of uniformity in policies, systems and rules across government levels and/or differences in how they are implemented and enforced.
- Another factor is the confusing mix of centralization and decentralization of functions and responsibilities, that prevents them to take full advantage of the relative autonomy facilities enjoy; for instance, procurement is decentralized, but facilities are obligated to purchase most drugs and other medical supplies from Central Medical Stores, which are not prepared to fulfill this role effectively. Tertiary level facilities are responsible for their own planning and budgeting, but actual resource allocation is defined centrally irrespective of the original plan and budget proposals. Human resource management is formally centralized, but facilities actually enjoy significant leeway in that area, with unclear policies and guidelines.
- The assessment covered only the two states of Niger and Ekiti; this prevents clear conclusions about across state variations; however, the cautious finding here suggests that broad conclusions are similar, but some variation exists in how the states implement and use systems and practices.
- Critical bottlenecks are found in the supply of drugs and medical supplies, which cannot be compensated for by facilities autonomy in procurement. First, facilities have to procure with the central medical stores, which incurs frequent stock-outs. Second local supply (by local pharmacies or distributors) is limited outside the larger cities.
- Managers lack appropriate management systems and tools, and that issue increases as we move to lower levels of the health system (from central offices to tertiary hospitals to PHC facilities). Information and reporting systems and tools are weak, and access to reliable information on expenditure or service delivery is limited at the facility level; only information from central systems (e.g. the budget) is easily accessible. As a consequence of the lack of uniform systems and tools, facilities often resort to developing their own systems, which are not consolidated or comparable.
- Most managers report that the problems they face are well understood, but a careful look at their responses suggest otherwise. Their perceptions of the issues are biased towards their symptoms or consequences, and often fail to identify the real causes of the problems. When asked to identify specific information needs, they tend to repeat the description of the issues.
- Little strategic planning, monitoring and evaluation takes place at the facility level, as facility managers use their relative autonomy to meet emergency situations or day-to-day needs.
- Even though substantial inefficiencies can be found in resource allocation and use, it appears that at the facility level there is also significant underfunding relative to financing needs, considering the major challenges in health care status that the country faces.
References


World Bank. 2016. World Development Indicators.


Note: For detailed references, go to Gauthier, et. al. 2017.