August 2011

Public Expenditure Management Review

Kaduna State

Kaduna State Health Sector

by

Paul Angbazo, PATHS2, Nigeria
Emeka Nsofor, National Consultant
Marianne El-Khoury, PATHS2
Hong Wang, PATHS2

ACKNOWLEDGEMENT

PATHS2 could not have embarked on this important initiative of Public Expenditure Management Review of the Kaduna State Health sector without the total support and commitment of the Honourable Commissioners, Permanent Secretaries, and staff of the Kaduna State Ministry of Health and Ministry of Local Governments. Also to be mentioned is the contribution of the entire staff of the 23 Local Government Areas towards the conduct of the study. Their support is a demonstration of the government's desire to a transparent management of the resources of the sector.

It is also very important to acknowledge the level of support received from Donor Partners agencies such as WHO, UNICEF, World Bank, UNFPA, and SPARC through the entire process of the study.

Worthy of special recognition is the support from Mr. Benson Obonyo, Dr. Kenneth Ojo, Dr. Zainab Mohammed Idris and Mr. Mohammed Okorie, Katherine Brouhard and Elias Epstein all of PATHS2 technical team. Your technical contribution during the design, data collection and collation, data analysis and report writing stages of this assignment is immeasurable.

The efforts of the enumerators and data entry clerks are also acknowledge for without which the data analysed in this report would not have been.

Finally, I would like to commend the team of authors who worked hard to ensure the success of this study. Emeka Nsofor (National Consultant), Marianne El-Khoury (PATHS 2) and Dr Hong Wang (PATHS 2), thank you all for bringing your expertise, experience and unwavering commitment, to the successful completion of this study.

Paul Angbazo,
PATHS2 Nigeria
August, 2011

ACRONYMS

CSO	Civil Society Organisation
DFID	UK Department for International Development
FA	Federation Account
FCT	Federal Capital Territory
FG	Federal Government
FMoH	Federal Ministry of Health
HS20/20	Health Systems 20/20
IGR	Internally Generated Revenues
LG	Local Government
LGA	Local Government Authority
MCH	Maternal and Child Health
MDA	Ministry, Divisions, Agencies
MTSS	Medium Term Sector Strategy
NGO	Non-Governmental Organisation
PATHS2	Partnership for Transforming Health Systems 2
PCA	Principal Component Analysis
PEMR	Public Expenditure Management Review
PHC	Primary Health Care
PMV	Patient Medicine Vendor
SHC	Secondary Health Care
SMoH	State Ministry of Health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
WHO	World Health Organisation

CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

The health sector policy priority of Kaduna State, as described in the Kaduna State Development Plan (KSDP) 2010–2012 and the 11-Point Agenda, is the provision of quality and affordable health services for the populace of the state. In recognition of the health demands of the state, commitments to the national health policy framework, and international conventions, the current administration at its inception embarked on a number of health service-focused reform agendas such as the Kaduna State Health Sector Development Strategy 2010–2015.

Although the state has demonstrated leadership in improving health outcomes, the effective use and allocation of resources remains a major concern when it comes to achieving the Federal Government's policy targets. This concern is shared by the state government and development partners like the Partnership for Transforming Health Systems 2 (PATHS2), which seeks to improve the planning, financing, and delivery of sustainable and replicable pro-poor services for common health problems in five states (Kano, Kaduna, Enugu, Jigawa, and Federal Capital Territory (FCT). PATHS2 is part of a wider portfolio of state-led programmes funded by the UK's Department for International Development (DFID), designed to collectively deliver improved government accountability to citizens through supply- and demand-side interventions.

In responding to this need, with technical and financial support from PATHS2, the state embarked on a sector-wide public expenditure management review (PEMR) assessment in Kaduna and other PATHS2 states. The primary objective of the PEMR in the health sector is to assist the government in improving its public financial management system to ensure efficient and effective use of health resources. The assessment involved the review of public expenditure management systems and the state's budgeting process for planning, execution, and use of the public resources.

The PEMR was conducted using the basic methodology developed by the World Bank, which has been used in multiple countries to track expenditures for health, education, and other social sectors. The activity complements the PEMR currently being conducted in three other states (Sokoto, Cross River and Nasarawa) under the USAID-supported Health Systems 20/20 (HS20/20) project. Together these reviews will produce a richer base of information on public expenditure systems for policy-makers in Nigeria.

The PEMR exercise was specifically designed to engage the active participation of all country stakeholders and international partners in the process. The objective is to reach a consensus on the issues related to public expenditure management in Nigeria and use evidence-based approaches to improve existing systems. The terms of reference for this study and the design of the exercise were developed using a consultative process involving multiple partners, namely the Nigerian government,

DFID/PATHS2, the World Bank, the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA).

The approach used for this study involved extensive survey work at the level of public health care facilities and local and state governments and public offices. The survey of primary-, secondary-, and tertiary-level facilities was to collect information on facility characteristics, human resources, governance structures, and financial information using facility records. These surveys were administered to health facility managers. Local- and state-level Ministries, Divisions, and Agencies (MDAs) were assessed to collect information on budgeted resources and key issues in budget preparation and execution processes.

For the purpose of the data collection, three survey questionnaires – the Strategic Audit, Administrative, and Facility questionnaires – were developed centrally for the five PATHS2 states and the three HS20/20 states through an interactive process of discussions that involved representatives of PATHS2, DFID, the Federal Ministry of Health (FMoH), WHO, UNFPA, and UNICEF. The design of the questionnaires followed a multi-angular data collection strategy, meaning similar and related information was collected from different sources as a means of cross-validating the information obtained separately.

The surveys were implemented during October – November 2010. In Kaduna, enumerators administered the Administrative and Strategic Audit questionnaires to the relevant public offices (Planning Department and Finance and Accounts) at each State Ministry of Health (SMoH) and within each Local Government Area (LGA). The facility surveys were administered to six randomly selected public sector primary health care (PHC) facilities (three urban and three rural) in each LGA, and to all public sector secondary- and tertiary-level facilities in each state. In all, a total of 189 locations were assessed: 138 PHC facilities, 18 Secondary Health Care facilities (SHCs), and 5 tertiary facilities, along with 23 LGAs and at the state government level.

Since the PEMR survey in Kaduna State was the first of its kind in the state, it encountered a number of challenges during the data collection process. Some notable examples include the lack of accurate financial record-keeping and reporting, especially at lower levels (facilities and LGAs); the inability to access the required information from the officers in charge at duty posts/offices; and reluctance to share even the most basic financial information, which suggested the presence of accountability problems at all levels. This was especially the case at the local government level, where information on resources allocated to facilities was required.

In addition to the aforementioned issues, data collectors faced a number of logistical challenges. Specifically, rural facilities were often difficult for the field teams to reach due to poor road infrastructure, and the data collection period coincided with political events in some states. Likewise, securing appointments with facility heads to respond to the survey was challenging, as most of

the facilities visited were understaffed, which made it very difficult for the respondent to allocate time to complete the tools.

Key findings from the PEMR indicate the existence of the main elements of a budget preparation process at the state level, including a strategic plan and a budget team that includes Civil Society Organisation (CSO) members. However, the capacity of the planning and budgeting team at the SMoH in Kaduna is lacking. Furthermore, the budget envelope for the state does not reflect a demand-driven process. The budgeting processes at the LGA level were significantly influenced by political considerations and state interference in spending. They lacked any strategic direction and included minimal active participation from the community.

The PEMR also highlighted weak budget execution at the state level, as suggested by the misalignment between over-ambitious budgets and actual spending. This fact undermines the credibility of the planning process. The documented evidence of spending at the LGA level suggests a lack of capacity and the absence of a sound reporting mechanism or a transparent internal system of checks and controls to reconcile and track resource flows across the different MDAs.

Regarding budget use, the survey indicated a misallocation of health resources across LGAs, reflecting a system of fund allocation and budgeting that is not based on real demand or needs. Per capita health spending differs significantly from one LGA to another, which may be partly due to weak budget execution in certain LGAs. Furthermore, there is a weak relationship between resources spent and facility conditions, suggesting that resources are not used effectively. Similarly, the absence of a positive relationship between facility performance and health spending suggests that resources are not aligned with actual health service use.

Based on the findings of the PEMR, several measures were recommended as the way forward or next steps. The state government should reform the current approach in budget preparation and planning for the health sector, including the LGAs. There is a need to harmonise the state and LGA response to limit the enormous political interference in funds meant for service delivery at the LGA level. In addition, both state and LGA budgeting and planning processes should be more accountable and participatory, involving all key stakeholders, especially civil society. The role of beneficiaries in determining the output of the government's annual financial plans should be clearly defined with actionable timelines. Likewise, it is important to improve the skills of the state and local government planning officers on the participatory budgeting methodologies and the Medium-Term Sector Strategy (MTSS), to contribute to the development of demand-driven budgets. Finally, there is a need to strengthen the macroeconomic framework and strategic plans at both the state and local government levels before embarking on budgetary reform.

INTRODUCTION AND STUDY OBJECTIVES

The allocation and effective use of resources has been a major concern in Nigeria, particularly in the health sector. A number of tools have been devised to expose weaknesses in the flow of funds and identify inefficient resource use and leakages. These include surveys such as the Public Expenditure Tracking Survey that examines flows of funds from the central government down to state and local governments and service providers, and the Quantitative Service Delivery Survey that examines the efficiency of frontline service delivery. A Public Expenditure Management Review (PEMR) combines elements of both, and goes beyond, by examining the overall governance environment of public expenditure management.

The primary objective of the PEMR in the Nigerian health sector is to assist the government in improving its public financial management system to ensure efficient and effective use of health resources. This is done through an assessment of the public expenditure management systems in place, including the processes of:

(a) Budget planning and preparation: How is the budget prepared and who is involved? Does the budget follow strategic priorities? Does civil society participate in the process?

(b) Budget execution: How much of the budgeted funds is spent? To what extent does spending follow budget planning?

(c) Budget use: How are the funds used at the level of the various agencies and service delivery institutions? How are funds utilized at the level of the various agencies and service delivery institutions?

The Partnership for Transforming Health Systems 2 (PATHS2) project, which is supported by the UK's Department for International Development (DFID), is conducting a PEMR in five states (Kano, Kaduna, Enugu, Jigawa, and the Federal Capital Territory (FCT), using the basic methodology developed by the World Bank. This methodology has been used in multiple countries to review spending in the health, education, and other social sectors. The activity complements the PEMR currently being conducted in three other states (Sokoto, Cross River and Nasarawa) under the USAID-supported Health Systems 20/20 (HS20/20) project. Together these activities will produce a richer base of information on public expenditure systems for policy-makers in Nigeria.

The PEMR exercise was specifically designed to engage the active participation of all country stakeholders and international partners in the process. The objective is to reach a consensus on the issues related to public expenditure management in Nigeria and use evidence-based approaches to improve existing systems. The terms of reference for this study and the design of the exercise were developed using a consultative process involving multiple partners, namely the Nigerian government, DFID/PATHS2, the World Bank, WHO, UNICEF, and UNFPA.

This report presents the findings of the PEMR in Kaduna State. It is organised as follows: Section 2 presents an overview of the Nigerian expenditure system and the health sector in Kaduna; Section 3 presents the methodology used to conduct the PEMR in all selected states; Section 4 discusses the main findings of the PEMR in Kaduna; and Section 5 concludes with recommendations.

OVERVIEW OF THE HEALTH AND EXPENDITURE SYSTEMS

2.1 The Nigerian Health System and The Flow of Health Funds

Nigeria is a federal state with three tiers of government, namely, the Federal Government (FG), 36 State Governments, and 774 Local Governments (LGs). Within the public sector, primary-level health care falls under the responsibility of Local Government Authorities (LGAs). This means that primary health care centres (PHCs) are owned and funded by LGAs. Secondary-level (and some tertiary-level) health care falls under the responsibility of State Governments. This level of care includes General Hospitals, the Teaching Hospitals of State Universities, and State Specialist Hospitals. The Federal Government is responsible for Teaching Hospitals of Federal Universities, Federal Medical Centres, and similar specialised tertiary-level health care facilities including the National Hospital in Abuja (FMoH 1988; FMoH 2004a; FMoH 2004b).

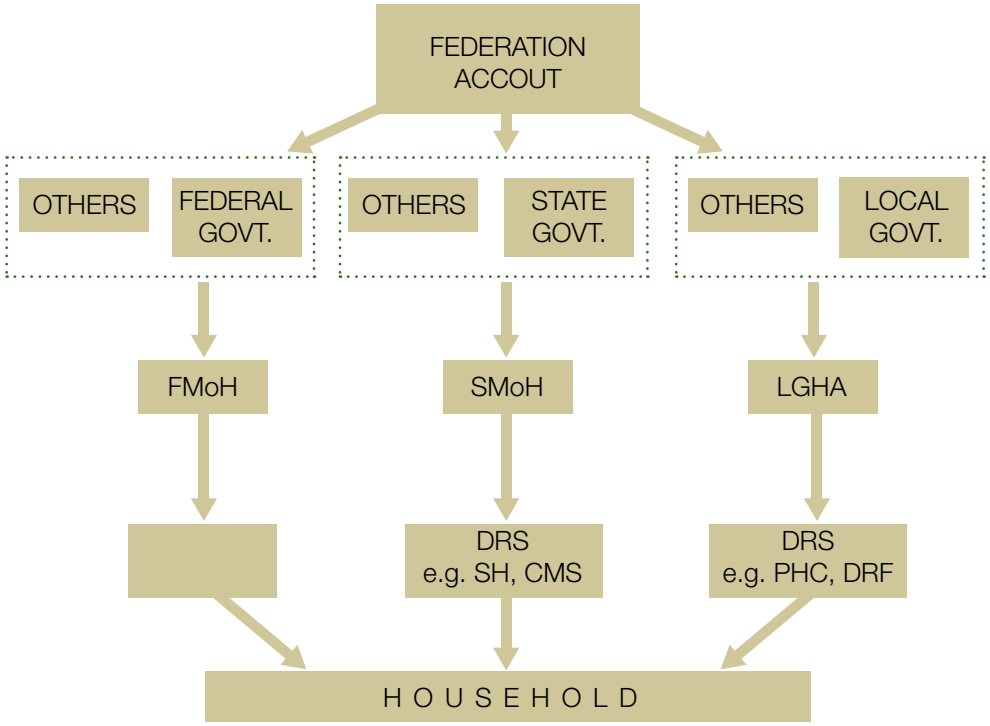
The Federal Ministry of Health (FMoH), the States' Ministries of Health (SMOH), and the LG's Departments of Health are each responsible for planning for and managing health spending in their respective jurisdictions. Under each of these ministries (federal and states), associated departments and agencies are referred to collectively as Ministries, Divisions, and Agencies (MDAs). Therefore, the principal actors in the Nigerian public health sector are the FMoH, the 36 SMoHs, the 774 LGA Departments of Health, and the authorities of the FCT and various government parastatals and training and research institutions that are concerned with health matters. Figure 1 shows the flow of health funds through these various agencies, down to the service provision level. It is worth noting that expenditure decisions of the three tiers of government are taken independently and the federal government has no constitutional power to compel other tiers of government to spend in accordance with its priorities.

Other important actors are the Ministry of Defense, Ministry of Education, and Ministry of Internal Affairs, which own and run extensive networks of health facilities providing treatment and care for armed forces personnel and their families, students, and prison inmates, respectively (FMoH 2005: 5).

The private sector consists of a network of privately owned health facilities that cut across the three levels of care – primary to tertiary. They include private for-profit as well as private not-for-profit health care facilities, including faith-based facilities and those owned and managed by Non-Governmental Organisations (NGOs) as well as Community-Based Organisations. These facilities include chemists, drug stores, pharmacies, clinics, hospitals, etc. (FMoH 2004b).

This PEMR does not include a review of the private sector or various other actors involved in the provision of health services in Nigeria (such as the Ministries of Defense, Education, and Internal Affairs).

Figure 1: Diagrammatic representation of the flow of public expenditure in health



CMS=Central Medical Stores; **DRF**=Drug Revolving Fund; **DRS**= Department Responsible for Service Delivery; Local Government Health Authority (**LGHA**); **SH**=Secondary Hospital; **TH**=Tertiary Hospital

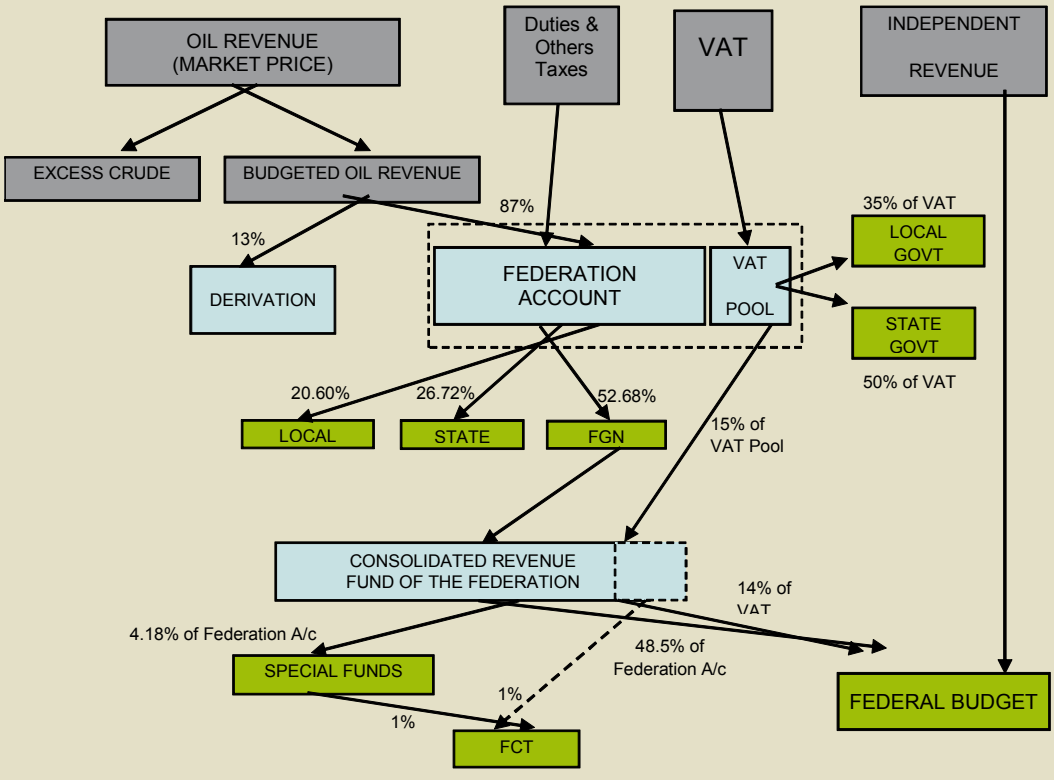
Box 1 - Decentralisation arrangements and intergovernmental fiscal transfers in Nigeria

The Nigerian intergovernmental fiscal arrangement is a complex one spanning a number of policies and institutional and administrative structures. These fiscal arrangements are strongly influenced by historical, political, and social, as well as economic, factors. Accordingly, the constitution assigns government functions and defines revenue sharing rights among these tiers of government. The most significant tax revenues are collected by the FG and paid into the Excess Crude Account, Federation Account (FA), or the Value Added Tax (VAT) Pool and are subsequently shared among the three tiers of government in accordance with the existing revenue sharing formula.

At present, 87% of all the budgeted oil revenues are paid to the FA and 13% to a Derivation Account, while excess oil revenues are paid into the Excess Crude Account. Similarly, all VAT revenues net of costs of collection are paid into the VAT Pool, while other federally collected taxes net of costs of collection are paid into the FA.

Of funds in the FA, 48.5% goes to the FG (and an additional 4.18% of it is passed through FG to Special Funds), 26.72% goes to the states, and 20.6% goes to the LGs. Of the funds in the VAT Pool, 14% goes to the FG (and an additional 1% goes to the Federal Capital Territory through the FG), 50% goes to the states and 35% goes to the LGs.
The FG revenues therefore consist of its independent revenues, share from the FA, and share from VAT Pool, while the revenues of states consist of their Internally Generated Revenues (IGR) and their shares from both the FA and the VAT Pool. Similarly, the revenues of the LGs are made up of their IGR, shares from their respective states' revenues, and their shares from both the FA and the VAT Pool

Figure: Distribution of Nigerian revenues among tiers of government



2.2. Organisational structure of the health system in Kaduna

Kaduna State, like the rest of Nigeria, has a broad health care delivery system, comprising a wide range of service providers including public, private for profit, and faith-based organisations. Health care providers vary from traditional birth attendants and informal medicine sellers to specialists in teaching hospitals. Excluding the Patient Medicine Vendors (PMVs), 40.2% of the health facilities in the state belong to the private sector. The distribution of health facilities in the state by type and ownership is shown in Table 1 below. Of the 1,682 health facilities in the state, 96.5% are primary health care facilities, 3.2% are secondary, and 0.3% are tertiary health care facilities.

Table 1: Health Facilities in Kaduna State

Type of Facility	Ownership					
	Federal	State	LGA	Total Public	Private	Total
Tertiary	5	1	0	**6**	0	**6**
Secondary	2	34	0	**36**	20	**56**
Primary	2	0	965	**967**	656 (plus 2500 PMVs)	**1,623 (excluding PMVs)**

Kaduna State has five tertiary health facilities belonging to the federal government, four of which provide specialised care, while the tertiary level hospital at Ahmadu Bello University serves as the highest level reference health care facility. In addition there are two hospitals that belong to the armed forces which were not included in the study. All the federal government health facilities are based in Kaduna (the state capital) and Zaria. The general hospitals belonging to the state have been categorised as either rural hospitals, general hospitals or specialist hospitals, with a range of services and skills. The primary health care facilities are divided into health clinics and primary health care centres, with the centres expected to provide the full range of primary services. This includes antenatal services, inpatient and outpatient preventive and curative services, and emergency services. These are all owned by the LGAs. The state is comparatively well endowed with private health facilities, the majority of which are providing primary care.

The dominant method of financing health care services in the state is fee-for-service at the point of service delivery. However, with the introduction of free Maternal and Child Health (MCH), a total of 115 public PHCs and 28 SHCs currently provide some components of MCH at no cost to the patient. In addition, through the Sustainable Drug Supply Programme, drug revolving funds have been revamped in 55 facilities in an effort to ensure availability of drugs in public primary and secondary health facilities. There are plans to increase the number to 150 (both primary and secondary health facilities).

[1] Patient Medicine Vendors (PMV) are community-based drug vendors; unlike registered pharmacy stores these vendors are not certified medical personnel. At these levels diagnosis and treatment of minor ailments are conducted by the vendors.

PEMR METHODOLOGY

3.1 Stakeholders' Engagement

The effective participation and support of health sector stakeholders was considered critical to the success of the PEMR study. A committee was established to facilitate the various activities of the PEMR. The Department of Planning, Research and Statistics of the FMoH headed the committee, which included representatives from PATHS2/DFID, World Bank, WHO, UNFPA, UNICEF, and the Nigerian government. The various representatives agreed on the framework, the PEMR model, and the survey questionnaires.
The committee held consultative meetings with the Permanent Secretaries and Directors of the SMoH and LGAs, as well as sensitisation workshops in the selected PEMR states to engage and gain support from key stakeholders. During the workshop the stakeholders were briefed on the purpose of the PEMR survey in the state and the need to cooperate with fieldworkers during questionnaire administration.

3.2 Survey Methods

The approach adopted to address the objectives of this study involved extensive survey work at the level of public health care facilities and local and state governments and public offices. Specifically:

- A survey of primary-, secondary-, and tertiary-level facilities to collect information on facility characteristics, human resources, governance structures, and financial information using facility records; the surveys were administered to health facility managers.
- A survey of local- and state-level MDAs to collect information on budgeted resources and key issues in budget preparation and execution processes. The surveys were administered to public officials at each MDA.

Three survey questionnaires – the Strategic Audit, Administrative, and Facility questionnaires – were developed centrally for the five PATHS2 states and the three HS20/20 states through an interactive process of discussions that involved representatives of PATHS2, DFID, FMoH, WHO, UNFPA, and UNICEF. The design of the questionnaires followed a multi-angular data collection strategy, meaning we planned on collecting similar and related information from different sources as a means of cross-validating the information obtained separately. Box 2 summarises the main types of information collected through each type of instrument.

3.3 Preparatory Work

The project hired a local consultant in each state to lead the data collection efforts, and form field teams, for their respective locations. In Kaduna State as in other states, the field teams, which were composed of 11 enumerators, attended training sessions prior to the data collection. During the training, the field teams were assigned survey sites and finalised their logistical arrangements and operation plans, including the established timelines and roles. Prior to the actual data collection process, the developed tools were pre-tested to establish: the respondents' interpretation of the questions; the most suitable

methodology for administration; the duration and the number of enumerators required; and the estimated timeline for data collection. One of the major outcomes of the pre-test of the questionnaire was the significance of procurement processes in budget implementation, hence the inclusion of some questions on procurement.

Following from the pre-test, the questionnaires were grouped according to the responding departments for ease of collection. Likewise, the tools were further reviewed to incorporate the findings and feedback from the field test.

Box 2. PEMR Survey Instruments

The Strategic Audit instrument –

The Strategic Audit instrument was designed to inform the budget preparation and budget execution processes, specifically:

- Existence of a budget and budget development
- Participatory budgeting, citizens' involvement, and issues of accountability
- Existence of strategic plans and policy documents
- Allocation of overall health resources across government agencies
- Allocation of health resources to health facilities

The Administrative instrument –

The Administrative instrument was designed to further inform the budget execution process through the collection of financial information, specifically:

- Government sources of funding
- Internally generated revenue
- Actual government budgets released for health facilities and actual expenditures incurred by the facilities
- Capital spending on health facilities (new construction, renovation)

The Facility instrument –

The Facility instrument was designed to collect information on budget use at the facility level, specifically:

- Characteristics of the health facility (rooms, amenities, availability of basic equipment and infrastructure)
- Human resources (professional qualifications, salary structure, official positions, gender, age, tenure)
- Types of services provided and their use (outpatient, inpatient)
- Facility organisation and governance
- Supervision and accountability
- Facility's sources of funding
- Facility's spending
- Data sheet to calculate the value of in-kind support in (=N=) value
- Quality of records and record-keeping

3.4 Sampling and Data Collection

The Administrative and Strategic Audit questionnaires were administered to the relevant public offices (Planning Department and Finance and Accounts) at each SMoH and within each LGA. The facility surveys were administered to six randomly selected public sector PHC facilities (three urban and three rural) in each LGA, and to all public sector secondary- and tertiary-level facilities in each state.

The surveys were implemented during October – November 2010. In Kaduna, enumerators administered the tools in a total of 189 locations: 138 PHCs, 18 SHCs, and 5 tertiary facilities, along with 23 LGAs and at the state government level.

In Kaduna State, the field team implemented quality control measures throughout the sampling process, as the project consultant/supervisor provided logistical support for those traveling to each facility, and screened the completed questionnaires and sent them back to respondents when further clarification and additional data was required. To ensure quality in the data collection process, data collectors were trained, two layers of supervision were established, questionnaires were screened for accuracy and completeness as stated above, and follow-ups were made to verify the accuracy of data collected and fill in missing data.

3.5 Data Processing and Analysis

Data processing and analysis was centralised. A customised programme was developed for data entry using CSpro. Data for all states were entered during January and February of 2011. Data validation and data cleaning were conducted prior to data analysis. The data were then transferred to Excel and STATA for cleaning, consistency checks, and analysis.

3.6 Potential Implementation Challenges

Past PEMR or similar exercises implemented in other countries have drawn attention toward several challenges. The sensitivity of the financial information collected through these surveys and the potential implications of the PEMR assessment have often resulted in a lack of political will to share financial data. The purpose of the advocacy and sensitisation workshops that were conducted ahead of this exercise was precisely to address this issue.

In addition, the absence of records or financial accounts, data inconsistencies, and other similar problems have been widespread in similar assessments, making it difficult to trace certain flows or make informative conclusions. This is often the result of weak systems, poor enforcement of sound financial principles, and a lack of technical capacity in financial management. Given that one of the objectives of the PEMR is to identify those very same issues, it was expected to encounter several challenges with data availability and accuracy during the exercise.

3.7 Other Sources of Information

Along with an analysis of the PEMR survey results, a number of policy documents and reports were reviewed to better understand Kaduna's macroeconomic environment and health sector. They include the 11-point Agenda, the Strategic Health Development Plan 2010 – 2015, the Kaduna State Annual Budget 2006 – 2009, Report of the Auditor General (2004 – 2008), and the Accountant General Report 2004 – 2009.

[2] While the PEMR aimed to survey all public sector secondary facilities in each state, there are 34 SHCs in Kaduna and only 18 were surveyed. At the time of data collection, enumerators obtained lists of facilities from which to draw the samples/survey from the state governments, and only the names of 18 facilities were provided.

MAIN FINDINGS

4.1 Challenges with Data Collection and Verification

The PEMR survey in Kaduna State is the first of its kind in the state. A number of challenges were encountered during the data collection, specifically:

- A widespread lack of accurate financial record-keeping and reporting, especially at lower levels (facilities and LGAs). In the majority of the PHCs visited, access to financial records was very difficult. In most cases the records did not exist.
- The inability to access the required information from the officers in charge at duty posts/offices, and a reluctance to share even the most basic financial information, suggestive of the presence of accountability problems at all levels. This was especially the case at the local government level, where information on resources allocated to facilities was required.
- While budget numbers were made available in some cases, records on spending and actual releases were much harder to obtain.

In addition, data collectors faced a number of logistical challenges, specifically:

- Rural facilities were often difficult for the field teams to reach due to poor road infrastructure.
- The data collection period coincided with political events in some states. Many respondents were thus unable to allocate adequate time with the enumerator to complete the questionnaires. In a system where records did exist and were accessible, enumerators would not need to spend so much time with respondents to obtain the required financial information.
- Likewise, securing appointments with facility heads to respond to the survey was challenging, as most of the facilities visited were understaffed, which made it very difficult for the respondent to allocate time to complete the tools.
- The 10-day time period for enumerators to collect data was insufficient, as several visits were required to obtain the necessary information.

As a result of these challenges, the findings presented in the rest of the report should be interpreted with caution. Nonetheless, regardless of the findings below, the lack of transparency as evidenced by the collection exercise and the absence of well-kept and easily accessible financial records are already symptomatic of a weak and fragmented financial management system.

4.2 Budget Preparation and Planning at the State Level

The Kaduna State Strategic Health Development Plan 2010 – 2015 and the Medium-Term Sector Strategy form the basis of the current health plan and budget of the Kaduna State health sector. The health sector plays a prime role in the development agenda of the Kaduna State government. Specifically, the provision of quality and affordable health services is a key priority of the health policy formulation process. The Kaduna State Strategic Health Development Plan 2010 – 2015 supports the reform agenda of the state government through eight thematic goal areas, including leaders and governance, health service delivery, human resources for health, health financing, National Health Management Information System, community participation and ownership, partnership for health, and research of health.

A three-year renewable Medium-Term Sector Strategy (MTSS) serves as the basis for articulating the annual operational plan and budgets for the sector for a three-year period. The MTSS is a multiyear budget planning tool aimed at addressing the fact that previous health sector budget preparations were not based on performance benchmarks, but rather on an incremental budgeting process taking the previous year's budget as the baseline for such increments.

The SMoH has Civil Society Organisations represented on its budget and planning team. These Civil Society Organisations (CSOs) are represented on the sector team by their umbrella or networking platforms such as Civil Society for HIV/AIDS in Nigeria and the Free Maternal and Child Health Coalition to mention a few. According to the Strategic Audit survey, CSO participation includes providing important feedback to the budget development process, submitting written comments, and organising public consultations and meetings. However, the sector's 2011 – 2013 MTSS report revealed that the capacity of the CSOs to adequately function as members of the planning and budget team is still very weak. They lack an understanding of the process and have not adequately explored the opportunities available for engaging the process.

The capacity of the planning and budgeting team at the SMoH may be lacking. When asked about their level of confidence in the capacity of their budget and planning teams, the SMoH reported that it was not confident that its budgeting and planning team was familiar with the budget preparation process. The sector team was recently constituted at the onset of the 2011 – 2013 MTSS process and is yet to acquire substantial experience from the budget process, since this is their first encounter with the budget process as members of the sector team.

Statutory allocations make up the majority of revenue sources for the state of Kaduna, or about 73% of total revenues. This implies that the Kaduna State budgeting process is significantly dependent on the federal funds, unlike Lagos State, where internally generated revenues (IGR) account for 65% of its revenue. This raises concerns about the state's ability to sustain its development priorities. Other revenue sources for Kaduna include IGRs, Value Added Tax (VAT) revenue, and grants from local and international partners (Table 2). Total revenues for the state have increased in nominal terms from about N69.6 billion in 2006 to N96.2 billion in 2009, with an average yearly nominal increase of approximately 11.4%.

Figure 2 shows the state's revenue profile in percentage terms for the period between 2006 and 2009. Contributions from the Federation Account (FA) ranged between 74% and 77% of the total state income between 2006 and 2008 but dropped to 73% in 2009. In contrast, IGR as a proportion of state income increased by 3 percentage points in 2008 and 2 percentage points in 2009. VAT also increased during the same period from 9.6% in 2008 to 11% in 2009. However, when converted to 2010 prices this is a rise of only 10% over a five-year period in real terms (on average less than 2% per year). From the table below, the statutory allocation to Kaduna State increased significantly, by 29%. Information was limited to justify the sharp increase in statutory allocation to the state. However, though this is not within the scope of this study, it may be important to compare trends in other states to ascertain the rationale for the increase. Health spending in 2009 constituted about 12.8% of total revenues for the state.

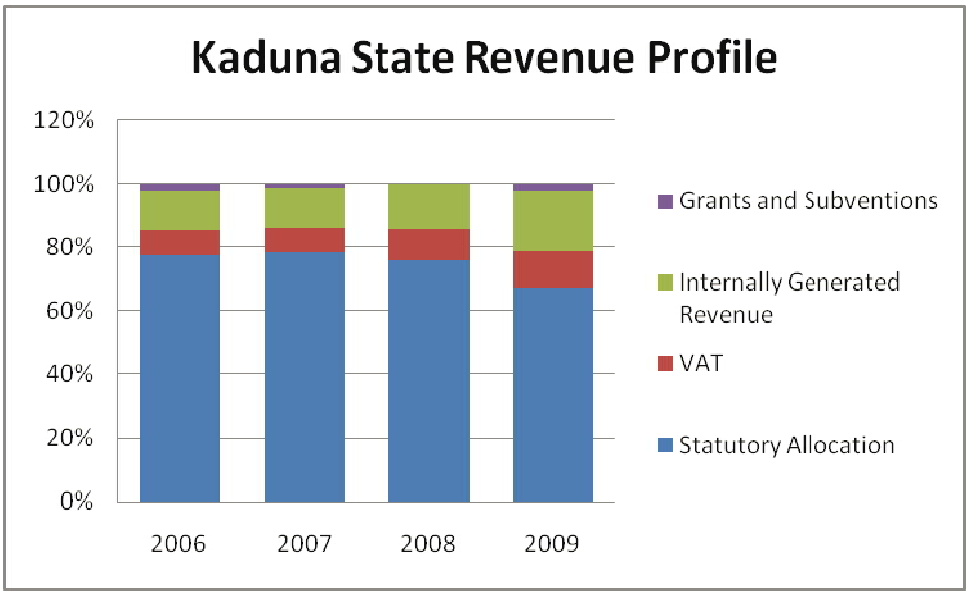
[3] The Lagos State 2010 budget.

Table 2: Kaduna's total revenues by source, 2006 – 2009

Receipts:	2006 N Million	2007 N Million	2008 N Million	2009 N Million
Statutory Allocation to State	33,339	42,967	42,414	37,029
VAT	3,426	4,239	5,569	6,366
Internally Generated Revenue	5,356	6,980	8,040	10,520
Grants and Subventions	998	798		1,272
Statutory Allocation to Local Governments	25,742	27,689	38,123	32,924
Below the Line Receipts/other	708	531	8	8,109
Total Receipts	**69,569**	**83,204**	**94,154**	**96,220**

Source: 2009 AG's Draft Financial Report

Figure 2: Kaduna State revenue profile 2006 - 2009



Source: 2009 AG's Draft Financial Report

4.3 Budget preparation and planning at the LGA level

Budgeting in the LGAs is not driven by strategic plans. When asked about local government plans, 10 out of the 16 LGAs that responded to the Strategic Audit questionnaire reported having a plan for their LGA (Table 3). Information from the budget office of the Ministry of the Local Government indicated that LGAs do not actually have any strategically informed development plans. This means that planning in the LGAs is primarily driven by political influences, with significant state interference in spending priorities.

Only half of LGAs in Kaduna reported having a budgeting team. According to the survey results, 8 out of 16 LGAs have a health sector planning and budgeting team that is responsible for the budget development (Table 3). For the remaining LGAs, the head of the health sector department and/or accountants/treasurers are given the responsibility for preparing the budget.

Civil society does not seem to actively participate in the LGAs' budget development process. According to the survey, 6 out of the 8 LGAs that have a health sector planning team reported having CSOs as members of the team (Table 3). The number of CSO members on the LGA planning teams ranges from 2 to 4 members. However, according to the budget office of the Ministry of the Local Government, minimal consideration is accorded to the issues raised by the CSOs during the prioritisation process of the LGA. On the other hand, 6 out of 9 LGAs that responded to the survey question reported having safety net programmes included in their annual budget in the past five years that target the poor, vulnerable, minority and disadvantaged populations.

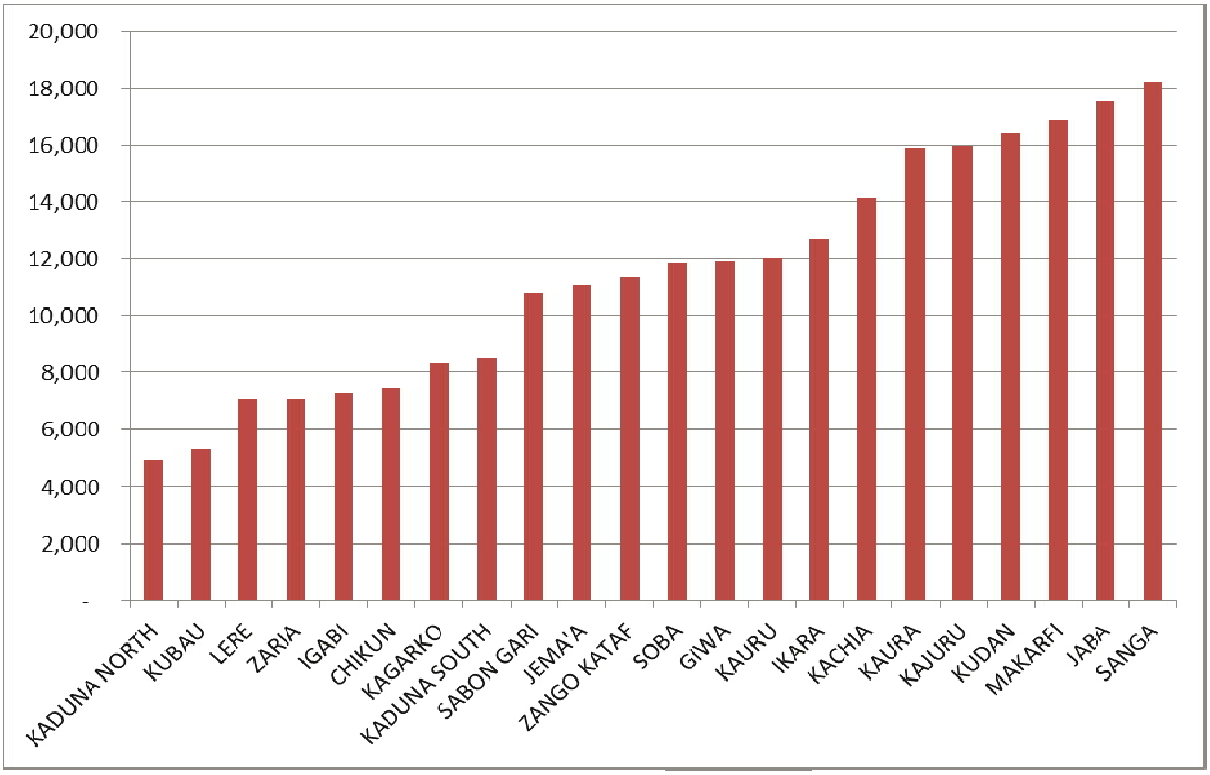
Table 3: Institutional environment for budget preparation, LGAs in Kaduna State

Number of LGAs*	LGAs (n=16)
With a "strategic" plan	10
With a planning and budgeting team	8
Confident about the capacity of the planning and budgeting team	5
With CSOs as members of the teams	6
With safety net programmes budgeted in the past 5 years	6

Source: Survey data – *Only 16 out of 23 LGAs responded to the Strategic Audit questionnaire. The remaining data were N.A.

Per capita recurrent and capital budgets in 2009 varied significantly across LGAs. Figure 3 shows the per capita budget in 2009 by LGA. At the lowest end are Kaduna North, Kubau, and Lere, with a total budget of less than N7,000 per person. In contrast, a number of LGAs, including Kaura, Kajuru, Kudan, Jaba, and Sanga, have a per capita budget more than twice as high (more than N16,000). This clearly supports the position that the budgeting processes at the LGA are not derived from any development plan. The allocations of resources are not adequately aligned with the demand or population served, hence the budgets at this level are not demand-driven.

Figure 3: Per capita recurrent and capital budget in 2009, selected LGAs (in Naira)



Source: Ministry of Local Government, Kaduna State

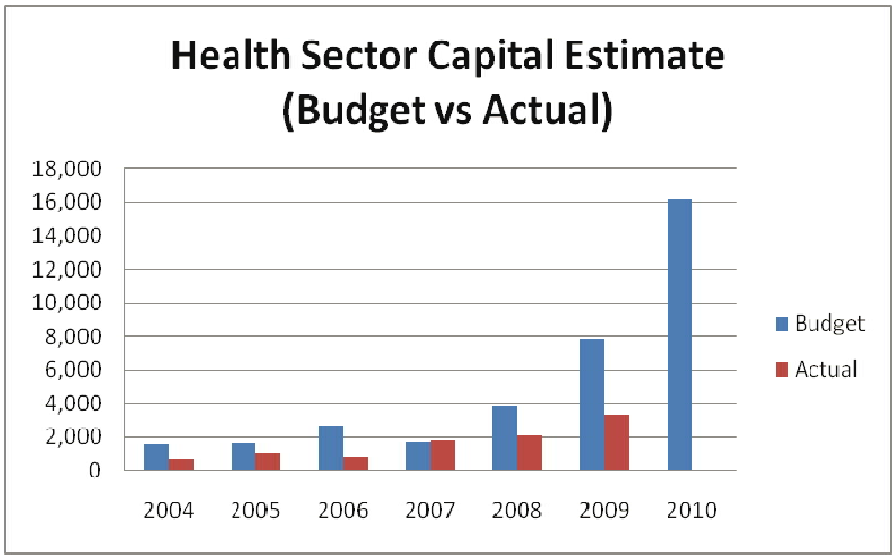
Figures for Birnin Gwari were N.A.

In summary, while the main elements of a budget preparation process do exist at the state level (a strategic plan and a budget team that includes CSO members), results suggest that the capacity of the planning and budgeting team at the SMoH is still lacking. The fact that the majority of State revenues originate from statutory allocations raises concerns about the State's ability to sustain its development priorities. At the LGA level, political considerations and state interference are driving spending, with minimal consideration from the community. This ultimately reflects on the appropriateness of budget allocation across and within the LGAs.

4.4 Budget Execution at the State Level

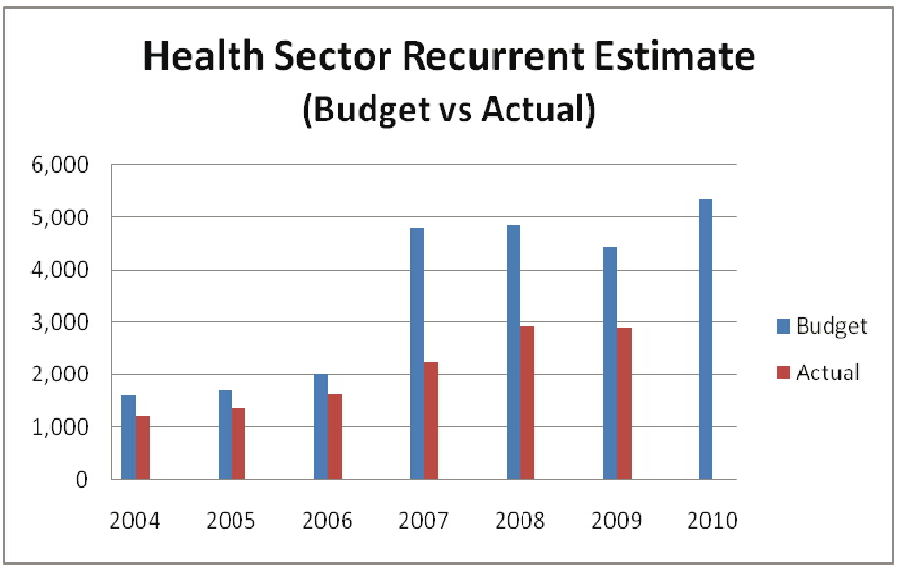
A large portion of the State's health budget is not actually spent. According to data provided by the Ministry of Economic Planning in Kaduna, budgetary executions for the health sector have been on a steady decline since 2005. There has been a decrease in the percentage of budgets (both capital and recurrent) that are actually disbursed for health spending (Figures 4 & 5). In 2009, the health capital budget for the state was estimated around N7.9 billion, of which approximately 3.6 billion were released (about a 46% execution). For recurrent spending, the budget was around N4.4 billion, with an actual release of N2.9 billion (66% execution). In total, actual release of funds for the health sector in Kaduna State is merely 53% of planned budgetary allocations, and has been on a decline since 2004 (Figure 6).

Figure 4: Capital health budget versus actual spending for Kaduna State, 2004-2010



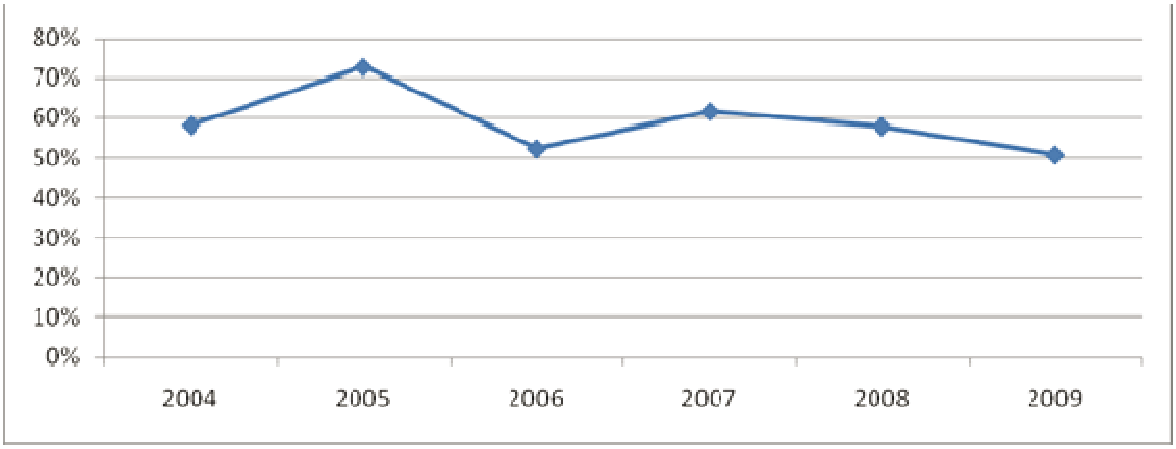
In =N million; Source: Ministry of Economic Planning, Kaduna State

Figure 5: Recurrent health budget versus actual spending for Kaduna State, 2004 – 2010



In =N million; Source: Ministry of Economic Planning, Kaduna State

Figure 6: Funds released to the health sector as a percentage of budgetary allocations in Kaduna State, 2004 – 2009



Source: Ministry of Economic Planning, Kaduna State

Gaps between the budget estimates and actual spending for capital funds may reflect the way in which transactions are recorded in budget and accounting books – either on a cash basis or an accrual basis. The latter is the better approach for sound financial management. It may take a while to incur spending for large capital projects, which would partly explain these gaps. On the other hand, there may be low absorptive capacity in the state that is preventing the health sector from assimilating the investments planned.

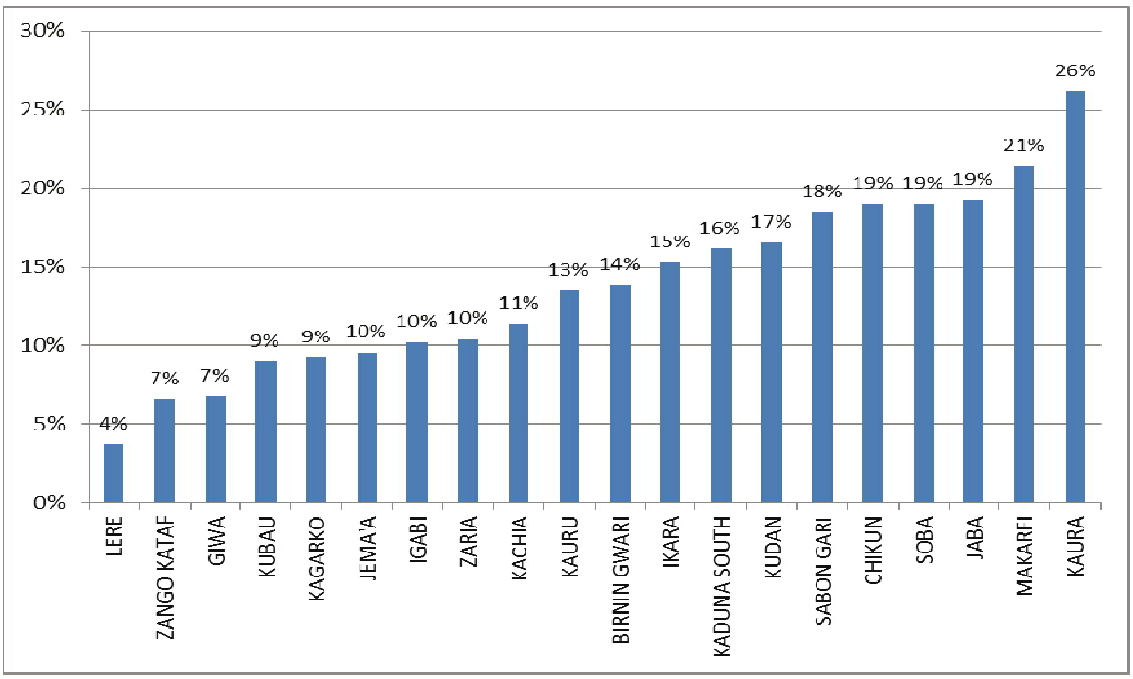
The gaps with recurrent spending are more serious, and usually reflect misalignment between budgeting priorities and actual spending. This is often the result of over-ambitious planning and budgeting, possibly driven by political over-promises on spending. Whatever the reasons might be, the weak budget execution rate is a clear sign of a deficient planning process that has undoubtedly impacted the performance and the ability of the state to deliver quality health services. In the context of a results-based process such as the MTSS, the decline in funds' utilisation rate as seen over the years will pose significant challenges in reaching targets on key performance indicators.

An estimated 86% of total actual health spending for the state is on 29 secondary facilities that receive state resources. The funding of the primary health care centres is the primary responsibility of the local governments, and these centres are exclusively funded (recurrent and capital) by the local governments. However, in Kaduna State, the government is currently implementing the Free MCH programme, which involves identified PHCs and all secondary health facility in the provision of free services to pregnant women and children under five. The state provides these PHCs with commodities and drugs to cushion the financial impact of the policy, and this represents the bulk of the state's support to the PHCs.

4.5 Budget Execution at the LGA Level

Health spending in LGAs constituted on average about 12% of total spending in 2009, albeit with significant variations across LGAs. Figure 7 shows health spending in each LGA as a share of total spending. At the lowest end are Lere, Zango Kataf, and Giwa, with less than 8% spent on health. At the highest end are Makarfi and Kaura, with 21% and 26% of spending allocated to health, respectively.

Figure 7: Health spending in 2009 as a share of total spending, by selected LGAs in Kaduna State



Source: Ministry of Local Government, Kaduna State

Figures for Kaduna North, Kajuru, and Sanga were N.A.

For the majority of LGAs in Kaduna, health spending in 2009 as reported by the state is aligned with budgeted funds. Table 4 shows total capital and recurrent budget allocations for health and actual spending in all LGAs in Kaduna. These figures are obtained from the budget documents of the Ministry of Local Government in Kaduna State.

Table 4: Capital and recurrent health funds in 2009 by LGA, budget versus actual (in Naira)

LGAs	Capital funds, 2009			Recurrent funds, 2009		
	Budget allocation	Actual spending	Actual as % of allocated	Budget allocation	Actual Spending	Actual as % of allocated
BIRNIN GWARI	N.A.	103,006,276	N.A.	N.A.	167,092,823	N.A.
CHIKUN	164,175,447	164,175,447	100%	226,634,078	216,945,569	96%
GIWA	110,701,207	83,222,257	75%	118,552,800	159,552,800	135%
IGABI	53,900,000	53,900,000	100%	234,080,832	211,971,829	91%
IKARA	81,000,000	81,000,000	100%	117,393,997	117,393,997	100%
JABA	108,991,892	108,991,892	100%	142,358,196	142,358,196	100%
JEMA'A	87,790,176	87,790,176	100%	98,337,412	98,337,412	100%
KACHIA	127,725,236	127,725,236	100%	140,612,814	140,612,814	100%
KADUNA NORTH	73,563,917	N.A.	N.A.	115,635,940	N.A.	N.A.
KADUNA SOUTH	81,250,000	81,250,000	100%	192,942,222	192,942,222	100%
KAGARKO	85,034,291	85,034,291	100%	98,805,172	98,805,172	100%
KAJURU	90,309,905	N.A.	N.A.	94,986,513	N.A.	N.A.
KAURA	88,000,000	88,000,000	100%	112,507,584	112,507,584	100%
KAURU	74,725,295	74,725,295	100%	133,501,094	133,501,094	100%
KUBAU	114,102,391	114,102,391	100%	135,122,620	70,622,621	52%
KUDAN	73,463,552	73,463,552	100%	113,353,549	113,353,549	100%
LERE	57,553,450	N.A.	N.A.	202,275,133	60,725,157	30%
MAKARFI	128,713,324	128,713,324	100%	90,351,476	90,351,476	100%
SABON GARI	85,000,000	85,000,000	100%	173,905,098	205,863,328	118%
SANGA	90,273,764	N.A.	N.A.	89,154,895	N.A.	N.A.
SOBA	104,100,000	124,100,000	119%	164,925,889	176,316,607	107%
ZANGO KATAF	121,100,000	121,100,000	100%	93,868,836	93,868,836	100%
ZARIA	129,581,858	63,570,000	49%	83,801,796	124,393,591	148%

Source: Ministry of Local Government, Kaduna

Table 4 shows that for the majority of LGAs, as reported by the Ministry of Local Government in Kaduna State, actual spending in health was equal to the amount of budgeted funds. However, a few LGAs such as Giwa, Sabon Gari, and Zaria spent more than their originally allocated recurrent budgets. According to the budget office of the Ministry of Local Government, these LGAs applied for supplementary appropriation midway into the implementation of the approved budget, hence the increase. However, little information was given regarding the rationale for the increase. In contrast, actual releases in Kubau and Lere, for instance, were merely 52% and 30% of the total recurrent allocation, respectively. The comparatively low health sector budget performance in this instance suggests that the LGA IGR performed poorly, resulting in the dependence on statutory allocations to drive the entire LGA expenditure. Consequently the available funds were inadequate to satisfy the initial health budget demands. Alternatively, the budgeting process was not aligned with the resource framework of the local government. In either of the two cases, the low performance reveals the weakness in the capacity of the Local Government to articulate realistic demand-driven budgets.

However, there seems to be significant misreporting of actual spending on health by the LGAs. It is important to note that the numbers presented in Table 4 originate from the budget documents at the state level. The survey collected the same information directly from the LGAs, and out of 23, only 13 provided information on budgets and 9 on actual spending. For these LGAs, the information provided is for the most part substantially different from the information provided by the state. Table 5 compares actual spending on health as reported by the state to spending reported by the various LGAs who responded to the questionnaire. The majority of LGAs reported spending less than what was recorded on the Ministry of Local Government's books (a negative percent deviation). A couple of LGAs, like Kaura and Kubau, reported a higher figure.

[4] The State Ministry of Local Government is the supervising ministry for local government in Nigeria. The ministry provides oversight on all activities of the local governments, especially their budget, but within the limits of the constitution, as LGAs are an autonomous level of government.

Table 5: Discrepancies in health spending by LGAs in 2009, as reported separately by the state and LGAs (in Naira)

LGA**	Actual health spending in 2009		
	Source: Ministry of Local Government Kaduna State	Source: Survey of LGAs	Percent Deviation
ZANGO KATAF	214,968,836	133,949,532	-38%
GIWA	242,775,057	104,992,431	-57%
KUBAU	184,725,012	280,356,515	52%
BIRNIN GWARI	270,099,099	171,168,283	-37%
IKARA	198,393,997	197,043,085	-1%
SABON GARI	290,863,328	180,611,730	-38%
SOBA	300,416,607	269,525,889	-10%
JABA	251,350,088	12,011,289	-95%
KAURA	200,507,584	563,598,903	181%

Sources: Ministry of Local Government, Kaduna State and Survey data

**Only 9 out of 23 LGAs provided data on actual spending. The remaining data were not available.

It is unclear what the reasons for such discrepancies might be. However, the results in Table 5 suggest that the reasons may include the lack of sound reporting and information systems and the absence of a transparent internal system of checks and controls to reconcile and track resource flows across the different MDAs.

Similarly, there is significant misreporting of health funds by hospitals financed by the state. Out of a total of 18 secondary facilities surveyed in Kaduna State, only 9 reported health resources received from the state. A comparison of these reported figures with the amount of funds disbursed to secondary facilities as reported by the State of Kaduna shows significant differences (Table 6). The hospitals are not named in the table, but the LGA in which they are located is shown. Again, the large gaps highlight the absence of accurate reporting at the facility level and raise questions as to whether an adequate reporting mechanism exists that reconciles resource flows between the various agencies and institutions.

Table 6: Discrepancies in health funds disbursed in 2009 to secondary facilities, as reported separately by the state and facilities (in Naira)

Health funds disbursed by the state to the secondary facility, as reported by:		
	Kaduna State	The secondary facility
BIRININ GWARI	27,712,009	100,000,000
CHIKUN	13,986,741	1,000,000
JABA	17,852,891	36,000,000
KADUNA NORTH	2,107,632,490	180,000,000
KAGARKO	20,277,193	60,000,000
ZANGO KATAF	16,873,672	60,000,000

Sources: Kaduna State and Survey data

**Only 9 out of 18 secondary facilities provided data on health funds. The remaining were N.A.

PHC facilities do not have much financial autonomy. In fact, evidence suggests that all transactions are conducted by the LGA on behalf of the facilities. The LGA budgets do not usually specify allocations to individual PHC facilities, while actual expenditures are recorded in disbursement journals, which are not easily made available to the public. LGAs were asked to report on the health expenditures incurred by the PHCs in their areas. The figures reported in the survey were highly deficient. This highlights the lack of reliable and transparent financial information at the LGA level. It is important to further investigate whether the LGAs have an accounting system in place that allows tracking of disbursements to and expenditures by PHC facilities, and whether they have a procurement process where requests are made and reconciled. It is unclear from the evidence gathered during the survey whether such systems exist.

In summary, weak budget execution at the state level since 2005 suggests a misalignment between over-ambitious budgets and actual spending, which is undermining the credibility of the planning process. This will undoubtedly impact the performance and the ability of the state to deliver quality health services. At the LGA level, the budget reports of the Ministry of Local Government in Kaduna State suggest that health spending in 2009 is generally aligned with budgeted funds for the majority of LGAs. However, spending figures reported by LGAs differ significantly from those reported at the state level, which reflects the absence of a transparent internal system of checks and controls that is able to reconcile and track resource flows across the different MDAs. This is also the case between the state and secondary facilities. Furthermore, there may be a lack of records or of transparent financial reporting at the LGA level, especially with regard to specific allocations to PHC facilities. Facilities indeed do not maintain their own budgets (as will be discussed in the next section) and are not given any financial autonomy.

4.6 Facility Governance

The vast majority of surveyed facilities reported having a health committee or a management board (including all tertiary facilities, 95% of secondary facilities, and 88% of PHCs). These committees meet regularly and discuss a variety of issues relevant to the management of the facility, such as service delivery, budgets, user fees, and human resources. There are on average 47 people on the health committees in tertiary facilities, 13 in regional hospitals, and 13 in PHCs. Committees/boards in tertiary hospitals met on average 12 times in 2008 and 21 times in 2009, as opposed to those in regional hospitals and primary facilities, who report meeting on average between four and five times annually in the last two years.

Table 7 shows the composition of these committees, as reported by the facilities. Thus, around 76% of secondary facilities and 92% of PHCs reported having district or community representatives on their health committees, respectively.

Table 7: Composition of health committees or management boards by type of facility, in percent

	Tertiary (n=2)	Secondary (n=17)	Primary (n=105)
Officer in charge of facility	100.0	100.0	96.2
Other staff	0.0	94.1	73.3
District/community rep.	100.0	76.5	92.4
Parent rep.	50.0	47.1	70.5
Reps from Mosques/churches/NGOs	100.0	41.2	89.5
Local politicians	100.0	76.5	79.1

Source: Survey data

Staff meetings are held at the majority of facilities, and they occur between two to six times per year, depending on the facility. Attendance is usually partial: 50%, 57% and 69% of staff attended the last staff meeting held in tertiary facilities, regional hospitals, and primary facilities, respectively.

Unlike in tertiary and secondary facilities, which have some degree of decision-making responsibility, decision-making at the PHC level falls almost exclusively on the LGA. The overwhelming majority of PHC facilities (88.3%) reported that the primary responsibility for decision-making for most of the facility-level provisions of PHCs falls on the LGAs (Table 8). This includes planning and preparation of the budget, budget implementation, budget monitoring and evaluation, setting the levels of user fees, choosing the staff to hire, and to some extent assessing the performance of staff and deciding on maintenance work. This probably explains why almost none of the PHCs reported having a budget on their own (see next section).

Table 8: Principal decision-makers for PHC facility functioning by activity, in percent

	State	LGA	Facility Head	Health Committee/ Board	Local politician	Community
Planning and preparation of budget	6.8	89.8	0.0	0.0	1.7	1.7
Budget implementation	8.5	88.1	0.0	0.0	1.7	1.7
Designing of procedures and protocols	6.5	88.7	1.6	0.0	1.6	1.6
Budget monitoring and evaluation	6.6	90.2	0.0	0.0	1.6	1.6
Setting the level of fees at the facility	5.2	87.9	0.0	1.7	1.7	1.7
Choosing the staff to hire	6.5	90.3	0.0	0.0	1.6	1.6
Assessing staff performance	6.1	85.7	4.1	0.0	2.0	2.0
Deciding on maintenance work	4.7	83.7	0.0	7.0	2.3	2.3
Overall	**6.4**	**88.3**	**0.7**	**0.9**	**1.8**	**1.8**

Source: Survey data

The survey provides evidence of some degree of accountability to the community. Facilities remain accountable to their clients in several ways. These are listed in Table 9 below.

Table 9: Accountability measures at the facility, in percent

	Tertiary (n=2)	Secondary (n=18)	Primary (n=119)
Suggestion boxes	**0.0**	**61.1**	**30.3**
Regular meetings with community	**50.0**	**50.0**	**73.9**
Making some citizens part of the management committee	**50.0**	**55.6**	**63.9**
Presentation of operations report to the community	**50.0**	**55.6**	**50.4**
Community participating in monitoring and evaluation of activities in facility	**100.0**	**55.6**	**45.4**

Source: Survey data

Facilities reported the number of annual supervisory visits by various government-level officers. On average, facilities were visited 1 – 5 times annually by federal-level officers (depending on the type of the facility), 8 –13 times by LGA-level officers, 3 – 5 times by state-level officers, and 3 – 6 times by development partners. Most of these visits are routine supervision of facility management, as well as monitoring and evaluation. Supervisors usually meet with the facility director, some staff, and to a lesser extent with patients and the community leaders. They often check facility records, and in some cases, particularly in PHCs, they observe consultations.

More than 50% of facilities do not keep detailed spending records. About two-thirds of PHCs and one-third of regional hospitals surveyed did not keep detailed spending records. The same goes for receipts of income and subsidies from various sources. Among the challenges with record-keeping cited by the facilities are the lack of capacity and the inadequate supply of materials for record-keeping.

According to the survey results, the majority of PHCs do not maintain a budget. Ninety-one percent of PHCs stated that they did not have a facility budget. For these reasons, we were unable to obtain financial and budgetary information from most of the PHCs, particularly on funds received and spent.

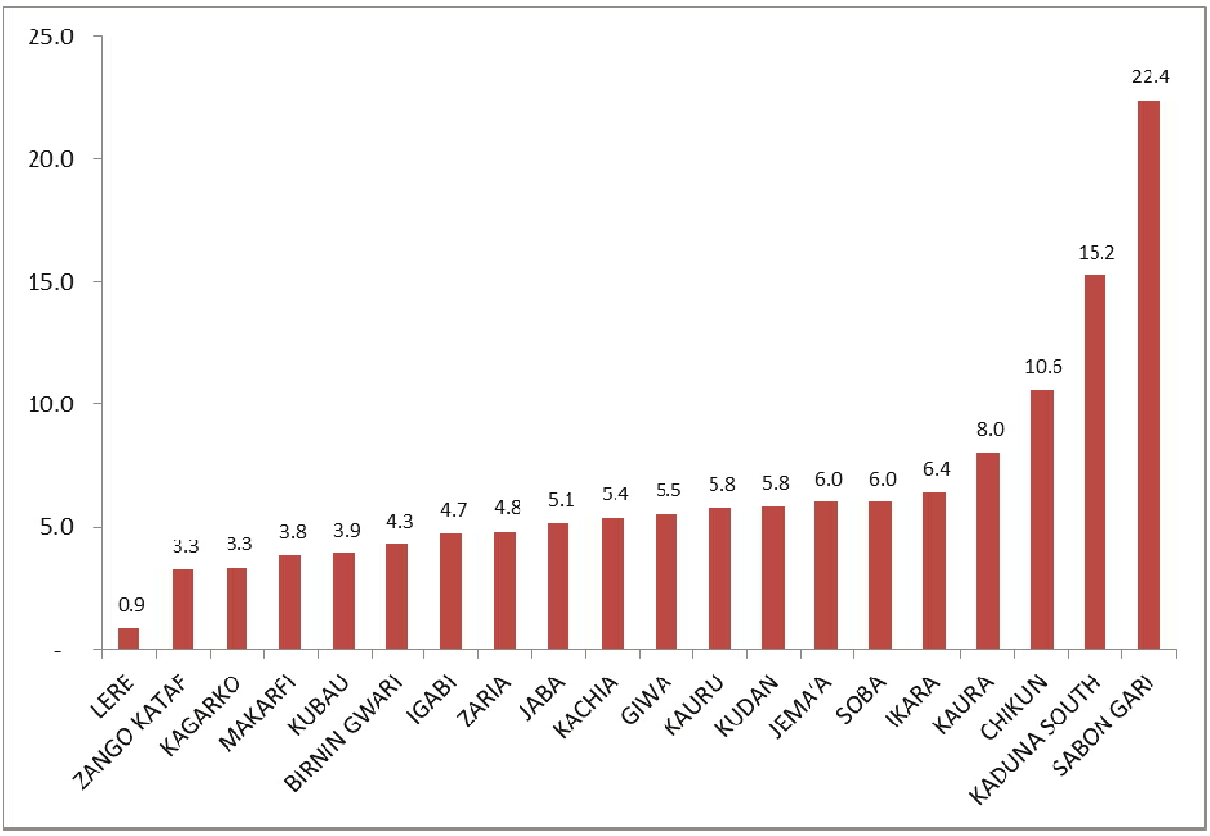
In summary, despite the fact that the majority of PHC facilities have a health committee or a management board, and take measures to ensure accountability to the community, responsibility for decision-making at the PHC level falls almost exclusively on the LGAs. This is compounded by the fact that almost no PHC facility maintains a budget and about two-thirds do not keep detailed expenditure records or receipts.

4.7 Budget Utilisation

The data suggest a misallocation of health resources across LGAs and a system of budget allocation that is not based on real needs. Due to the absence of information on health spending in each facility, we divided total health funds spent by the LGAs (as reported by the Ministry of Local Government) by the number of PHCs in each to get an estimate of the relative size of these funds.

For the majority of LGAs, the ratio of health funds to the total number of PHCs ranges between N4 million and N7 million (Figure 8). One may think of these figures as the share of an average PHC facility in the health spending of an LGA, assuming that the majority of that spending in LGAs is incurred by PHC facilities. Figure 8 shows, however, that there are a few outlier LGAs. In particular, a PHC facility in LGAs like Kaduna South and Sabon Gari (with a share of N15.2 million and N22.4 million, respectively) has a share of health spending that is more than 15 and 20 times higher than a PHC facility in Lere or Zango Kataf (with a share of less than N4 million). This may be due to a weak budgeting process at the LGA level that results in a misallocation of resources, or a lack of local capacity to spend the budget out.

Figure 8: Health spending by LGAs in 2009 as a ratio of the number of PHCs in selected LGAs (in million Naira)

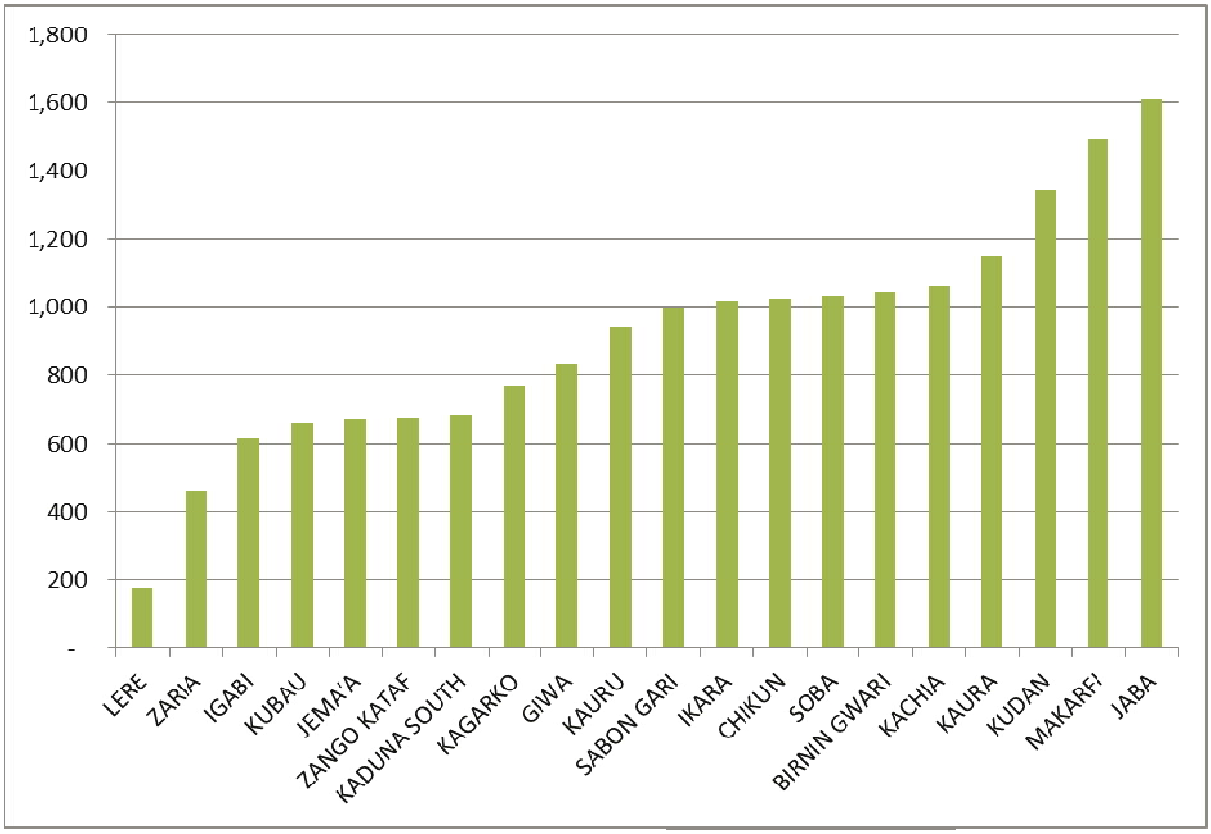


Source: Ministry of Local Government, Kaduna State

Data is N.A. for Kaduna North, Kajuru, and Sanga.

Per capita health spending differs significantly from one LGA to another. Another way to look at patterns of budget use across LGAs is to estimate the per capita health expenditure for each LGA. Figure 9 shows per capita health spending in 2009 in selected LGAs. Thus on average, a person in Jaba has a share in health spending almost 10 times as high as a person in Lere. This variation may be partly due to weak budget execution in certain LGAs. Indeed, it is interesting to note that Lere, Zaria, Igabi and Kubau, which have the lowest per capita shares in spending, each have lower than 100% execution of health budgets (refer to Table 4 in the previous section). In contrast, Jaba, Makarfi, Kudan, Kaura, and Kachia, which have the highest per capita shares, have each spent 100% of their health budgets. It is important to remember, though, that these numbers are those reported by the State of Kaduna, and not by each individual LGA.

Figure 9: Per capita health spending in LGAs in 2009, selected LGAs (in Naira)



Source: Ministry of Local Government, Kaduna State

Data is N.A. for Kaduna North, Kajuru, and Sanga.

Facility conditions

Facility output, as measured by the number of outpatient and inpatient consultations, depends on the amount of resources (monetary, equipment, human resources, etc.) available to the facility, but also on the enabling environment (facility conditions) that eventually affect the quality of service delivery. We analysed survey data to better understand the conditions for service delivery at the facility level and try to establish links with health resources spent at the LGA level. This will allow an examination of the ways in which the budget gets used at the service delivery levels. We link the data obtained at the facility level with data collected at the state and local government levels, specifically data related to financing arrangements, to identify potential links between resource availability and facility performance.

An estimated 48% of consultation rooms in surveyed secondary facilities and 52.5% in primary facilities are "poorly equipped." The conditions in PHC facilities are especially weak. Less than half of PHC facilities have a pharmacy on the premises, while the majority of hospitals do (Table 10). There is a real shortage of working laboratories in PHC facilities: only 37.8% have a laboratory, which suggests that diagnosis and treatment are rarely based on testing. Basic amenities such as toilets and electricity also seem to be too rare: only 41% of PHC facilities and 33.3% of secondary facilities said they had toilets, and as few as 21.8% of PHC facilities said they had alternative sources of electricity. The vast majority of secondary hospitals (95%) and 60% of PHCs get their water from wells or bore holes. Water is not available all year round, and in some cases not at all: 17.6% of PHCs reported not having any water source. Access to transport vehicles for emergencies is almost non-existent at the PHC level (only 2.5% of PHC facilities reported having an ambulance).

Table 10: Conditions of facilities, by type (in percent)

	Tertiary (n=2)	Secondary (n=18)	Primary (n=119)
Outpatient area	100.0	94.4	78.9
Pharmacy	100.0	88.9	47.9
If yes, functional?	100.0	100.0	92.9
Facility secure at all times	100.0	38.9	40.4
Facility walled or fenced	50.0	61.1	28.6
Laboratory	50.0	88.9	37.8
If yes:			
Availability of standard of practice?	100.0	68.7	44.4
Space with temp regulator?	100.0	56.2	26.7
Reagent?	100.0	93.7	40.0
Electricity?	100.0	62.5	35.6
Lab equipment?	100.0	87.5	37.8
Water	100.0	100.0	37.8
Toilets	100.0	33.3	41.2
If yes, separate for females?	100.0	83.3	83.7
Alternative electricity source	100.0	72.2	21.8
Power shortages:			
Half of the time	0.0	5.6	2.5
Most of the time	0.0	33.3	18.5
All the time	0.0	44.4	57.2
Water available all year round?	50.0	55.6	47.1
Ambulance	50.0	66.7	2.5
Specialist doctor	50.0	5.6	2.5
Kitchen/cafeteria	50.0	16.7	2.5
IEC material	100.0	44.4	48.7

Source: Survey data

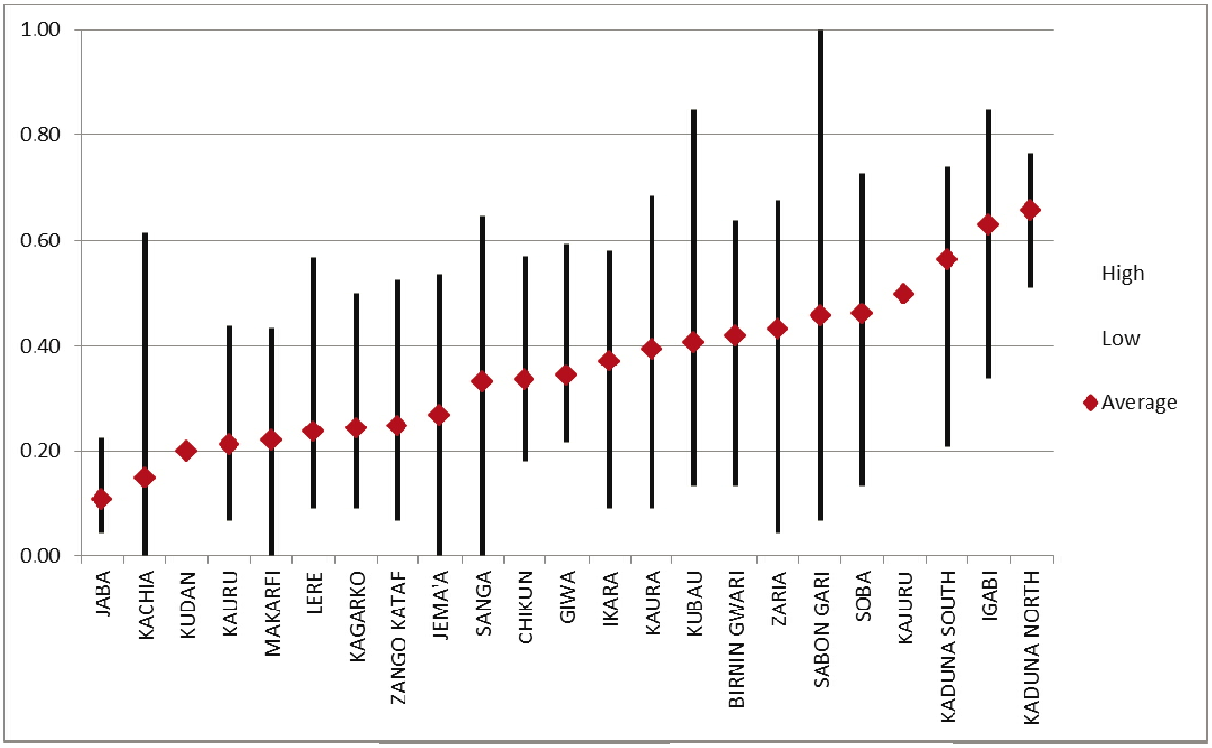
We used Principal Component Analysis (PCA) to combine 10 indicators of a facility's physical conditions into one aggregate index (hereafter Physical Condition Index). PCA is a statistical technique that seeks a linear combination of variables such that the maximum variance is extracted from the variables. The Physical Condition Index was constructed using the following 10 indicators:

1. Does the facility have a functional pharmacy?
2. Does it have a working laboratory?
3. Does it have working toilets?
4. Is the facility secure at all times?
5. Is it walled or fenced?
6. Does it get electricity?
7. Does it have an alternative source of electricity?
8. Is water available all year long?
9. Does it have a kitchen or cafeteria?
10. Does it have an outpatient area?

The Physical Condition Index can thus be considered an aggregate indicator for the overall quality of the facility, which has a direct effect on service delivery. We ran the PCA for PHC facilities only (we excluded hospitals because of the small sample size; a large variability in the data is needed for PCA to be effective). We created the Physical Condition Index and rescaled it to vary between 0 and 1: the higher the Index, the better the condition of the facility.

The average value of the Physical Condition Index over all sampled PHCs in Kaduna is 0.36. As expected, the value is higher for urban facilities (0.55) then for rural facilities (0.28). For each LGA, we plotted PHC facilities according to the value of their Index and calculated the average across sampled facilities in each LGA. The results are shown in Figure 10.

Figure 10: PHC facilities ranked according to the Physical Condition Index, by LGA



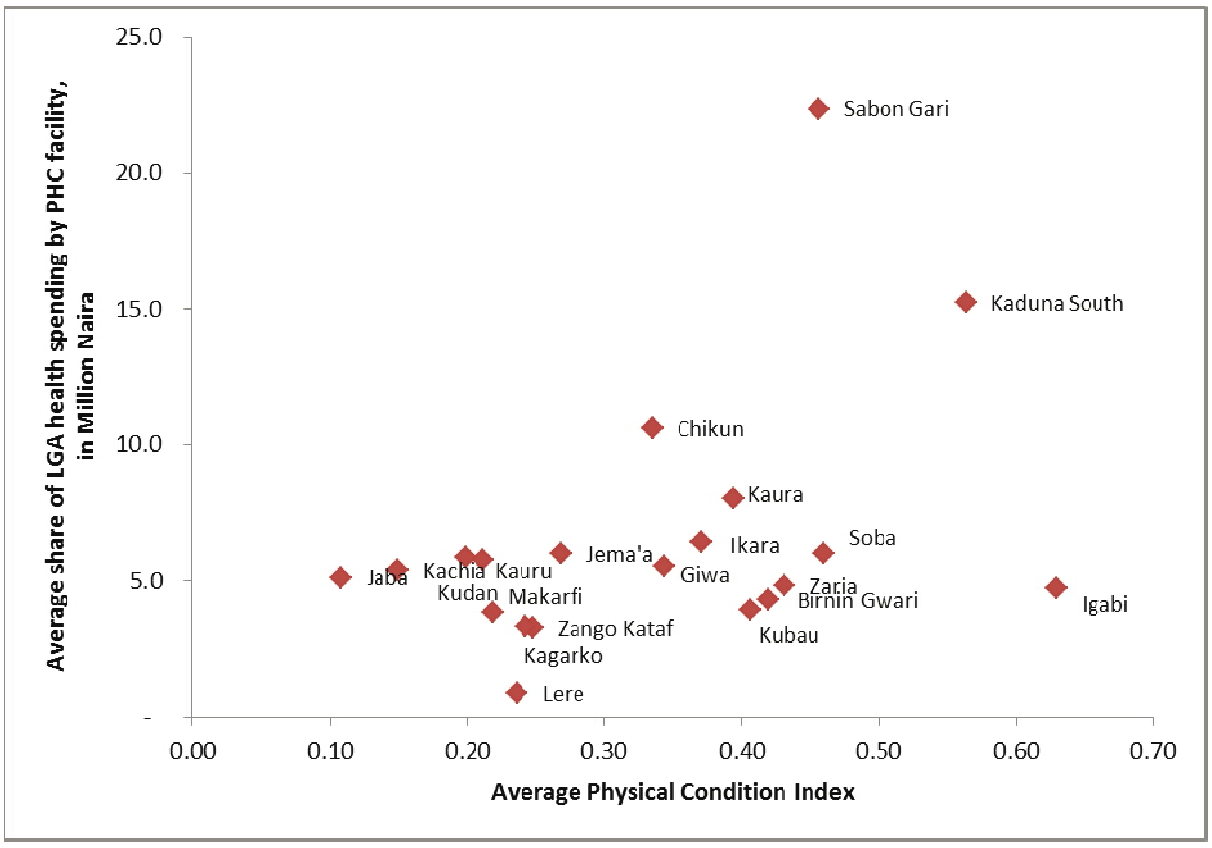
Source: Survey data and estimations

Note: For Kudan and Kajuru, only one PHC reported answers to the indicators in the Index.

Figure 10 ranks LGAs from the one with the lowest average value of the Physical Condition Index to the one with the highest. The averages are shown in the red diamond, and the ranges of values (high, low) within each LGA are shown by the black bars. For instance, the sampled PHCs in Giwa have an average Index of 0.34. The PHC in Giwa with the lowest value of the Index has a value of 0.22, while the highest has a value of 0.59. According to Figure 10, surveyed facilities in Kaduna North have the highest average Index, while those in Jaba have the lowest.

There is a weak correlation between facility condition and available resources. Figure 10 above shows facilities in Jaba, Kachia, Kudan and Kauru with the lowest average Physical Condition Index compared to the rest of the surveyed facilities in the state. However, Figure 8 showed that average health spending for each facility in these LGAs is in the mid-range compared to the rest of the state. We plotted the average share of health spending per PHC facility (as estimated in Figure 8) against the average Physical Condition Index for each LGA (Figure 11). Not accounting for Sabon Gari and Kaduna South (which appear as outliers compared to the rest), the results show a weak relationship between resources spent and facility conditions, suggesting that resources are not being used most effectively. Note, however, that the surveyed facilities are not representative of all facilities in the LGAs.

Figure 11: Average share of health spending per PHC facility versus average Physical Condition Index, selected LGAs

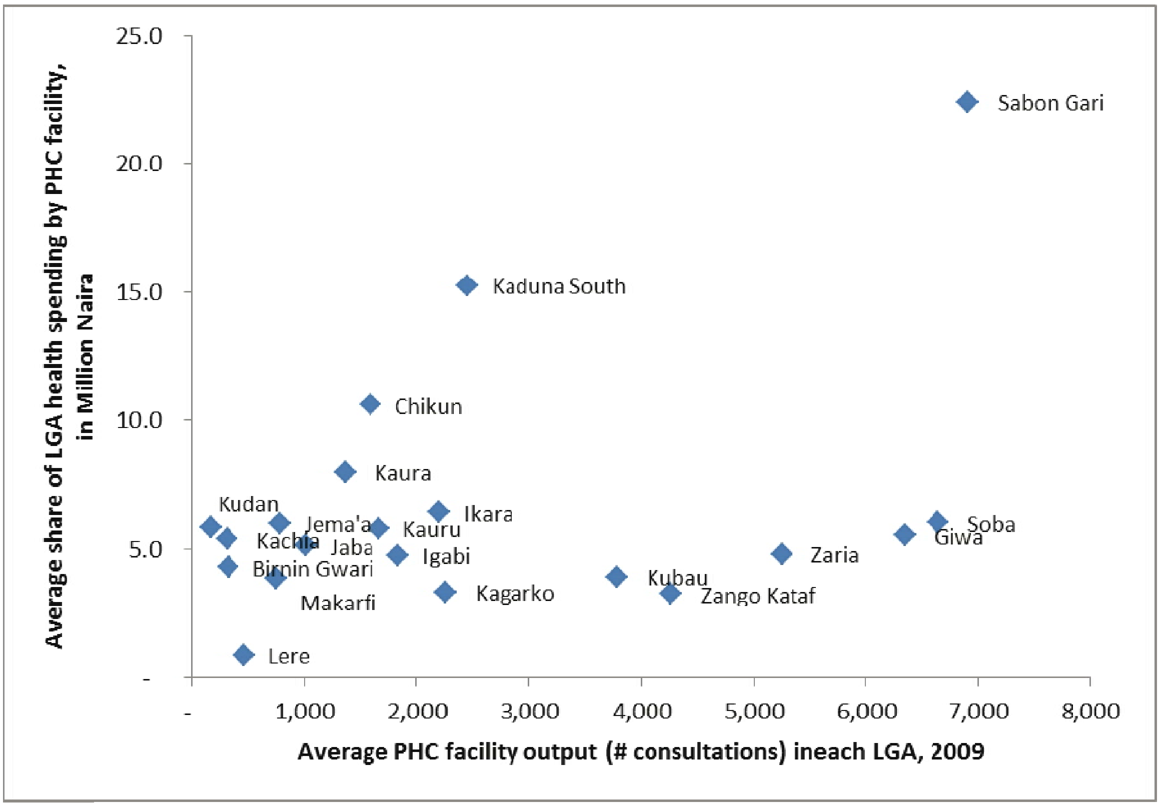


Source: Ministry of Local Government, Kaduna State, survey data and estimations

Data for some LGAs are N.A.

Similarly, there is a weak relationship between facility performance and health spending. Figure 12 plots health resources against average output per PHC facility, that is, the total number of clients served against spending by facility for each LGA in Kaduna State. Again, not accounting for Sabon Gari and Kaduna South, there does not seem to be any particularly strong positive correlation, as one would expect, between health spending and facility output. This suggests that some facilities are performing better than others, despite receiving relatively the same share of health resources. This reiterates the previous finding of resource allocation not being in line with actual service use or demand.

Figure 12: Average share of health spending versus average output per PHC facility, selected LGAs



Source: Ministry of Local Government, Kaduna State, survey data and estimations

Data for some LGAs are N.A.

Discrepancies between recurrent spending as reported by the state and salary estimates in certain LGAs may indicate the presence of fund leakage. Given the absence of budgets and accounting records at the PHC level, we use survey data on the salaries of health workers in PHC facilities to estimate total spending on salaries in each LGA, and compare with recurrent spending by LGA as reported by the Ministry of Local Government. Table 11 shows that for a number of LGAs, the difference between recurrent spending and salary spending is significant. For instance, in Sabon Gari, yearly salary spending represents only 16% of total recurrent spending in PHC facilities, when one would expect a figure closer to 80% (as the majority of recurrent spending is usually salary expenditures). Similarly, in Kaduna South and Chikun, estimated salary spending accounts for less than half of total recurrent spending.

On the other hand, we find that a few LGAs like Lere, Zango Kataf, and Kubau have estimated salary expenditures that are higher than reported recurrent spending. It is important to note that these salary figures are estimates. More accurate figures from the financial records of LGAs are needed to improve the reliability of these results.

Table 11: Recurrent spending versus estimated yearly salary spending by LGA, 2009

	# PHCs	Recurrent spending (in Naira)	Estimated yearly salary spending (in Naira)	Difference (in Naira)	Difference (in % of recurrent spending)
SABON GARI	13	205,863,328	32,604,000	173,259,328	84%
KADUNA SOUTH	18	192,942,222	45,144,000	147,798,222	77%
CHIKUN	36	216,945,569	90,288,000	126,657,569	58%
KAURA	25	112,507,584	62,700,000	49,807,584	44%
IKARA	31	117,393,997	77,748,000	39,645,997	34%
IGABI	56	211,971,829	140,448,000	71,523,829	34%
KAURU	36	133,501,094	90,288,000	43,213,094	32%
GIWA	44	159,552,800	110,352,000	49,200,800	31%
KUDAN	32	113,353,549	80,256,000	33,097,549	29%
SOBA	50	176,316,607	125,400,000	50,916,607	29%
ZARIA	39	124,393,591	97,812,000	26,581,591	21%
JEMA'A	31	98,337,412	77,748,000	20,589,412	21%
JABA	49	142,358,196	122,892,000	19,466,196	14%
KACHIA	50	140,612,814	125,400,000	15,212,814	11%
BIRNIN GWARI	63	167,092,823	158,004,000	9,088,823	5%
KAGARKO	55	98,805,172	137,940,000	(39,134,828)	-40%
MAKARFI	57	90,351,476	142,956,000	(52,604,524)	-58%
KUBAU	47	70,622,621	117,876,000	(47,253,379)	-67%
ZANGO KATAF	66	93,868,836	165,528,000	(71,659,164)	-76%
LERE	69	60,725,157	173,052,000	(112,326,843)	-185%

Source: Ministry of Local Government, Kaduna State, survey data and estimations

Data for some LGAs are N.A.

In summary, results in this section suggest a misallocation of health resources across LGAs, reflecting a system of fund allocation and budgeting that is not based on real demand or needs.

Per capita health spending differs significantly from one LGA to another, which may be partly due to weak budget execution in certain LGAs. Furthermore, there is a weak relationship between resources spent and facility conditions, suggesting that resources are not used most effectively. Similarly, there is no strong positive relationship between facility performance and health spending, which highlights misalignment of resources with actual health service use. Finally, discrepancies between recurrent spending as reported by the state and salary estimates in certain LGAs may indicate the presence of resource leakage between the LGAs and facilities. More accurate data is needed to confirm these claims.

CONCLUSIONS AND RECOMMENDATIONS

In the context of a decentralised system, the primary objective of the PEMR in the Nigerian health sector is to assist the various government agencies in improving their public financial management system to ensure efficient and effective use of health resources. This report presented the findings of the PEMR in Kaduna State. The main results are summarised below:

Budget preparation and planning:

- While the main elements of a budget preparation process do exist at the state level, including a strategic plan and a budget team that includes CSO members, results suggest that the capacity of the planning and budgeting team at the SMoH in Kaduna is still lacking.

- With the majority of state revenues coming from statutory allocations, the budget envelope for the state does not reflect a demand-driven process. This also raises concerns about the State's ability to sustain its development priorities.

- At the LGA level, political considerations and state interference are driving spending, without any strategic direction and with minimal active participation from the community in the budgeting process. This ultimately reflects on the appropriateness and effectiveness of budget allocation across and within the LGAs.

Budget execution:

- Weak budget execution at the state level suggests a misalignment between over-ambitious budgets and actual spending, which is undermining the credibility of the planning process. This will undoubtedly impact the performance and the ability of the state to deliver quality health services.

- At the LGA level, the budget reports of the Ministry of Local Government in Kaduna State suggest that health spending in 2009 is generally aligned with budgeted funds for the majority of LGAs. However, spending figures reported by LGAs differ significantly from those reported at the state level, which highlights the absence of either a sound reporting mechanism or a transparent internal system of checks and controls to reconcile and track resource flows across the different MDAs. This is also apparent between the state and secondary facilities.

- Furthermore, there is lack of sound and/or transparent financial reporting at the LGA level, especially with regard to specific allocations to PHC facilities. Facilities do not maintain their own budgets and are not given any financial autonomy.

Use of budgeting:

- Despite the fact that most of the PHC facilities have a health committee or a management board and take certain measures to ensure accountability to the community, responsibility for decision-making at the PHC level falls almost exclusively on the LGAs. This is compounded by the fact that almost no PHC facility maintains a budget and about two-thirds do not keep detailed expenditure records or receipts.

- Findings suggest a misallocation of health resources across LGAs, reflecting a system of fund allocation and budgeting that is not based on real demand or needs. Per capita health spending differs significantly from one LGA to another, which may be partly due to weak budget execution in certain LGAs.

- Furthermore, there is a weak relationship between resources spent and facility conditions, suggesting that resources are not used most effectively. Similarly, the absence of a positive relationship between facility performance and health spending suggests that resources are not aligned with actual health service use.

- Finally, discrepancies between recurrent spending as reported by the state and salary estimates in certain LGAs may indicate the presence of resource leakage between the LGAs and facilities. More accurate data is needed to confirm these claims.

Recommendations:

The findings of the PEMR have identified several areas for urgent intervention. This section discusses some key recommendations.

The state government needs to reform the current approach in budget preparation and planning, and explicitly involve the LGAs in the process. Although the state has adopted the sector-wide approach to health care delivery, this excludes the LGA level. The new approach that we advocate here would require the LGAs to articulate clear outputs within the framework of the National Strategic Health Development Plan and the state's health care policies, thereby strengthening the coordination of a comprehensive sector-wide response to health services. This would minimize political interference in fund allocation between the various levels of government and impose some accountability structure to the budgeting and planning process.

In addition, both state and LGA budgeting and planning processes should be more accountable and participatory, involving all key stakeholders, especially civil society. The role of beneficiaries in determining the output of the government's annual financial plans should be clearly defined with actionable timelines.

It should be considered a priority to improve the skills of the state and local government planning officers in the participatory budgeting methodologies and the MTSS to contribute to the development of demand-driven budgets. Likewise, Civil Society Organisations should be trained to engage and monitor all the stages of the budget process.

The State Ministry of Local government should review its internal control mechanisms to adequately track local government funds. Even more importantly, the disbursements of resources for and on behalf of the primary health care facilities need to be more transparent, to reduce the occurrence of discrepancies such as those observed during the survey implementation. It would be considered good practice for the facilities to maintain records of all financial transactions, both cash and in-kind.

It is also important to highlight the need for a review of the macroeconomic framework of the state and LGAs to strengthen the very weak performance of the budget. This will be further enhanced by the accelerated passage of the state's fiscal responsibility law, which is currently undergoing legislative action to check the current practice of over-ambitious budgeting.

REFERENCES

Ablo, Emmanuel and Ritva Reinikka (1998). "Do Budgets Really Matter? Evidence from Public Spending on Education and Health in Uganda." Policy Research Working Paper 1926. Washington, DC: World Bank.

Besley, Timothy and Maitreesh Ghatak (2003). "Incentives, Choice and Accountability in the Provision of Public Services." Oxford Review of Economic Policy 19(2): 235–249.

Chaudhury, N. and J.S. Hammer (2004). "Ghost Doctors: Absenteeism in Rural Bengladeshi Health Facilities." World Bank Economic Review 18(3): 423–441.

Chaudhury, N., J. S. Hammer, M. Kremer, K. Muralidharan and F. Halsey Rogers (2006). "Missing in Action: Teacher and Health Worker Absence in Developing Countries." Journal of Economic Perspectives 20(1): 91–116.

Dehn, Jan, Ritva Reinikka and Jakob Svensson (2003). "Survey Tools for Assessing Performance in Service Delivery." In Francois Bourguignon and Luiz Pereira da Silva (eds.), The Impact of Economic Policies on Poverty and Income Distribution: Evaluation Techniques and Tools. A copublication of the World Bank and Oxford University Press.

Filmer, Deon and Lant H. Pritchett (1999). "The Impact of Public Spending on Health: Does Money Matter?" Social Science and Medicine 58: 247–258.

Federal Ministry of Health: Nigeria (FMoH) (1988). National Health Policy. Lagos.

Federal Ministry of Health: Nigeria FMoH (2004). Revised National Health Policy. Abuja.

Federal Ministry of Health: Nigeria FMoH (2004b). National Health Sector Strategic Plan for HIV & AIDS. Abuja.

Federal Ministry of Health: Nigeria FMoH (2010). National Strategic Health Development Plan. Abuja.

Filmer, Deon, Jeffrey S. Hammer and Lant H. Pritchett (2000). "Weak Links in the Chain: A Diagnosis of Health Policy in Poor Countries." World Bank Research Observer 15(2): 199–224.

Filmer, Deon, Jeffrey S. Hammer and Lant H. Pritchett (2002). "Weak Links in the Chain II: A Prescription for Health Policy in Poor Countries." World Bank Research Observer 17(1): 47–66.

Greenley, G.E. (1994). "Strategic Planning & Company Performance, An Appraisal of the Empirical Evidence." Scandinavian Journal of Management 40(4), December 1994, 383 – 396.

Jimoh, A. (2003). "Strategic Management and the Performance of the Nigerian Banking Industry." African Review of Money Finance and Banking 2003, Pp.119-138.

Karger, D. and Z. Malik (1975). "Long Range Planning and Organizational Performance." Long Range Planning Dec., 1975.

Khemani, Stuti (2006). "Local Government Accountability for Health Service Delivery in Nigeria." Journal of African Economies 15: 285–312.

Lewis, Maureen (2006). "Governance and Corruption in Public Health Systems." Working Paper 78, January. Washington, DC: Center for Global Development.

Lindelow, Magnus and Adam Wagstaff (2003). "Health Facility Surveys: An Introduction." Policy Research Working Paper 2953. Washington, DC: The World Bank.

Miller, C.C. & Cardinal, L.B. (1994). "Strategic Planning and Firm Performance: A Synthesis of More Than Two Decades of Research." Academy of Management Journal 37(6) 1649 – 1663.

Reinikka, Ritva and Jakob Svensson (2003). "Survey Techniques to Measure and Explain Corruption." Policy Research Working Paper 3071. Washington, DC: World Bank.

Reinikka, Ritva and Jakob Svensson (2004a). "Efficiency of Public Spending: New Microeconomic Tools to Assess Service Delivery." In Tony Addison and Alan Roe (eds.). Fiscal Policy for Development: Poverty, Reconstruction and Growth. Palgrave Macmillan.

Reinikka, Ritva and Jakob Svensson (2004b). "Local Capture: Evidence from a Central Government Transfer Program in Uganda." Quarterly Journal of Economics 119 (2): 1–28.

Reinikka, Ritva and Jakob Svensson (2005). "Using Micro Surveys to Measure and Explain Corruption." World Development 33 (12) (December).

Robson, W. (1997). Strategic Management & Information Systems (Second Edition). London: Financial Times Pitman Publishing.

Rogers, F. Halsey, J.R. Lopez-Calix, N. Cordoba, N. Chaudhury, J. Hammer, M. Kremer and K. Muralidharan (2004). "Teacher Absence and Incentives in Primary Education: Results from a New National Teacher Tracking Survey in Ecuador." In Ecuador: Creating Fiscal Space for Poverty Reduction. Washington, DC: World Bank, Chapter 6.

World Bank (2004). World Development Report 2004: Making Services Work for Poor People. Washington, DC: World Bank and Oxford University Press.


paths2
Partnership for Transforming Health Systems 2


UKaid
from the Department for
International Development