



A REVIEW OF PUBLIC EXPENDITURE MANAGEMENT IN NIGERIA

NASARAWA STATE REPORT

February 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Marianne El-Khoury, Elizabeth Ohadi, Chinyere Omeogu, and Oluwaseun Adeleke, Abt Associates Inc.

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NASARAWA STATE REPORT

DISCLAIMER

This study and report are made possible by the support of the American People through the United States Agency for International Development (USAID.) The contents of this report are the sole responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government, Abt Associates Inc.

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ACRONYMS

CSO	Civil Society Organization
DFID	Department for International Development
FA	Federation Account
FCT	Federal Capital Territory
FMoH	Federal Ministry of Health
IGR	Internally Generated Revenues
LG	Local Government
LGA	Local Government Authority
MDA	Ministry, Departments, and Agencies
MoLG	Ministry of Local Government and Chieftaincy Affairs
MTSS	Medium-Term Sector Strategy
NGO	Nongovernmental Organization
PATHS2	Partnership for Transforming Health Systems Phase II
PCA	Principal Component Analysis
PEMR	Public Expenditure Management Review
PHC	Primary Health Care
SHDP	Strategic Health Development Plan
SMoF	State Ministry of Finance
SMoH	State Ministry of Health
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organization

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EXECUTIVE SUMMARY

The USAID-funded Health Systems 20/20 project conducted a Public Expenditure Management Review (PEMR) for the health sector in three Nigerian states: Sokoto, Cross River, and Nasarawa. The PEMR examines the flow of funds across government levels down to the service providers and reviews the overall governance environment of public expenditure management. Specifically, the exercise is designed to answer the following questions:

- *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?
- *Budget execution:* How much of the budgeted funds get spent? To what extent does spending follow budget planning?
- *Budget utilization:* What resources are available for service delivery? How are funds utilized at the level of the various agencies and service delivery institutions?

The activity complements the PEMR conducted in five other states (Kano, Kaduna, Enugu, Jigawa, and the Federal Capital Territory) under the Department for International Development (DFID)-funded Partnership for Transforming Health Systems Phase II (PATHS2) project. This activity combined with the PATHS2 project PEMR will produce a richer base of information on public expenditure systems for policymakers in Nigeria. The ultimate purpose is to assist the government of Nigeria and its various agencies in improving public financial management systems in order to ensure an efficient and effective use of health resources.

The PEMR exercise was specifically designed to engage the active participation of all country stakeholders and international partners in the process. 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, World Health Organization, USAID, United Nations International Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA).

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. Three survey questionnaires – the strategic audit, administrative, and facility – were developed through an interactive process involving the various stakeholders. The administrative and strategic audit questionnaires were administered to the relevant public offices (Planning department and Finance and Accounts) at each State Ministry of Health and within each local government authority (LGA). The facility surveys were administered to six randomly selected public sector primary health care (PHC) facilities in each LGA and to all public sector secondary and tertiary level facilities in each state.

This report presents the findings of the PEMR in Nasarawa state. Nasarawa state, with its capital in Lafia, is located in the northern central part of Nigeria. The state has 13 LGAs that are officially recognized by the federal government. Approximately 70 percent of health facilities in the state operate as public institutions owned by either the federal, state, or local government. More than two-thirds of PHC facilities are owned by the LGAs. Despite the fact that provision of quality health care is high on the priority list of the state government, the health sector currently faces a number of challenges. These include low utilization of health services, lack of skilled health professionals, poor logistics management capacity, and a broken-down health infrastructure. The PEMR revealed additional weaknesses that partly explain the poor state of health services in Nasarawa.

The main results of the PEMR in Nasarawa state are summarized as follows:

Budget preparation and planning

- As a result of low investments in health over the past three years, the share of health in the overall state budget has significantly decreased from 11.33 to about 6.5 percent of the total budget. This decrease is inconsistent with the strategic priorities of the Nasarawa State government as highlighted by the Strategic Health Development Plan.
- The fact that the majority of state revenues originate from statutory allocations from the Federation Account raises concerns about the state's ability to sustain its development priorities and respond to the demand of its population. In fact, civil society is largely absent from the budget preparation and planning process. Moreover, large inconsistencies between the total state budget and statutory allocations indicate that the state cannot be expected to spend according to its budget.
- At the LGA level, political considerations and interference are driving planning, with minimal consideration from the community. While budgets are typically developed by the heads of various LGA departments and submitted on an annual basis, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. Revenues originate from the federal government using predetermined indicators that do not take into account state or LGA input. The resulting resource allocation is highly inconsistent across LGAs.

Budget execution

- A large portion of the state's health budget is not actually spent. Weak capital budget execution, primarily attributed to a lack of political will to procure the necessary funds, is undermining the credibility of the budget planning process. This has impacted the state's performance and ability to improve its health infrastructure and deliver quality health services.
- At the LGA level, budget reports show weak budget execution, for both recurrent and capital spending. Spending figures reported by LGAs are widely unavailable – or undisclosed – while those that are, differ significantly from those reported at the state level. This highlights the absence of a transparent internal system of checks and controls that reconciles and tracks resource flows across the different levels of government.

Budget utilization

- Despite the fact that most facilities have a health committee and seemingly take measures to ensure accountability to the community, facilities do not possess much financial autonomy. Facilities do not maintain their own budgets and thus have very little influence on actual spending. For PHC facilities, responsibility for decision making falls almost exclusively on the LGAs. In fact, evidence suggests that all transactions are conducted by the LGA on behalf of the facilities.
- A misallocation of health resources across LGAs reflects a system of fund allocation and budgeting that is not aligned with real demand or needs. Per capita health spending differs significantly from one LGA to another, partly as a result of weak budget execution in certain LGAs.
- There is evidence of a weak relationship between resources spent and facility conditions, suggesting that resources are not effectively utilized.
- Large discrepancies between recurrent spending, as reported by the state, and salary estimates in certain LGAs suggest the presence of resource leakage between the LGAs and health facilities. However, more accurate data are needed to confirm these claims.

The PEMR survey in Nasarawa is the first of its kind in the state. While department heads at the various local governments and other key officials provided the necessary logistical support to the teams, a

number of challenges were encountered during data collection. The most significant was the widespread lack of accurate financial record keeping and reporting, especially at lower levels (facilities and LGAs). In the majority of the primary and secondary facilities visited, access to financial records was very difficult, and where available, data were recorded in formats that did not allow easy retrieval. Facilities did not keep expenditure records nor did they have knowledge of the budget allocated to them. Although budget numbers were made available in some cases, records on spending and actual releases were much harder to obtain. In general, the absence of accurate and detailed records on budgets and expenditures indicates that the government does not have the means to ensure that health resources are distributed equitably, efficiently, and effectively. As a result, holding government officials accountable is difficult, and leakage of funds is more likely to occur.

Strong processes for tracking health budgeting and expenditures provide the foundation for ensuring that health priorities are met and that the right services are delivered. The following is a summary of recommendations:

- Reform the current approach in budget preparation and planning at the state and local levels. LGAs need to articulate clear outputs within the framework of the National Strategic Development Plan and the state's health care policies. Local governments should be able to develop their own strategic plans. This would minimize political interference in fund allocation between the various levels of government and impose an accountability structure to the budgeting and planning process.
- Review the current system of revenue allocation from the federal government to LGAs to allow a more equitable, transparent, and fair allocation process across LGAs.
- Improve the skills of the state and local government planning officers in participatory budgeting methodologies. Likewise, civil society organizations should be trained to effectively engage in and monitor all the stages of the budget planning and implementation process.
- Build capacity in sound financial management processes, tools, and techniques at the federal, state, and LGA levels. Impose adequate financial management and control mechanisms that can effectively track funds at all levels. A financial reporting manual should be developed and adopted at all levels of government. Facilities should be endowed with the capacity (human, financial) to maintain records of all financial transactions, both cash and in-kind.

I. INTRODUCTION AND STUDY OBJECTIVES

Resource allocation and the effective use of these resources have been two major concerns in Nigeria, particularly in the health sector. In 2008, the USAID-supported Health Systems 20/20 project conducted a health systems assessment in Nigeria, which revealed significant weaknesses in health resource tracking across various government levels. Data needed to track resource flows, budgets, and expenditures were largely unavailable (Kombe et al, 2009). Resources at frontline service delivery points were also found to be inadequate. The assessment highlighted the need to perform an in-depth review of public health expenditure systems in Nigeria to provide a better understanding of the current links between public spending and outcomes of health service delivery.

A number of tools are available to review the process of funding flows and management and to identify resource use and leakages. These include surveys such as the Public Expenditure Tracking Surveys, which examine the flow of funds from the central government down to decentralized levels and to service providers, and the Quantitative Service Delivery Surveys, which examine the efficiency of frontline service delivery. A Public Expenditure Management Review (PEMR) combines elements of both surveys and examines the overall governance environment of public expenditure management.

The Health Systems 20/20 project conducted a PEMR in the health sector in three Nigerian states (Cross River, Nasarawa, and Sokoto) based on the methodology developed and used by the World Bank. Multiple countries have used this methodology to review spending in the health, education, and other social sectors. The Health Systems 20/20 PEMR activity complements the PEMR conducted in five other states [Kano, Kaduna, Enugu, Jigawa, and the Federal Capital Territory (FCT)] under the Department for International Development (DFID)-funded PATHS2 project. Together these two activities will produce a richer base of information on public expenditure systems for policymakers in Nigeria.

The ultimate objective of conducting a PEMR for the Nigerian health sector is to assist the government in improving its public financial management system to ensure an efficient and effective use of health resources. The PEMR in Nasarawa was done through a review of the following:

- *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?
- *Budget execution:* How much of the budgeted funds get spent? To what extent does spending follow budget planning?
- *Budget utilization:* What resources are available for service delivery? How are funds utilized at the level of the various agencies and service delivery institutions?

The PEMR exercise was specifically designed to engage the active participation of all country stakeholders and international partners in the process. The aim was to reach consensus over 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 Organization (WHO), USAID, UNICEF, and UNFPA.

This report presents the findings of the PEMR in Nasarawa state. The remainder of the report is organized as follows: Section 2 presents an overview of the Nigerian expenditure system, Section 3 presents the methodology used to conduct the PEMR in all selected states, Section 4 discusses the main findings, and Section 5 ends with some concluding remarks.

2. OVERVIEW OF HEALTH EXPENDITURE SYSTEMS IN NIGERIA

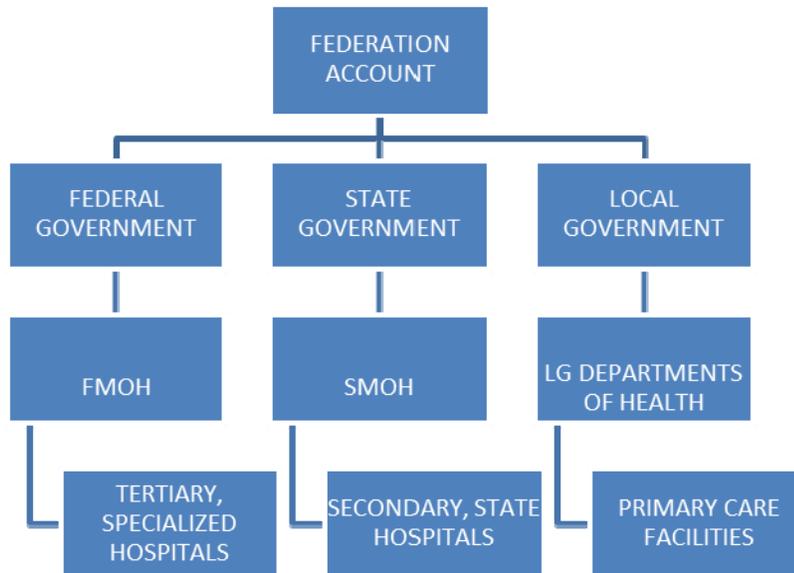
Nigeria is a federal state with three tiers of government, namely, the federal government, 36 state governments, and 774 local governments. Within the public sector, primary level health care falls under the responsibility of local government authorities (LGAs). This means that primary health care (PHC) facilities are for the most part owned and funded by LGAs. Secondary level (and some tertiary) health care, which includes general hospitals, the teaching hospitals of state universities, and state specialist hospitals, falls under the responsibility of state governments. Teaching hospitals of federal universities, federal medical centers, and similar specialized tertiary level health care facilities, including the National Hospital in Abuja, are the responsibility of the federal government (FMoH 1988, FMoH 2004a, FMoH 2004b).

The Federal Ministry of Health (FMoH), the State Ministries of Health (SMoH), and the LGA's Department of Health are each responsible for planning for and managing health spending in their respective jurisdictions. Under each of the ministries (federal and state), associated departments and agencies are referred to collectively as ministries, departments, and agencies (MDAs). The principal actors in the Nigerian public health sector are therefore the FMoH, the 36 SMoHs, the 774 LGA Departments of Health, and the authorities of the FCT, as well as various government parastatals and training and research institutions that are concerned with health matters. Figure 1 illustrates 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.

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 nongovernmental organizations (NGOs), as well as community-based organizations. These facilities include drug stores, pharmacies, clinics, and hospitals (FMoH 2004b). This PEMR study did not include a review of the private sector or other actors involved in the provision of health services (such as the Ministries of Defense, Education, and Internal Affairs).

FIGURE I: DIAGRAMMATIC REPRESENTATION OF THE FLOW OF PUBLIC EXPENDITURE IN HEALTH*



*Note: In some states, the federal government funds and runs certain model primary health care centers through national primary health care development agencies. Funds are typically received for initial logistical support.

Box I. Decentralization Arrangements and Intergovernmental Fiscal Transfers in Nigeria

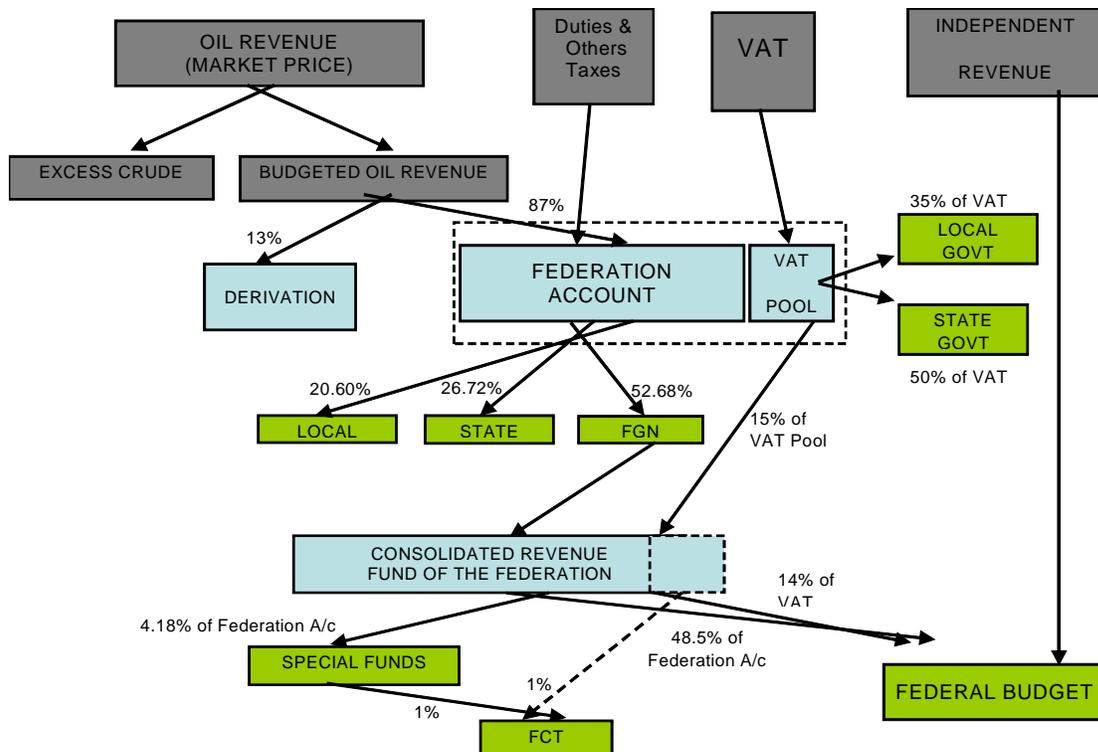
The Nigerian intergovernmental fiscal arrangement is complex, spanning a number of policies and institutional and administrative structures. These fiscal arrangements are strongly influenced by historical, political, social, and economic factors. Accordingly, the constitution assigns government functions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

Currently, 87 percent of all the budgeted oil revenues are paid to the FA and 13 percent 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 percent goes to the federal government (and an additional 4.18 percent is passed through the federal government to special funds), 26.72 percent goes to the state governments, and 20.6 percent goes to the local governments. Of the funds in the VAT pool, 14 percent goes to the federal government (an additional 1 percent goes to FCT through the federal government), 50 percent goes to the state governments, and 35 percent goes to the local governments.

The federal government revenues therefore consist of independent revenues, share from the FA, and share from the VAT pool while the revenues of state governments consist of their Internally Generated Revenues (IGR) and their shares from both the FA and the VAT pool. Similarly, the revenues of the local governments are made up of their IGR, shares from their respective state government’s revenues, and their shares from both the FA and the VAT pool.

Distribution of Nigerian Revenues among Tiers of Government



Source: Revenue Mobilization Allocation and Fiscal Commission (RMAFC)

3. PEMR METHODOLOGY

3.1 STAKEHOLDERS' ENGAGEMENT

The effective participation and support of health sector stakeholders was considered critical to the organization of the PEMR. A committee was established to facilitate the various activities of the review. The Department of Planning, Research and Statistics of the FMoH headed the committee, which included representatives from PATHS2/DFID, the World Bank, WHO, USAID's Health Systems 20/20 project, 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 targeted SMOH and LGAs, as well as sensitization 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 and the need to cooperate with fieldworkers during data collection efforts.

3.2 SURVEY METHODS

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

- 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 when available. These surveys were administered to health facility managers.
- A survey of local- and state-level MDAs to collect information on budgeted resources and key issues related to budget preparation and execution processes. The surveys were administered to public officials at each MDA.

Three survey questionnaires – the strategic audit, administrative, and facility – were developed centrally for the three states in the Health Systems 20/20 project and the five states in the PATHS2 project through an interactive process of discussions among the various stakeholders. The design of the questionnaires followed a multi-angular data collection strategy, which means similar and related information was collected from various sources as a way to cross-validate the information obtained separately. Box 2 summarizes the main information collected through each type of instrument.

3.3 PREPARATORY WORK

The project hired local consultants to lead the data collection efforts in each state and formed field teams for their respective locations. The field teams, composed of supervisors, monitors, and enumerators, attended several training sessions prior to the data collection. During the training, field teams finalized their logistical arrangements and operation plans, and established timelines and roles.

Prior to the data collection process, the developed survey tools were pretested to check the respondent's level of understanding and interpretation of the questions, as well as to determine the most suitable methodology for administration, the length of the questionnaires, the number of enumerators required, and the estimated timeline for data collection. Following the pretest, questionnaires were revised and grouped into modules for ease of data collection.

Box 2. PEMR Survey Instruments

The Strategic Audit instrument –

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

- 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 the following:

- Government sources of funding
- IGR
- 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 utilization* at the facility level, specifically the following:

- Characteristics of the health facility (e.g., rooms, amenities, availability of basic equipment, and infrastructure)
- Human resources (e.g., professional qualifications, salary structure, official positions, gender, age, and tenure)
- Types of services provided and utilization (outpatient, inpatient)
- Facility organization and governance
- Supervision and accountability
- Facility's sources of funding

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 November and December 2010. In Nasarawa, enumerators completed questionnaires in a total of 95 locations: 63 PHC facilities, 17 secondary health care facilities, and one tertiary facility, along with 14 MDAs (13 LGAs and the SMoH).

Field teams implemented quality control measures throughout the sampling process, as project consultants and supervisors provided logistical support for those traveling to each facility, screened questionnaires, and sent questionnaires back to respondents when further clarification and additional data were required.

3.5 DATA PROCESSING AND ANALYSIS

Data processing and analysis were centralized. A customized program was developed for data entry using CSPro. Data for all states were entered during January and February of 2011. Data were then transferred to Excel and STATA for cleaning, consistency checks, and analysis.

Preliminary results were validated and discussed with a number of state and LGA authorities, including the director of planning, research and statistics at the SMoH, the state director of PHC, a representative of the budget office, PHC coordinators, and representatives of the State Ministry of Finance (SMoF), Ministry of Local Government and Chieftaincy Affairs (MoLG)¹, and the auditor's general office.

3.6 IMPLEMENTATION CHALLENGES

A number of challenges were expected during the implementation of this study. First, the sensitivity of the financial information collected through the surveys and the potential implications of the PEMR assessment often result in some resistance to share financial data. The advocacy and sensitization workshops at the beginning of the process were conducted to address this issue. Second, the absence of financial records and the presence of data inconsistencies have been widespread in similar assessments conducted in other countries. This is often the result of weak systems, poor enforcement of sound financial principles, and the lack of technical capacity in financial management. One of the objectives of the PEMR was to identify such weaknesses, and, therefore, challenges with data availability and accuracy were expected from the onset of the exercise.

¹ The State Ministry of Local Government and Chieftaincy Affairs is the supervising ministry for local government in Nigeria. The ministries provide oversight on all activities of local governments, especially their budgets, but within the limits of the constitution, as LGAs are considered an autonomous level of government.

4. MAIN RESULTS

4.1 OVERVIEW OF NASARAWA STATE

Located in the northern central part of Nigeria, Nasarawa state, with its capital in Lafia, was created on October 1, 1996, from the then Plateau state. It has boundaries with Benue state in the south, Kogi state in the west, the FCT in the northwest, Kaduna and Plateau states in the northeast, and Taraba state in the southeast. According to the 2006 census, the population of Nasarawa is 1.8 million and includes more than 30 ethnic groups. The state derives most of its funds from statutory allocation from the Federation Account (FA). Economically, it depends heavily on agriculture.

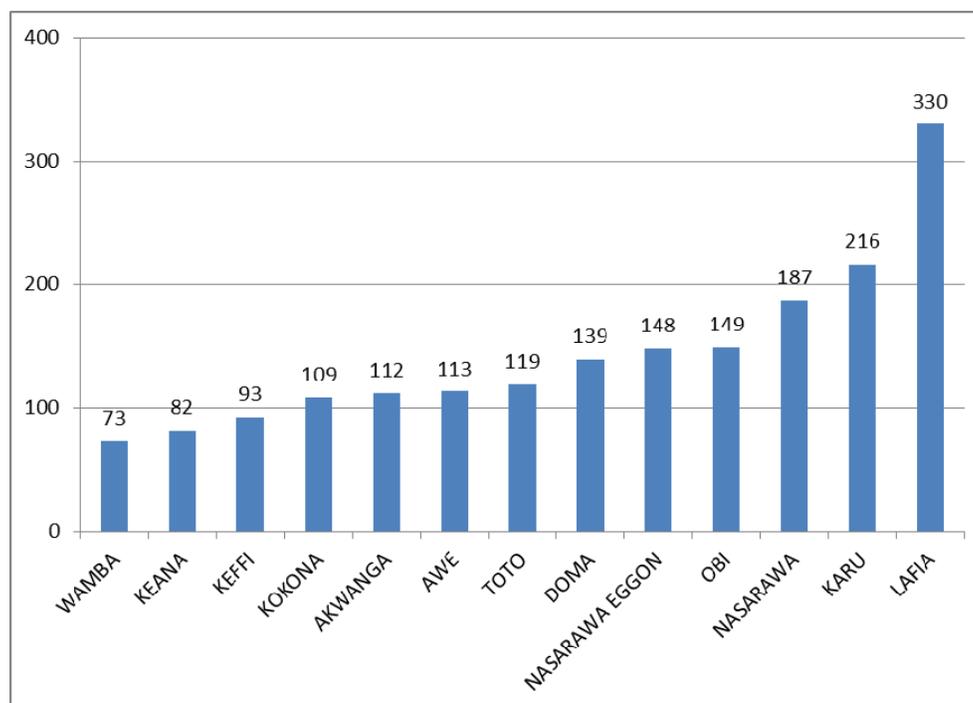
The state has 13 LGAs that are officially recognized by the federal government. However, for administrative purposes and at the discretion of the state, the LGAs are further broken down to a number of semi-independent development areas. Nasarawa has a total of 16 development areas; thus, federal resources that are allocated to the 13 LGAs are in effect shared with a total of 29 jurisdictions. The local governments include Akwanga, Awe, Doma, Karu, Keana, Keffi, Kokona, Lafia, Nasarawa, Nasarawa Eggon, Obi, Toto, and Wamba (see Figure 2). Each LGA is headed by a chairman and assisted by a deputy chairman and councilors, who are all democratically elected. Five heads of departments cover the basic functions of agriculture, education, health, finance, and supplies and works. Indigenous traditional institutions of authority exist alongside the state and local government councils. They also provide leadership and facilitate community administration, especially at the grassroots level.

FIGURE 2: NASARAWA STATE AND LGAS



Lafia is the most populated LGA (Figure 3), with approximately 329,922 people, followed by Karu with 216,230 people, and Nasarawa with 187,220. The least populated LGAs are Wamba (72,687), Keana (81,801), and Keffi (92,550).

FIGURE 3: LGA POPULATION, IN THOUSANDS (2006)



Source: 2006 Census

Nasarawa 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 organizations. The distribution of health facilities in the state by type and ownership is shown in Table I. Of the 684 health facilities in the state, the majority (95 percent) are PHC facilities, 4.5 percent are secondary, and 0.3 percent are tertiary health care facilities.

The majority (70 percent) of health facilities in the state operate as public institutions owned by either the federal, state, or local government while privately owned health facilities (30 percent) are owned by private individuals and NGOs. More than 70 percent of PHC facilities are owned by the LGAs.

TABLE I: HEALTH FACILITIES IN NASARAWA STATE (2009)

Type of Facility	Ownership					
	Federal	State	LGA	Total Public	Total Private	Overall
Tertiary	1	1	0	2	0	2
Secondary	0	18	0	18	14	32
Primary	0	0	461	461	190	651
Total	1	19	461	481	204	685

Source: Nasarawa State Service Directory

Provision of quality health care is a priority based on the Nasarawa State government's 13-point agenda. Nonetheless, the health sector in the state faces major challenges, including low utilization of health services, lack of skilled health professionals, poor logistics management capacity, and a dilapidated health infrastructure. This is further exacerbated by inadequate funding and deficiencies in data collection, reporting, and utilization for planning purposes. The state has not recorded much improvement in the quality of health services in recent years. There is evidence of a decline in the provision of certain services, such as in the provision of a Drug Revolving Fund.

A significant proportion of public sector facilities (PHC and secondary health care facilities) lack the appropriate human and materials resources (SMoH 2010). Most of these PHC facilities are in desperate need of renovation, essential drugs, consumables, and equipment. The facilities have poor sanitary conditions mainly due to lack of running water and waste disposal systems. Clinics often run as day clinics due to lack of electricity. In addition, inadequate staffing, low skills, and inadequate working conditions affect staff motivation and contribute to the poor service delivery in the state. Immunization coverage, already low (only 23 percent of children under 5 are fully vaccinated), has been declining due to a weak cold-chain storage and distribution system (SMoH 2010).

Malaria, diarrhea, tuberculosis, pneumonia, and HIV/AIDS are the main causes of morbidity and mortality in the state. Specifically, malaria is one of the major health problems. Every year, as much as one-quarter of the population has a serious episode of malaria (SMoH 2010).

At the state level, 64.4 percent of the population indicated that they had access to a health facility. Accessibility was lowest in the south, where 61.1 percent of the population said they had access to a health facility, and highest in the north, where 66.7 percent had access (SMoH 2010).

The state's health sector is mainly financed through budgetary allocation, capitation from the National Health Insurance Scheme grants, World Bank credit, donations from other development partners, and household out-of-pocket expenses.

4.2 DATA COLLECTION AND VERIFICATION

The PEMR survey is the first of its kind in Nasarawa. Heads of the health departments at the various local governments and other key officials provided the necessary logistical support to the survey teams. However, a number of challenges were encountered during data collection, the most significant of which was a widespread lack of accurate financial record keeping and reporting, especially at lower levels (facilities and LGAs). In the majority of the primary and secondary facilities visited, access to financial records was very limited, and where available, data were recorded in formats that did not allow easy retrieval. This was particularly the case at the LGA levels. Facilities did not keep expenditure records nor did they have knowledge of the budget allocated to them. In Nasarawa, facilities seldom participate in budget preparation. Although budget numbers were made available in some cases, records on spending and actual releases were much harder to obtain. Poor and unreliable record keeping was compounded by the fact that Nasarawa state effectively runs 16 development areas. Each LGA is responsible for aggregating and harmonizing its records with those of the 16 development areas before submission to the federal government.

In addition, data collectors faced a number of logistical challenges with the facility surveys, specifically the following:

- Rural facilities were often difficult for the field teams to reach due to poor road infrastructure.
- Securing appointments with facility heads or administrative staff to respond to the survey was challenging because most of the facilities visited were understaffed, which made it very difficult for the respondents to allocate time to complete the questionnaires.

- The time period provided 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 remainder of this report should be interpreted with some caution. Nonetheless, the absence of well-kept and easily accessible financial records as such is symptomatic of a weak and fragmented financial management system.

4.3 BUDGET PLANNING AT THE STATE LEVEL

Budgets prepared by state-level line ministries and MDAs are evaluated and harmonized by the budget office of the SMoF and presented for consideration by the State Executive before presentation to the State Assembly for enactment into appropriation law.

The Nasarawa State Strategic Health Development Plan (SHDP) 2010-2015 forms the basis of the current health plan and budget of Nasarawa State. At least on paper, the health sector plays an important role in the development agenda of Nasarawa State government. Specifically, the provision of quality and affordable health services is a key priority of the health policy formulation process. The 2010-2015 SHDP supports the reform agenda of the state government through eight thematic goal areas, which include leadership 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.

Primarily attributed to a lack of political will, the state has not yet implemented a Medium-Term Sector Strategy (MTSS). The MTSS is a multiyear budget planning tool aimed at ensuring that health sector budget preparations are based on actual performance benchmarks. This would replace the current process of ad-hoc yearly incremental budgeting. The adoption of an MTSS is essential for the development of demand-driven budgets. Preparatory work on an MTSS in Nasarawa state was only initiated in August 2011.

Statutory allocations make up the majority (about 80 percent) of revenues for the State of Nasarawa (SMoF, 2009 figures). This heavy dependence on federal subventions for financing its budget raises concerns about the state's ability to sustain its development priorities. Other revenue sources include IGRs and VAT revenue, albeit at much less significant amounts. In particular, the IGR profile of the state has been an issue of serious concern since the inception of the state in 1996. Collections from this source have been very discouraging, totaling less than 1 percent in 2009 (SMoF).

Statutory allocations from the FA to Nasarawa state are well below the total state budget. According to SMoF data, the state's total budget in 2009 is approximately 58.5 billion Naira. On the other hand, total revenues received by the FA in 2009 were 15.9 billion Naira, a mere fraction of the state budget. Given that statutory allocations constitute the majority of state revenues, this large discrepancy shows that the state cannot be expected to spend according to its budget.

The health budget in 2010 constituted about 6.5 percent of the total budget for the state, down from 11.33 percent in 2007 (Table 2). While the total state budget has increased from 34.9 billion Naira in 2007 to 67.8 billion in 2010 – an average increase of 94 percent over three years – the budget allocated to health has increased only slightly, from 3.9 to 4.4 billion over the same period, thus an average 13-percent increase. The increase in the health budget has clearly not kept up with the pace of increase in the overall state budget. The decrease in the health budget is hence inconsistent with the strategic priorities of the government as highlighted by the SHDP.

TABLE 2: NASARAWA'S STATE BUDGET, 2007-2010 (IN NAIRA)

	State's total budget	Health budget	Health budget (in % of total)
2007	34,965,477,046	3,960,289,762	11.33%
2008	53,658,191,355	2,485,125,515	4.63%
2009	58,476,204,516	4,484,547,970	7.67%
2010	67,865,244,536	4,408,124,415	6.50%

Source: Ministry of Health, Lafia

The SMOH's budget and planning team does not include members of civil society organizations (CSOs), the private sector, or the State Assembly. According to the strategic audit survey, the budget and planning team strictly includes government officials.

4.4 BUDGET PLANNING AT THE LGA LEVEL

Similarly to the state's revenue situation, local governments receive most of their funding from the Joint Account (which mainly derives from the federation allocation to local governments). Each individual LGA prepares its own budget. It should be noted that allocation to LGAs occurs at the federal level through the Revenue Mobilization and Allocation Commission using predetermined indicators that do not take into account state or LGA input (Box 1).

Political pressures drive the budget planning process at the LGA level. Only five of the 13 LGAs surveyed reported having a local development plan for their LGA (Table 3). Additional consultations with state and LGA representatives revealed that LGAs in fact do not rely on strategically informed plans. Instead, planning is primarily driven by political influences with significant interference from higher political figures at both the local and state levels. Specifically, although the heads of various LGA departments typically develop and submit budgets on an annual basis, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. If health is not a top priority on their agenda, little money is allocated to the sector (or just enough to cover recurrent expenditures). Follow-ups are rare once budgets are submitted. In the few cases where health budgets do get approved, funds do not get released (see next section).

Less than two-thirds of LGAs in Nasarawa reported having a budgeting team. According to the survey results, eight of the 13 LGAs have a health sector planning and budgeting team responsible for budget development (Table 3). For the remaining LGAs, PHC coordinators, the LGA planning department, the head of the health sector department, and/or accountants or treasurers are responsible for preparing the budget. Half of the LGAs who have a planning and budgeting team stated that they were confident in the budgeting capacity of their team (according to survey data).

Civil society does not actively participate in the LGAs' budget development process. According to the survey, only two of the eight LGAs that have a health sector planning team reported having CSOs as members of their team (Table 3). The number of CSO members on the LGA planning teams range from two to three members, representing approximately one-fifth of the total size of the team. On the other hand, only three of the 13 LGAs reported having safety net programs included in their annual budget in the past five years that target the poor, the vulnerable, minorities, and disadvantaged populations.

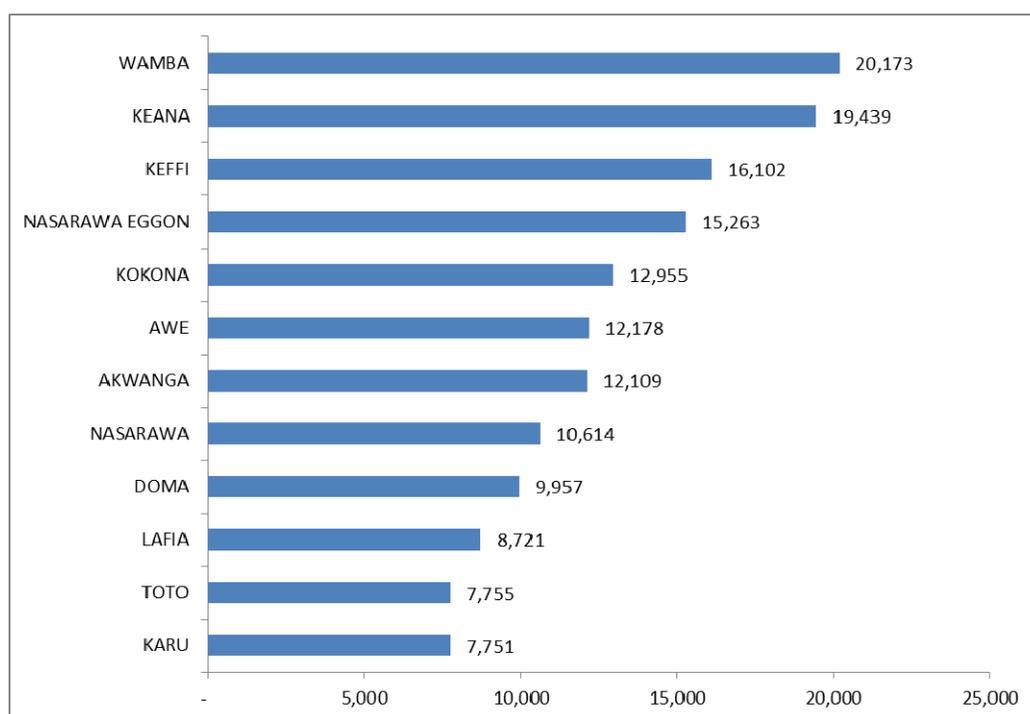
TABLE 3: INSTITUTIONAL ENVIRONMENT FOR BUDGET PREPARATION, LGAs IN NASARAWA STATE

Number of LGAs...	LGAs (n=13)
With a 'strategic' plan	5
With a planning and budgeting team	8
Confident about the capacity of the planning and budgeting team	4
With CSOs as members of the teams	2
With safety net programs budgeted in the past 5 years	3

Source: Survey data

Per capita health budgets in 2009 varied significantly across LGAs. Figure 4 shows per capita health budget in 2009 for each LGA. At the lowest end are Karu, Toto, and Lafia, with a total annual budget of less than 9,000 Naira per capita. In contrast, a number of LGAs, including Wamba, Keana, Keffi, and Nasarawa Egon, have a per capita health budget almost twice as high (more than 15,000 Naira). As mentioned earlier, LGA funds are heavily influenced by allocations from the federal level, which explain the inadequate distribution of health funds across LGAs. Funding at the local level is therefore not aligned with the demand in health care at each LG.

FIGURE 4: PER CAPITA HEALTH BUDGET PER LGA IN 2009 (IN NAIRA)



Source: MoLG, Lafia

Note: Data for Obi is N.A.

In summary, as a result of low investments in health over the past four years, the share of health in the overall state budget has shrunk significantly. This decrease is inconsistent with the strategic priorities of the Nasarawa State government as highlighted by the SHDP, and explains the poor quality of health care in Nasarawa. The fact that the majority of state revenues originate from statutory allocations raises concerns about the state's ability to sustain its development priorities and respond to the demand of its

population. In fact, civil society is largely absent from the budget preparation and planning process. Moreover, large discrepancies between statutory allocations to the state and the state's overall budget in 2009 indicate that the state cannot be expected to spend according to its budget. At the LGA level, political considerations and interference are driving planning (and spending), with minimal consideration of the community's concerns and input. Allocation of resources is highly inconsistent, as indicated by highly variable per capita health budgets across LGAs.

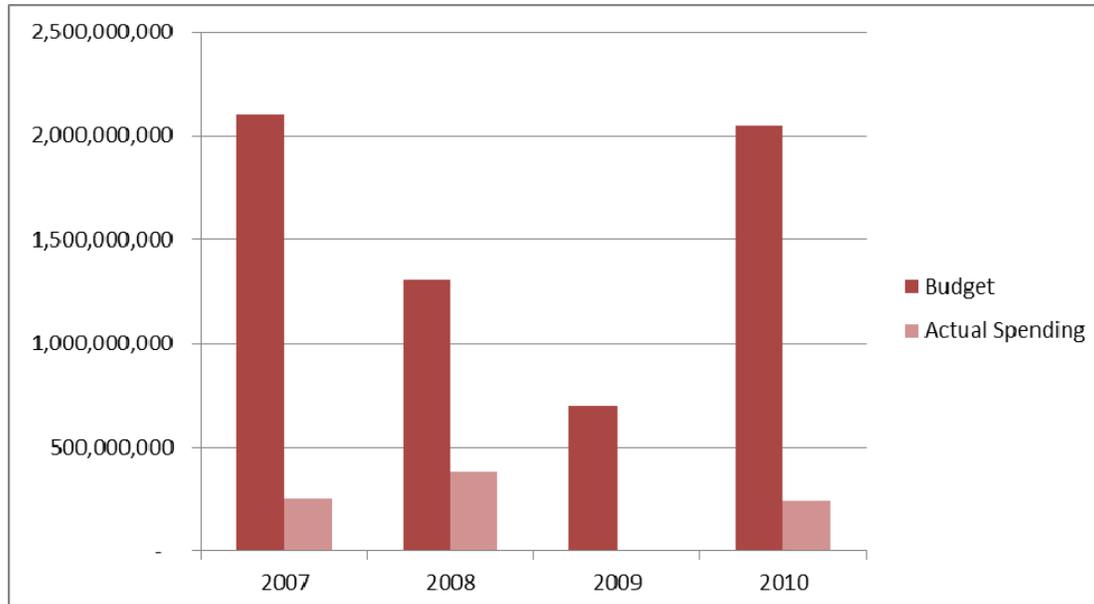
4.5 BUDGET EXECUTION AT THE STATE LEVEL

A large portion of the state's health budget is not actually spent. According to data provided by the SMoH in Lafia, budgetary executions for capital funds in the health sector are very weak. The percentage of capital budgets that is actually disbursed for health spending ranged between 12 and 30 percent over the past four years, with no releases in 2009 (Figures 5 and 7). In 2010, the health capital budget for the state was estimated around 2 billion Naira, of which approximately 0.25 billion was spent (barely a 12-percent execution rate).

The outlook for recurrent spending on health is more encouraging: budget execution ranged between 54 and 97 percent during 2007–2010, with the exception of 2009² (Figures 6 and 7). In 2010, the recurrent budget on health was around 2.36 billion, with actual spending of 2.28 (thus a 97-percent execution).

In total, actual spending of health funds in Nasarawa state in 2010 is estimated at 57 percent of planned budgetary allocations, largely due to the shortfall in capital fund spending (Figure 7).

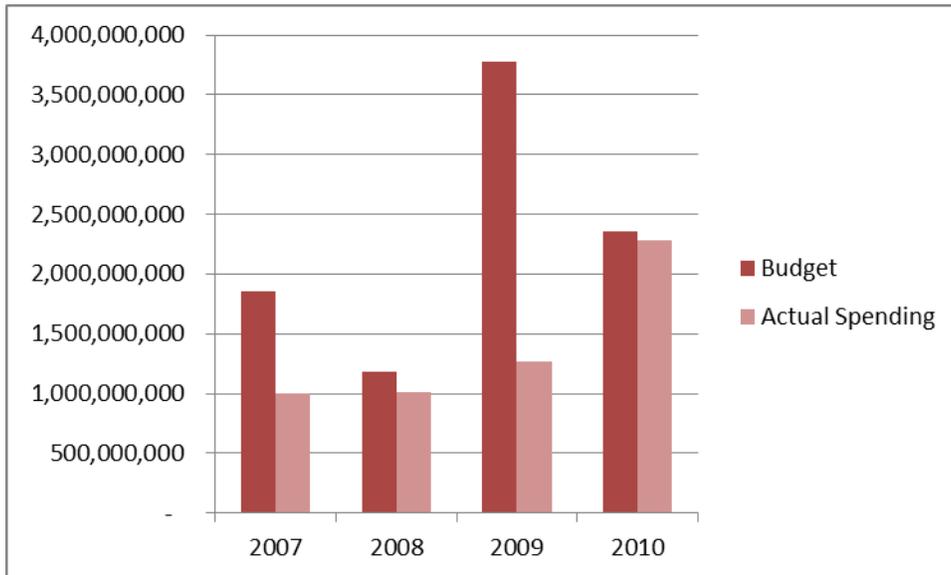
FIGURE 5: CAPITAL HEALTH BUDGET VERSUS ACTUAL SPENDING FOR NASARAWA STATE, 2007-2010 (IN NAIRA)



Source: Ministry of Health, Lafia

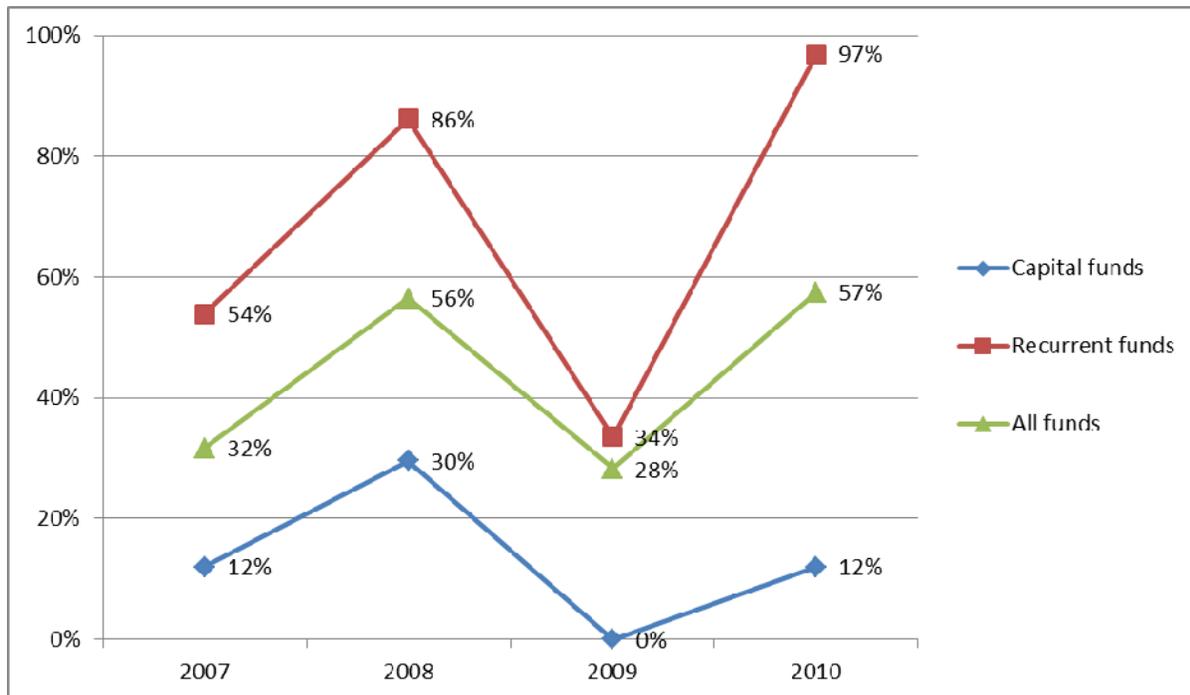
² According to state authorities, the high recurrent budget in 2009 is partly attributable to an upward review of salaries of health staff.

FIGURE 6: RECURRENT HEALTH BUDGET VERSUS ACTUAL SPENDING FOR NASARAWA STATE, 2007-2010 (IN NAIRA)



Source: Ministry of Health, Lafia

FIGURE 7: ACTUAL HEALTH SPENDING AS A PERCENTAGE OF BUDGETARY ALLOCATION IN NASARAWA STATE, 2007-2010



Source: Ministry of Health, Lafia

Weak budget execution is typically the result of overambitious planning, possibly driven by unrealistic political promises on spending, and/or low absorptive capacity to spend much of planned investments. Weak budget execution may also be the result of resource leakage and poor management of funds. In Nasarawa, state and LGA representatives indicated that while health budget plans were often realistic

and the state had the capacity to spend resources, the lack of political will to execute the budget and procure the resources needed for health explains much of the weak budget performance. It was noted that funds do not usually get released (if at all) until year end, leading to rushed spending during the final months of the year. In fact, poor political leadership and differing economic priorities of elected officials at the higher levels was attributed to the absence of capital health spending in 2009 (Figure 5).

The weak budget execution rate has undoubtedly impacted the performance and the ability of the state to deliver quality health services. With more than 90 percent of actual health expenditures in the state devoted to recurrent spending (most likely personnel remunerations), the lack of budget execution for capital funds is thus consistent with the poor state of Nasarawa’s health infrastructure and has significant implications concerning the state’s capacity to improve facility and work conditions.

4.6 BUDGET EXECUTION AT THE LGA LEVEL

Consistent with the trends observed at the state level, budget execution for the majority of LGAs in Nasarawa is weak. Table 4 shows total health budget allocations and actual spending in each LGA.

TABLE 4: TOTAL HEALTH FUNDS IN 2009 BY LGA, BUDGET VERSUS ACTUAL SPENDING (IN NAIRA)

LGA	Total revenues from the FA	Health budget	Actual spending	Actual spending as % of health budget
Akwanga	1,084,710,756	1,355,034,974	215,227,130	16%
Awe	1,209,566,121	1,377,090,000	170,910,000	12%
Doma	1,243,395,141	1,383,984,255	NA	NA
Karu	1,389,719,911	1,676,095,408	483,033,388	29%
Keana	1,001,645,355	1,590,105,879	329,003,955	21%
Keffi	1,020,142,507	1,490,255,070	438,698,182	29%
Kokona	1,104,813,356	1,406,369,460	NA	NA
Lafia	1,737,499,741	2,877,397,605	860,670,904	30%
Nasarawa	1,558,240,388	1,987,062,445	609,700,246	31%
Nasarawa Eggon	1,232,425,512	2,265,040,335	1,701,022,856	75%
Obi	1,178,307,377	NA	NA	NA
Toto	1,177,047,477	923,208,087	NA	NA
Wamba	1,026,491,055	1,466,322,440	NA	NA

Source: MoLG, Lafia, SMoF

The numbers show that for the majority of LGAs, actual spending in health ranges between a low of 12 percent of total budgeted funds (in Awe) and a high of 75 percent (in Nasarawa Eggon). On average, about 30 percent of the health budgets in LGAs are actually spent. Unlike at the state level where weak budget execution was mainly driven by low capital spending, the issue in LGAs is seen at the level of both recurrent and capital spending. The second column of Table 4 shows total revenues (of which health is a part) received by each LGA from the FA. For most LGAs, total revenues in 2009 were in fact lower than the health budget alone, which helps explain the weak budget execution. Distorted political priorities and a lack of will to procure the necessary resources were cited by LGA authorities as the main reasons for low levels of spending. The table also shows that many LGAs did not maintain records on actual spending.

There seems to be significant misreporting (or lack of reporting) 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 13, only three LGAs provided complete information on budgets and actual spending. For these LGAs, the information provided is substantially different from the information the state provided. LGAs reported spending less than what was recorded on the MoLG's books (e.g. one LGA reported spending fivefold less). While it is difficult to determine the reasons for such discrepancies, especially with the absence of enough data points, these observations suggest a lack of a sound reporting system and a transparent internal process of checks and controls that reconciles and tracks resource flows across the different MDAs.

In summary, weak capital budget execution at the state level, mostly attributed to a lack of political will to execute the budget and procure the resources needed, is undermining the credibility of the planning process. This appears to have had an effect on the performance and ability of the state to improve its health infrastructure and deliver quality health services. The health budget reports of the MoLG in Nasarawa state also show weak budget execution at the LGA level, for both recurrent and capital spending. Spending figures reported by LGAs are widely unavailable – or undisclosed – while those that are, 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 MDAs.

4.7 FACILITY GOVERNANCE AND FINANCES

The majority of surveyed facilities reported having a health committee or a management board (88 percent of secondary facilities and 83 percent of PHC facilities). These committees meet regularly and discuss a variety of issues relevant to the management of the facility, such as service delivery, budgets, user fees, facility maintenance, and human resources. On average, these health committees have 10 people who meet about five times a year (survey data).

Table 5 shows the composition of these committees, as reported by the facilities. Approximately 53 percent of secondary facilities and 96 percent of PHC facilities reported having district or community representatives on their health committees, respectively. It is unclear however how much influence these committees have and to what extent they actually represent the interest of the people.

TABLE 5: COMPOSITION OF HEALTH COMMITTEES OR MANAGEMENT BOARDS BY TYPE OF FACILITY (IN PERCENTAGES)

	Secondary (n=15)	Primary (n=52)
Officer in charge of facility	93.3	94.2
Other staff	86.7	67.3
District/community representatives	53.3	96.2
Parent representatives	40.0	55.8
Mosques/churches/NGOs	33.3	76.9
Local politicians	33.3	82.7

Source: Survey data

Note: No data were reported for the surveyed tertiary facility.

Staff meetings are held at the majority of facilities, and they occur between 3 to 5 times per year, depending on the facility. Attendance is usually partial: 68 and 72 percent of staff attended the last staff meeting held at regional hospitals and primary facilities, respectively.

Contrary to tertiary and secondary facilities that have some degree of autonomy, decision making at the PHC level falls almost exclusively on the LGA (Table 6). The majority of PHC facilities (98 percent) reported that the primary responsibility for decision making for most of the facility-level provisions falls under the LGAs. This includes planning and preparing the budget, implementing the budget, monitoring and evaluation, setting the levels of user fees, hiring staff, and, to some extent, assessing the performance of staff and deciding on maintenance work. This explains why almost no PHC reported having a budget on its own (see next section).

TABLE 6: PRINCIPAL DECISION MAKERS FOR PHC FACILITY FUNCTIONING (IN PERCENTAGES)

	State	LGA	Facility head	Health committee/ board	Local politician	Community
Planning and Preparation of Budget	3.5	96.6	0.0	0.0	0.0	0.0
Budget Implementation	1.7	96.6	1.7	0.0	0.0	0.0
Designing of procedures and protocols	1.8	96.4	1.8	0.0	0.0	0.0
Budget Monitoring and Evaluation	0.0	100.0	0.0	0.0	0.0	0.0
Setting the level of fees at the facility	0.0	100.0	0.0	0.0	0.0	0.0
Choosing the staff to hire	1.8	98.3	0.0	0.0	0.0	0.0
Assessing staff performance	0.0	100.0	0.0	0.0	0.0	0.0
Deciding on maintenance work	0.0	97.6	2.4	0.0	0.0	0.0
Overall	1.2	98.0	0.7	0.0	0.0	0.0

Source: Survey data

The survey provides evidence of some degree of accountability to the community. Facilities remain accountable to their community through a variety of ways. These are listed in Table 7.

TABLE 7: ACCOUNTABILITY MEASURES AT THE FACILITY (IN PERCENTAGES)

	Secondary (n=17)	Primary (n=63)
Suggestion boxes	29.4	6.4
Regular meetings with community	88.2	77.8
Making some citizens part of the management committee	58.8	68.3
Presentation of operations report to the community	41.2	49.2
Community participating in M&E of activities in facility	47.1	49.2

Source: Survey data

Note: No data were reported for the surveyed tertiary facility.

Facilities reported the number of annual supervisory visits by various government level officers. On average, federal level officers visited between 1 to 3 times annually (depending on the type of the facility), state level officers visited 3 to 5 times, LGA level officers visited 3 to 10 times, and development partners visited 5 to 8 times. Most of the visits are routine supervision of facility management and monitoring and evaluation. Supervisors usually meet with the facility director, some staff, and, to some extent, patients and community leaders. They often check facility records, and in some cases, particularly in PHC facilities, they observe consultations. Usually, feedback is provided verbally to facility staff at the end of the visit. According to survey data, only 17 percent of hospitals and 9 percent of PHC facilities reported having received written feedback.

More than 50 percent of facilities do not keep detailed spending records (about 89 percent of PHC facilities and 59 percent of secondary facilities surveyed). This is also true of receipts of income and subsidies from various sources. The lack of human resource capacity and adequate supply of material were cited as the main reasons for the absence of record keeping in the facilities.

According to the survey results, the majority of secondary hospitals and PHC facilities do not maintain a budget. Approximately 94 and 98 percent of secondary hospitals and PHC facilities, respectively, stated that they did not have a budget. For this reason, the study team was unable to obtain financial and budgetary information from most of the facilities, particularly on funds received and spent.

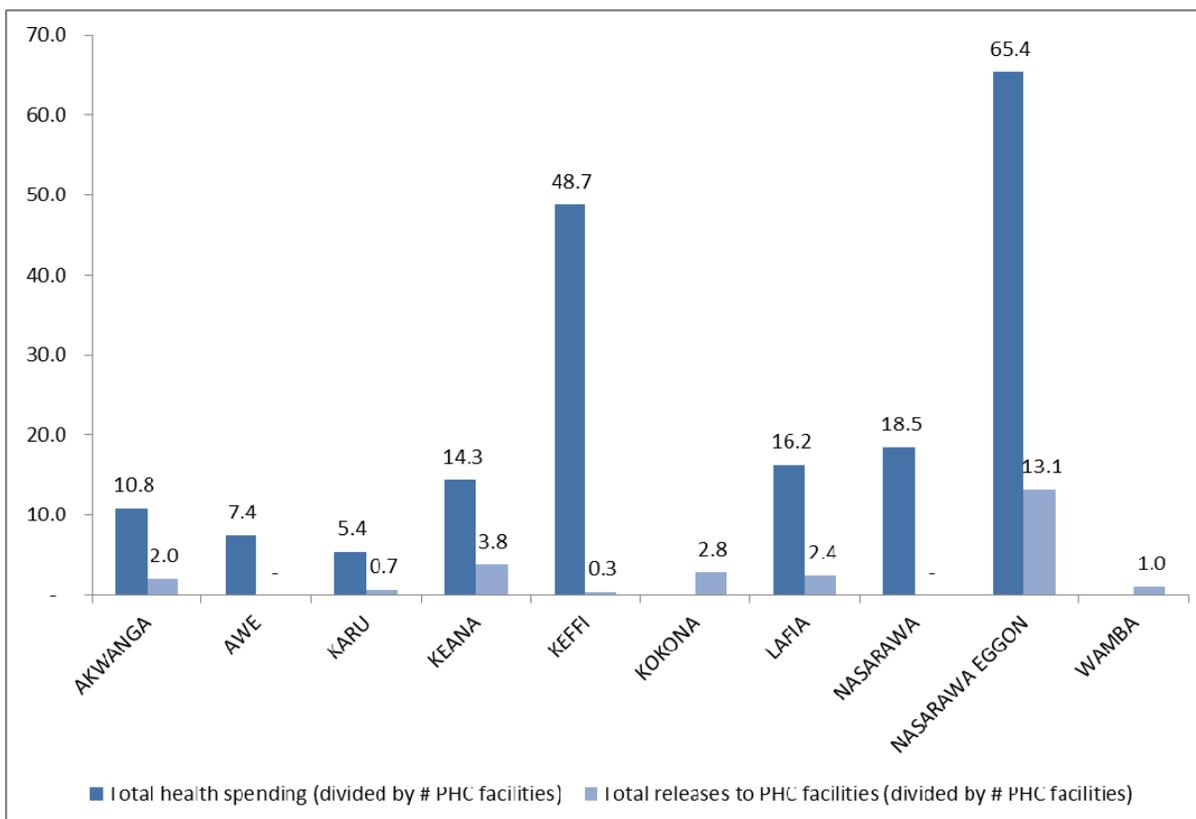
In summary, despite the fact that most facilities have a health committee (or a management board) and take measures to ensure accountability to the community, they do not possess much financial autonomy. Facilities do not maintain their own budgets and thus have very little say on actual spending. For PHC facilities, responsibility for decision making falls almost exclusively on the LGAs. In fact, all transactions are conducted by the LGA on behalf of the facilities. LGA budgets do not usually specify allocations to individual PHC facilities, and actual expenditures are recorded in disbursement journals, which are not easily made available to the public.

4.8 BUDGET UTILIZATION

Uneven health spending across LGAs highlights a misallocation of resources within the state.

Figure 8 shows health spending by LGAs as well as releases to PHC facilities (as reported by the MoLG). The figures are divided by the number of PHC facilities in each LGA for better comparison across LGAs. Figure 8 highlights two potential issues with fund utilization at the LGA level. First, total health spending differs significantly across LGAs. Taking into account the number of PHC facilities in each LGA, Nasarawa Eggon is spending at least 10 times more than several other LGAs, such as Karu, for example. This reflects the weak budgeting process at the LGA level and results in a misallocation of resources. Second, releases to PHC facilities represent only a very small proportion of total health spending by LGAs. This again is an indication of health facilities' lack of financial autonomy and confirms earlier claims concerning the absence of budget accountability. Note that much of the data in certain LGAs were not reported.

FIGURE 8: HEALTH SPENDING AND RELEASES TO PHC FACILITIES BY LGA IN 2009 (DIVIDED BY THE NUMBER OF PHC FACILITIES IN EACH LGA, IN MILLION NAIRA)

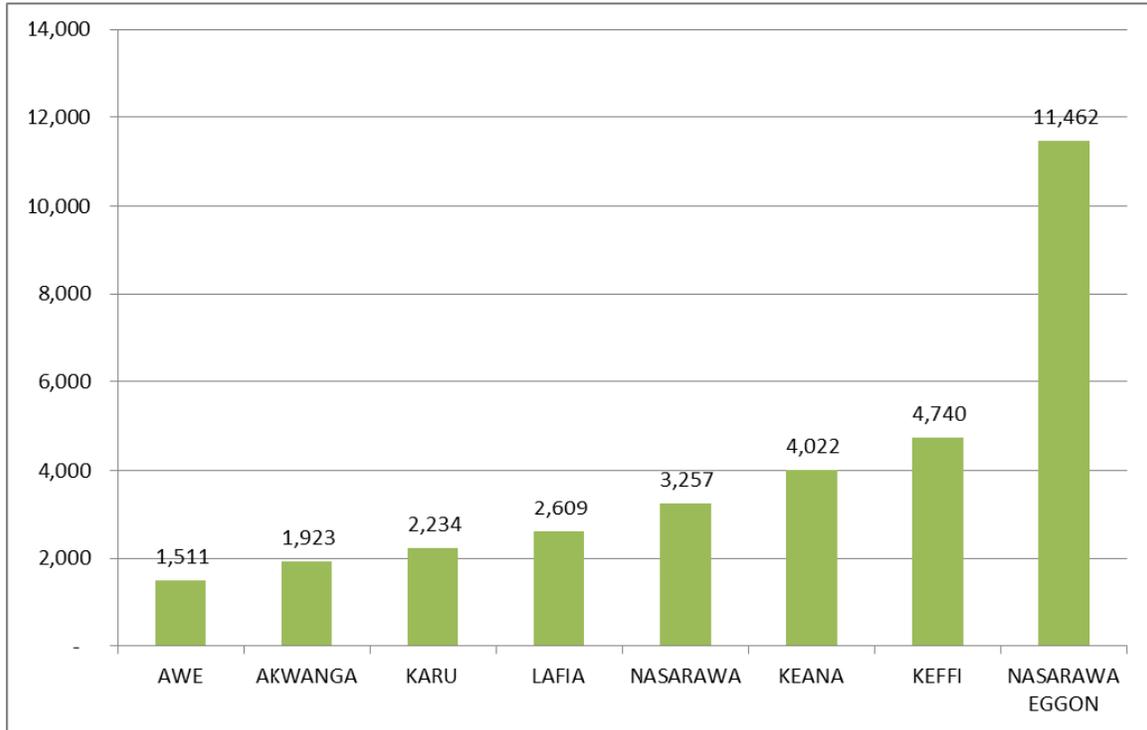


Source: MoLG, Lafia

Data are NA for Doma, Obi, and Toto. Data on releases to PHC facilities are NA for Awe and Nasarawa.

Per capita health spending differs significantly from one LGA to another. Another way to look at utilization patterns across LGAs is to estimate per-capita share of health spending. Figure 9 shows per capita health spending in 2009 in selected LGAs. Thus on average, a person in Nasarawa Eggon has a share in health spending almost eight times as high as a person in Awe. This variation again may be partly due to weak budget execution in LGAs with lower per capita spending. Indeed, it is interesting to note that Awe and Akwanga, which have the lowest per capita shares in spending, each have the lowest percent execution of health budgets (12 and 16 percent, respectively; refer to Table 4 in the previous section). Nasarawa Eggon, which has the highest per capita share, also has the highest budget execution rate (75 percent of health budgets). It is important to remember, however, that these numbers were reported by the State of Nasarawa, and not by each individual LGA.

FIGURE 9: PER CAPITA HEALTH SPENDING IN LGAS IN 2009, SELECTED LGAS (IN NAIRA)



Source: MoLG, Lafia

Data are NA for Obi, Toto, Wamba, and Kokona.

Facility conditions

The study team analyzed survey data to better understand the conditions for service delivery at the facility level and to attempt to establish links with health resources spent at the LGA level. The purpose was to allow the team to examine how the budget gets utilized at the service delivery levels. The data obtained at the facility level were linked to those collected at the state level, specifically those related to financing arrangements, to identify potential links between resources available and facility outlook.

An estimated 47 percent of surveyed secondary facilities and more than 75 percent of primary facilities reported that their consultation rooms were ‘poorly equipped.’ Deficiencies in basic amenities such as toilets and electricity are especially severe (Table 8): only 33 percent of PHC facilities and 59 percent of secondary facilities have toilets, and as little as 28 percent of PHC facilities have alternative sources of electricity. Water is not available year round according to 58 percent of surveyed facilities. Access to transport vehicles for emergencies is almost nonexistent at the PHC level (only 3.2 percent of PHC facilities reported having an ambulance).

TABLE 8: CONDITIONS OF FACILITIES, BY TYPE (IN PERCENTAGES)

	Secondary (n=17)	Primary (n=63)
Outpatient area	82.4	71.4
Pharmacy	88.2	12.7
If yes, functional?	93.3	87.5
Facility secure at all times	82.4	46.0
Facility walled or fenced	58.8	30.2
Laboratory	94.1	44.4
If yes:		
Availability of standard of practice?	100.0	67.9
Space with temp regulator?	62.5	17.9
Reagent?	68.8	64.3
Electricity?	81.3	46.4
Lab equipment?	87.5	57.1
Water	81.3	71.4
Toilets	58.8	33.3
If yes, separate for females?	90.0	90.5
Alternative electricity source	82.4	28.6
Power shortages:		
Half of the time	23.5	4.8
Most of the time	47.1	9.5
All the time	23.5	63.5
Water available all year round?	58.8	58.7
Ambulance	70.6	3.2
Specialist doctor	23.5	0.0
Kitchen/cafeteria	23.5	4.8
IEC material	58.8	47.6

Source: Survey data

Principal Component Analysis (PCA) was used to combine 10 indicators of a facility's physical conditions into one aggregate index (thereafter 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 is constructed using the following 10 indicators:

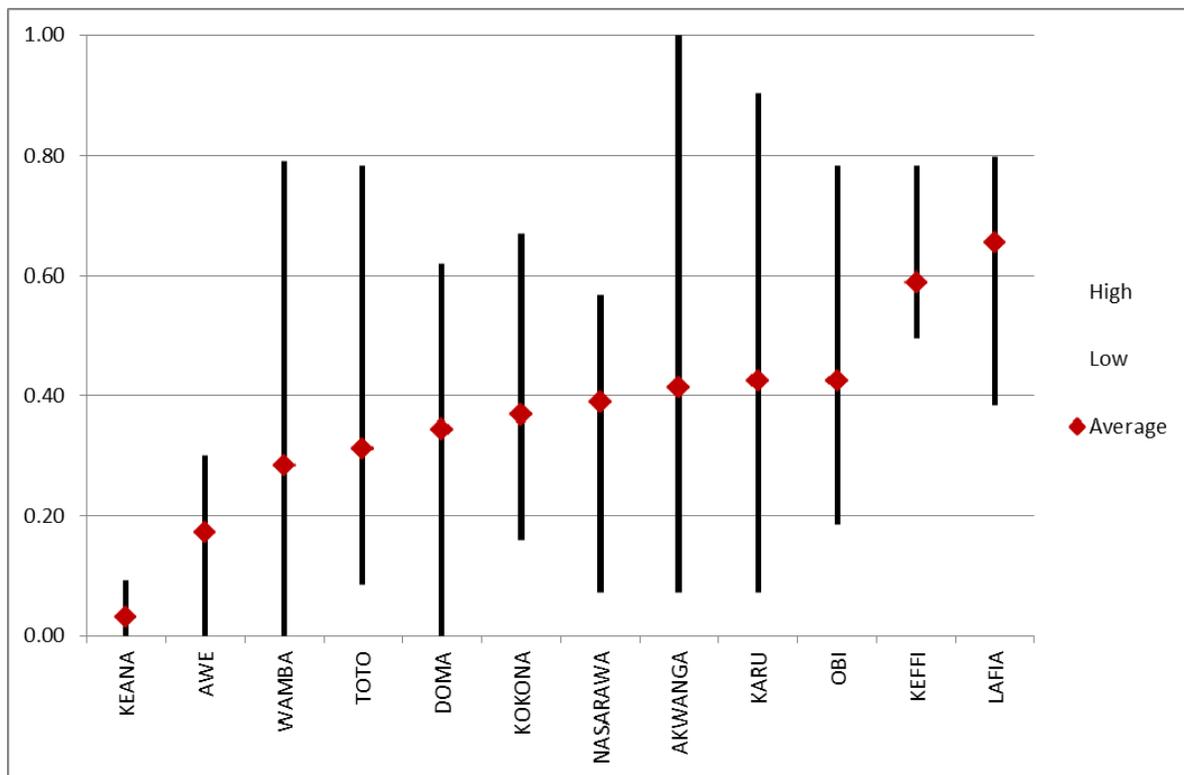
1. Does the facility have a functional pharmacy?
2. Does it have a working laboratory?
3. Does it have working toilets?
4. Is the facility secure at all times?
5. Is it walled or fenced?
6. Does it get electricity?
7. Does it have an alternative source of electricity?
8. Is water available all year long?

- 9. Does it have a kitchen or cafeteria?
- 10. Does it have an outpatient area?

The Physical Condition Index can thus be considered as an aggregate indicator for the overall quality of the facility, and this has a direct effect on service delivery. The PCA was done for PHC facilities only (hospitals were excluded because of the small sample size). A Physical Condition Index was computed and rescaled 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 PHC facilities in Nasarawa was 0.35. As expected, the value is higher for urban facilities (0.55) than for rural facilities (0.26). Figure 10 plots PHC facilities according to the value of their index and calculates the average across sampled facilities in each LGA.

FIGURE 10: PHC FACILITIES RANKED ACCORDING TO THE PHYSICAL CONDITION INDEX, BY LGA

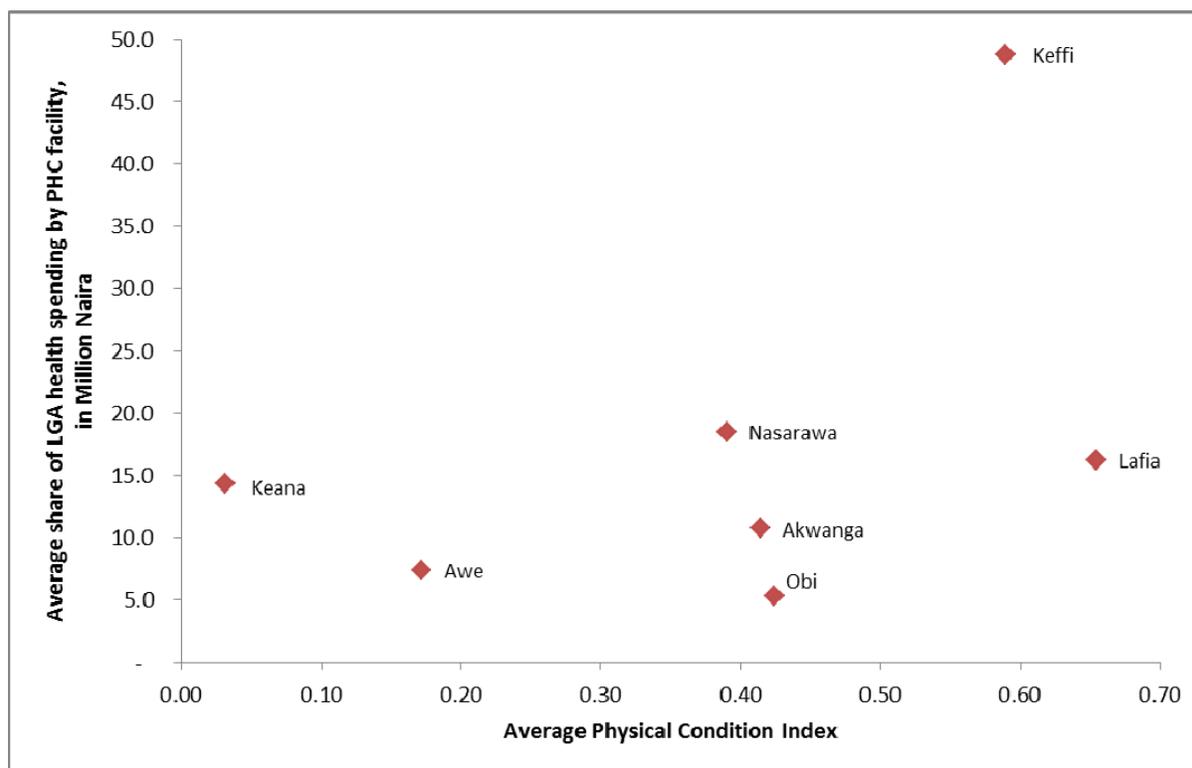


Source: Survey data and estimations
 Data for Nasarawa Eggon were not reported in the survey.

Figure 10 ranks LGAs from the one with the lowest average value of the Physical Condition Index to the one with the highest. Averages are shown by the red diamond, while the ranges of values (high, low) within each LGA are shown by the black bars. For example, the sampled PHC facilities in Kokona have an average index of 0.37. The PHC facility in Kokona with the lowest value of the index has a value of 0.16, while the highest has a value of 0.67. According to Figure 10, surveyed facilities in Lafia have the highest average index, while those in Keana have the lowest. State and LGA representatives explained that monitors and supervisors can easily access facilities in Lafia, which encourages upkeep of better conditions at these facilities. In urban areas, such visits are often done to create visibility for elected officials and reflect on their performance in office.

There is a weak correlation between facility conditions and available resources. Figure 11 combines data from Figures 8 and 10, and plots LGAs according to their Physical Condition Index and health spending. Note that the figure does not show any particular pattern. Keffi and Lafia, which have the highest average index are quite different in terms of amount of health resources spent. While Keffi spent approximately 50 million Naira in 2009 (divided by the number of PHC facilities), Lafia spent around 16 million. On the other hand, Keana has similar spending figures as Lafia, yet has the lowest average Physical Condition Index compared to the rest of the surveyed facilities in the state. This suggests that there is a weak link between resources invested in the LGA and facility conditions. 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 IN 2009, SELECTED LGAS



Source: MoLG, Lafia, 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. Salary spending typically constitutes the majority of recurrent spending. Nonsalary spending includes funds for the maintenance of office equipment, transportation, stationary supplies, and other related items. Given the absence of budgets and accounting records at the PHC level, the team used survey data on salaries of health workers in PHC facilities to estimate total spending on salaries in each LGA, and compared these amounts with recurrent spending by LGA as reported by the MoLG. To estimate salary spending, it was assumed that every PHC facility has approximately six staff members (average according to survey results) with an average monthly salary of 25,000 Naira (average salary according to state and LGA sources). Table 9 shows that for the majority of LGAs, the difference between recurrent spending and estimated salary spending is significant. For instance, in Keffi, Nasarawa Eggon, and Lafia, yearly salary spending represented only 4, 5, and 12 percent of total reported recurrent spending by LGA, respectively, when

one would expect a number closer to 80 percent (as the majority of recurrent spending would usually go for salary expenditures). The same is true for other LGAs listed. On the other hand, for Obi, estimated salary expenditures were higher than reported recurrent spending. This may suggest that some health workers are not receiving their salary income on time. It is important to note that these figures are estimates. More accurate figures from the financial records of LGAs are needed to improve the reliability of these results.

TABLE 9: RECURRENT SPENDING VERSUS ESTIMATED YEARLY SALARY SPENDING BY LGA, 2009 (IN NAIRA)

	# PHC facilities	Recurrent spending on health	Estimated yearly salary spending	Difference	Difference (in % of recurrent spending)
AKWANGA	20	117,717,130	36,000,000	81,717,130	69%
AWE	23	100,092,000	41,400,000	58,692,000	59%
KARU	90	402,527,790	162,000,000	240,527,790	60%
KEANA	23	306,003,595	41,400,000	264,603,595	86%
KEFFI	9	412,576,982	16,200,000	396,376,982	96%
LAFIA	53	800,600,064	95,400,000	705,200,064	88%
NASARAWA	33	509,000,246	59,400,000	449,600,246	88%
NASARAWA EGGON	26	1,000,022,818	46,800,000	953,222,818	95%
OBI	18	14,685,664	32,400,000	(17,714,336)	-121%

Source: MoLG, Lafia, survey data and estimations
Data for Doma, Kokona, Toto, and Wamba are N.A.

In summary, results in this section suggest a misallocation of health resources across LGAs, reflecting a politically driven process of fund allocation and budgeting that does not reflect considerations of real demands or needs. Per capita health spending differs significantly from one LGA to another, partly due to weak budget execution in certain LGAs. Furthermore, there is evidence of a weak relationship between resources spent and facility conditions, implying that resources are not effectively utilized. Large discrepancies between recurrent spending, as reported by the state, and salary estimates in certain LGAs may suggest the presence of resource leakage between the LGAs and health facilities. More accurate data are needed to confirm these claims.

5. CONCLUDING REMARKS

In the context of a decentralized system, the ultimate objective of the PEMR in the Nigerian health sector is to assist various government agencies in improving the financial management system to ensure an efficient and effective use of health resources. This report presented the findings of the PEMR in Nasarawa state. The main results are reiterated below:

Budget preparation and planning

- The health budget in the state has decreased over the past few years from 11.33 to about 6.5 percent of the total budget. This decrease is inconsistent with the strategic priorities of the Nasarawa State government, as highlighted by the SHDP, and may explain much of the poor quality of health care in Nasarawa.
- The fact that the majority of state revenues originate from statutory allocations from the FA raises concerns about the state's ability to sustain its development priorities and respond to the demand of its population. In fact, civil society is largely absent from the budget preparation and planning process. Moreover, large inconsistencies between the total state budget and statutory allocations indicate that the state cannot be expected to spend according to its budget.
- At the LGA level, political considerations and interference are driving planning, with minimal consideration from the community. Revenues originate from the federal government using predetermined indicators that do not take into account state or LGA input. The resulting resource allocation is highly inconsistent across LGAs.

Budget execution

- Weak capital budget execution at the state level, primarily attributed to a lack of political will, is undermining the credibility of the planning process. This has impacted the state's performance and ability to improve its health infrastructure and deliver quality health services.
- At the LGA level, the budget reports of the MoLG in Nasarawa state also show weak budget execution, for both recurrent and capital spending. Spending figures reported by LGAs are widely unavailable – or undisclosed – while those that are, differ significantly from those reported at the state level. This highlights the absence of a transparent internal system of checks and controls that reconciles and tracks resource flows across the different MDAs.

Budget utilization

- Facilities do not possess much financial autonomy. They do not maintain their own budgets and thus have very little influence on actual spending. For PHC facilities, responsibility for decision making falls almost exclusively on the LGAs. In fact, evidence suggests that all transactions are conducted by the LGA on behalf of the facilities.
- A misallocation of health resources across LGAs reflects a system of fund allocation and budgeting that is not aligned with real demand or needs. Per capita health spending differs significantly from one LGA to another, partly as a result of weak budget execution in certain LGAs.
- There is evidence of a weak relationship between resources spent and facility conditions, suggesting that resources are not effectively utilized.
- Large discrepancies between recurrent spending, as reported by the state, and salary estimates in

certain LGAs suggest the presence of resource leakage between the LGAs and health facilities. More accurate data are needed to confirm these claims.

While financial data is often challenging to obtain, the widespread absence of accurate financial records was a significant finding of the PEMR. In the majority of the PHC facilities visited, access to financial records was very difficult. In most cases the data did not exist. The analysis in this report largely relied on state-level financial records. In general, the absence of accurate and detailed financial records indicates that the government does not have the means to ensure that health resources are distributed equitably, efficiently, and effectively. As a result, holding government officials accountable is difficult, and leakage of funds is more likely to occur.

Recommendations

Strong processes for tracking health budgeting and expenditures provide the foundation for ensuring that health priorities are met and that the right services are delivered. The following recommendations address some of the weaknesses revealed by the PEMR in Nasarawa:

- Strengthen accountability for use of public funds and financial management by reforming the current approach in budget preparation and planning at the state and local levels. LGAs need to articulate clear outputs within the framework of the National Strategic Development Plan and the state's health care policies. Local governments should be able to develop their own strategic plans. This would minimize political interference in fund allocation between the various levels of government and impose an accountability structure to the budgeting and planning process.
- Review the current system of revenue allocation from the federal government to LGAs to allow a more equitable, transparent, and fair allocation process across LGAs.
- Improve the skills of the state and local government planning officers in participatory budgeting methodologies and in the MTSS. Likewise, CSOs should be trained to effectively engage in and monitor all the stages of the budget planning and implementation process.
- Build capacity in sound financial management processes, tools, and techniques³ at the federal, state, and LGA levels. Impose adequate financial management and control mechanisms that can effectively track funds at all levels. A financial reporting manual should be developed and adopted at all levels of government. Importantly, the disbursements of resources for and on behalf of PHC facilities need to be more transparent to reduce the occurrence of discrepancies such as those observed during the survey implementation. Facilities should be endowed with the capacity (human and financial) to maintain records of all financial transactions, both cash and in-kind.

³ For more information, see the forthcoming Health Systems 20/20 report on the health systems financial management training pilot project in select Gombe State LGAs and Abuja Federal Capital Territory Councils (Musimenta, forthcoming 2012).

ANNEX A: BIBLIOGRAPHY

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