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AKWA IBOM STATE 2012-2016 PUBLIC EXPENDITURE REVIEW

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The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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AKWA IBOM STATE
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PUBLIC EXPENDITURE REVIEW

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ACRONYMS

AG	Accountant General
CSOs	Civil Society Organizations
FMoH	Federal Ministry of Health
GGE	Government general expenditure
HFG	Health Finance and Governance
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMB	Hospital Management board
HMOs	Health Maintenance Organizations
IGR	Internally Generated revenue
AKSACA	Akwa Ibom State Agency for the control of AIDS
LGA	Local Government Area
MDAs	Ministries Departments and Agencies
MDG	Millenium development goals
MNCH	Maternal, Neo-natal and Child health
MoF	Ministry of Finance
MoLG	Ministry of Local Government
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Primary Health Center
SMoH	State Ministry of Health
SSHDP	State strategic health development plan
SSHIS	State Supported Health Insurance Scheme
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VAT	Value Added Tax

EXECUTIVE SUMMARY

Background

Globally, health systems are faced with increasing demands and limited financial resources from internal and external sources. Increasing population numbers, high levels of poverty, emerging and new disease areas and costly non-communicable diseases jointly contribute to the pressures being placed on health systems in low and middle-income countries.

In a bid to improve the health outcomes, Nigeria and many countries have subscribed to the principle of Universal Health Coverage (UHC) which is aimed at ensuring equitable access to needed health care without inflicting financial hardship[1] on health system users. Akwa Ibom State, like many other states, is in the process of embracing health financing policy reform thrust introduced at the national level in order to achieve more money for health and more health for the money. The state has therefore keyed in to health financing policy reform thrusts including decentralization of health insurance scheme that will usher in State Supported Health Insurance Scheme, PHC management integration policy called PHCUOR (in process), Revitalization of PHC for UHC policy and other laudable policy thrusts.

However, it is increasingly recognized that public funding will play a crucial role towards achieving UHC and efficiency of public spending on health is as important as the volume of the resources; in order words, more money for health and more health for the money are the key intermediate objectives on the path towards UHC. To understand the magnitude and flow of health resource which will enable the state to put available meagre resources into better utilization, the USAID funded Health Finance and Governance Project embarked on Public Expenditure Review (PER) in collaboration with the state stakeholders. A public expenditure review (PER) analyzes government expenditures over a period of years to assess their consistency with policy priorities, and what results were achieved.

The aim of the PER is to collect, collate and compare health expenditures over a period of four years in order to help the state government and state ministry of health to determine the adequacy of public expenditures on health in total terms and in terms of the categories of expenditures, e.g. recurrent compared to capital expenditures, which allows decision makers to assess their capacity to meet health policy objectives. Expenditures can be compared across sectors, with other states, and with other appropriately selected countries. Equally, policy makers and planners can also use the result of the review to infer whether current public spending is sustainable, equitable and efficient.

Objectives

The main objective of the review is to analyze and establish the trend in budgetary allocation and expenditure considered necessary for evidence-based decision making in the health sector. Its specific objectives include:

[1] (WHO 2017) Universal Health coverage

- Analysis of the state capital and recurrent budget and expenditure for 2013 to 2016
- Analysis of budget and expenditure trends for the four key sectors (health, education, agriculture and works & transport) with a view to establishing the level of priority accorded the health sector
- Assessment of the allocative efficiency of the performance of health financing system where feasible
- To make recommendations on improved public health expenditure

Methodology

The PER team was constituted with members drawn from the State Ministry of Health, Ministry of Finance, Budget and economic planning, office of the Auditor General for local government areas (LGA), Akwa Ibom State Agency for the Control of AIDS (AKSACA) and HFG. The team was led by the State Ministry of Health with technical support from the HFG project.

During the set-up of the PER activity, the stakeholders' forum was convened to provide a platform for sharing the objectives and methodology for the exercise. The forum provided the medium for dialogue, to agree on data requirements and identification of data sources as well as outlining the roles and responsibilities of all stakeholders involved. It also provided the opportunity to understand the contextual peculiarities of the State and achieve a consensus on the relevant outputs required.

The method of data collection was carefully designed and pretested to collect health expenditure data from all stakeholders. The PER team collected primary and secondary data from State Ministries, departments and Agencies as well as the interviews with relevant stakeholders. The main healthcare financing information provided by the state government were obtained from approved budgets and actual expenditure reported for years 2013 to 2016. Literature review of relevant document was equally carried out to elicit relevant information for quality of the assessment. Data management and analysis were done by HFG, in conjunction with State officials.

Limitations

Several data limitations required a modification of the proposed analysis plan.

- There was insufficient LGA level financing data for in-depth analysis. .
- Health budget and financial statements were not disaggregated into health program and intervention areas which make it hard to track the allocation of health fund, especially for the recurrent health investment.
- Health budget and expenditure statements were not linked to expected health outcome or target which make it difficult to assess the effectiveness and developmental impact of health financing.

Assumption

1. Annual population growth rate of 3.46% from 2006 population result[2]

[2] Population by state and gender : population.gov.ng

2. Foreign Exchange Rate of N150, N170, N190 and N300 for 2013, 2014, 2015 and 2016 respectively

Main Findings

Government funding remains the dominant source of health sector financing during the period under review. An analysis of Akwa Ibom state's fiscal profile indicates that the state revenue was highly dependent on the statutory allocation from the federation account. During the years under review, contribution of statutory allocation ranges from 83 percent in 2014 to 74percent in 2016 while the contribution from Internally generated revenue (IGR) increased from 4 percent in 2013 to 9 percent in 2016.

Public health sector financing ranged between 3.7 and 4.2 percent over the four-year period under review (2013-2016), and the share of the health budget in the total government budget remains below the 15 percent recommended under the Abuja Declaration. Although government committed to achieve its health plan as highlighted in the SHDP (2010 – 2015), health sector budget decreased from N24.1 billion in 2013 to N15.7billion in 2016 while the actual health expenditure dropped from N14.4 billion in 2013 N13.11 billion in 2015 and then nose-dived to N6 billion in 2016.

Large share of public health sector expenditure had spent on capital investment from 2013-2015 but it sharply shrunk in 2016. The analysis shows that the actual capital expenditure was N8.8 billion in 2013, however, it shrunk to N0.5 billion in 2016. The recurrent expenditure increased from N4.9 billion in 2014 to N5.6 billion in 2016; From 2013 to 2015, a huge proportion of the health spending went into capital expenditure. While in 2016, a higher allocation to recurrent expenditure with as high as 92% share of the total actual health expenditure. The sudden shortage in capital investment in 2016 addressed the concerns for capital project's sustainability and efficiency.

Per capita health budget and expenditures had declined consistently from 2013 to 2016 and falls significantly short of the World Health Organization (WHO)-recommended benchmark to address health challenges. The per capita health budget was N4,878($33), N4,109($24), N3,743($20) and N2,872($10) respectively for each of the years under review. The per capita health expenditure was N2,917($19), N2,767($16), N2,475($13) and N1,104($4) in 2013, 2014, 2015 and 2016 respectively

The performance of the health sector budget implementation was not satisfactory throughout the review period, it remains vulnerable to persistent challenges in the implementation of the capital budget. The performance of the health sector budget has been lower than appropriate throughout the review period, with an average annual execution rate of about 64 percent from 2013 to 2015. The implementation rate of the recurrent budget has consistently exceeded 60 percent from 2013 to 2015, and experienced a sharp decline in 2016, that implementation rate dropped to 38 percent only. The execution rate of the recurrent budget fell to 74 percent in 2015, and ended by 98 percent, in 2015. The execution performance of the capital budget has been generally lower than for the recurrent budget, where needs attention to address the causes of delays in the implementation of the health capital budget.

Recommendations

Government and key stakeholders should be effectively engaged to advocate for increased allocation to the health sector. The budget and expenditure trend in Akwa Ibom show that health is not being accorded the priority it deserves. As a state with considerably high burden of disease, the state urgently needs to invest more than 10 percent of its resources on health. Despite the government's stated commitment to increase the share of health sector financing in the government budget to at least the 15 percent recommended in the Abuja Declaration, this has yet to be achieved. Governments and stakeholders should build consensus and work collaboratively to have political attention addressed on health financing to public health.

Improve the budget implementation capacity among major sectors including health sector. The budget implementation rate was extremely low in the sectors with large share of budget especially in 2016. Execution of the development budget continues to be plagued by several impediments, such as the current practice of fragmented financing systems. The efforts should be addressed to those impediments to ensure the smooth implementation of the budget.

Strengthen the capacity of LGAs in the areas of financial management and procurement. Although the delivery of primary health services is largely concentrated at the local government level, the largest share of health sector financing is still managed at the central level. During the review period only very limited health financing information could be tracked at LGA level.

Consider developing a resource-tracking database to improve reporting systems and data availability for monitoring financial resource inflow and expenditures. As in many developing countries, the state government has very limited capacity to measure the impact of public expenditure and most agencies are pre-occupied with reporting how inputs have been used rather than highlighting outcomes achieved. In view of this, the HMIS/M&E team needs to be better engaged in order to identify the most feasible way to link performance to productivity. Increase the capacity of institutionalizing the PER and other resource tracking initiatives such as State National Health Accounts (NHA) etc. is important for sustainable capacity build up.

Further assessment is recommended to identify the cause of the current absorptive capacity for capital funds within the health sector and necessary technical support should be sought to remove identified bottlenecks. The low capital investment is inimical to realization of investment needed to address the critical infrastructural gap being lamented by the populace. The capital budget execution rate is unacceptable and needs to be improved upon. Some of the findings of this Public Expenditure Review (PER) suggest the need to conduct further studies in particular a review of public financial management (PFM) bottle necks that will produce additional evidence for decision making.

1. INTRODUCTION

1.1 Background

Akwa Ibom State, like many other states in Nigeria, is in the process of embracing health financing policy reform directives introduced at the federal level in order to achieve more money for health and more health for the money including the decentralization of health insurance scheme that will usher in State Supported Health Insurance Scheme, PHC management integration policy called PHCUOR (in process), Revitalization of PHC for UHC policy and other laudable policy thrusts.

Akwa Ibom State has made progress towards the introduction of state supported health insurance scheme as the legal framework has been passed into law by the law makers and it is currently awaiting the assent of the state Governor.

In order to achieve context-appropriate and sustainable health financing reform in Akwa Ibom State, HFG is working with the state to conduct health financing diagnostic assessments in a number of important areas including public expenditure review (PER), public financial management and fiscal space analysis. PER analyzes government expenditures over a period of years to assess their consistency with policy priorities, and what results were achieved.

Our expectation is that the PER will generate needed evidence to make necessary changes to the flow and magnitude of government health expenditure that is aimed at achieving the desired goal of more money for health and more health for the money.

1.2 Situation Analysis

1.2.1 History

Akwa Ibom State is one of the 36 States of the Federal Republic of Nigeria; Akwa Ibom State is in the South-South geo-political zone of the country with Uyo as its capital. The population of the State was put at 3,902,051 by the 2006 census with a growth rate of 3.46% per annum, the State was projected to have had a population of 5,482,993 by the end of 2016. There are 31 LGAs in the state. Economic activities are predominantly commerce and farming with 85 percent of the population living in the rural areas.

1.2.2 Health status of the population

The demographics in Akwa Ibom State shows that women of child bearing age and under five children, who are considered to be the most vulnerable, populations, constitute 22% and 20% of the population respectively. The health situation in the State, like the situation at the national level, is characterized by poor indicators and growing population that stretches health resources. Major causes of morbidity and mortality in the state (both communicable and non-communicable) include malnutrition, malaria, hepatitis, HIV/AIDS and TB.

Table 1: Akwa Ibom State Health Performance Indicators

S/N	INDICATOR	SOUTH-SOUTH	AKWA IBOM	NATIONAL
1	Infant Mortality rate (deaths/1000 live births)	39	42	70
2	Child mortality rate (deaths/1000 children surviving to age one)	21	32	54
3	Under-five mortality rate (deaths/1000 live births)	59	73	120
4	Estimated % of children 12 – 23 months with full immunization coverage by first birthday (measles by second birthday)	52	47	23
5	Use of FP modern method by married women 15-49 (%)	11	11	10.8
6	ANC provided by skilled Health workers (% of women with a live birth in the last two years)	81	80.5	65.8
7	No of deliveries in health facilities (% of women with a live birth in the last two years)	66.8	62.2	37.5
8	Skilled attendants at birth (% of women with a live birth in the last two years)	64	40	43

Source: Multiple Indicator Cluster Survey (MICS) 2016-2017

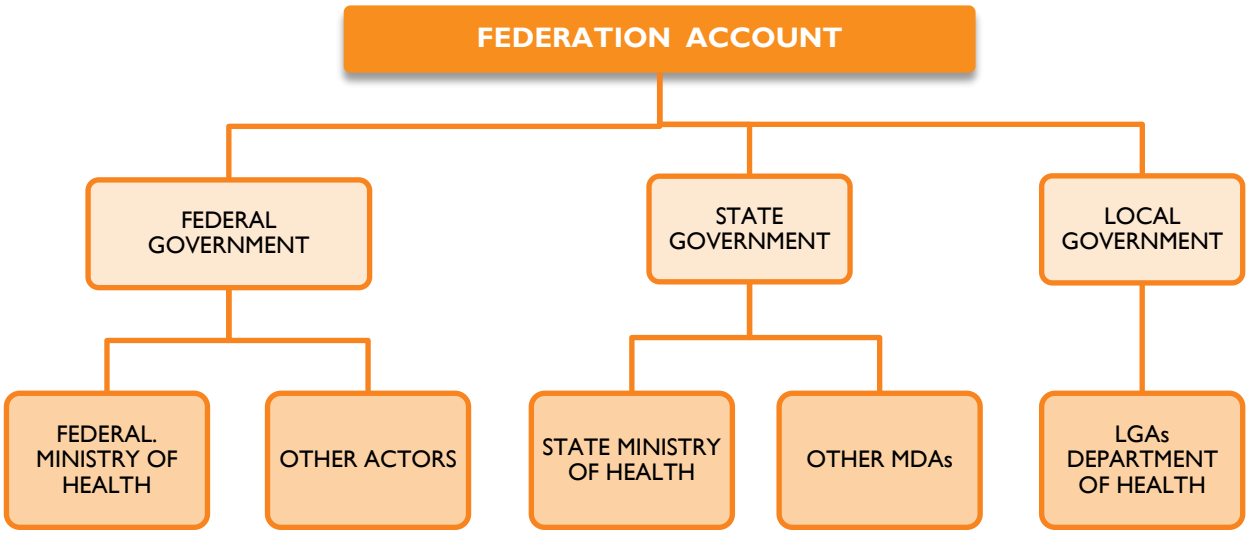
1.2.3 Overview of the State Health System

Nigeria is a Federal entity with three tiers of government, namely the federal, state and local governments. Within the health 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, funded and managed by LGAs through their Departments of Health. Secondary level (and some Tertiary-level) health care falls under the responsibility of state Government through the Ministry of Health (SMoH), this level of care includes General Hospitals, the state-owned teaching hospitals and state specialist hospitals. The federal Government is responsible for teaching Hospitals of federal universities, FMCs and similar specialised tertiary level health care facilities and of course through the Federal Ministry of Health (FMoH).

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 and likewise, the State government cannot compel the LGAs to spend in line with its policy directives.

The Nigerian government financial system operates a structure where funds flow to the three tiers of government from what is termed the Federation Account which serves as the central account through which government – federal, state and local government – fund development projects as well as maintain their respective workforce. Figure 1 shows the flow of health fund from the federation account to the major actors in the health system.

FIGURE 1: FUNDS FLOW FROM FEDERATION ACCOUNT



1.2.4 Akwa Ibom State Strategic health development plan (2010 – 2015)

As contained in the SSHDP, the state is committed to reducing the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of residents its citizens[3].

The state strategic plan was structured after the Strategic framework which has 8 priority areas as listed below:

1. Health service delivery
2. Human Resources for health
3. Leadership and governance for health
4. Finance for health
5. National health management information system
6. Community participation and ownership
7. Partnerships for health
8. Research for health

In pursuit of this commitment, the state embarked on various activities aimed at reforming the health system, these activities include

[3] Akwa Ibom State Strategic health development plan 2010 - 2015

- Passage into law of the SPHCDA bill, this will set the stage for the commencement of the PHCUOR
- Passage into law of the SHIS bill and currently awaits the executive Governor's assent
- Phased rehabilitation of secondary facilities
- Free medical care for pregnant women, children aged under 5 and the aged
- Introduction of community-based health insurance scheme in one LGA (Ukana)

The State planned to involve all partners (government, private health care providers, health development partner Agencies, CSOs, NGOs) in the implementation of the plan while the State is expected to coordinate the activities of all the players to enhance efficiency.

2. PUBLIC SECTOR EXPENDITURE REVIEW

This chapter presents an assessment of public health budget and expenditure trends between 2012 and 2016. The chapter also evaluates the sector budgetary absorptive capacity to key priority areas to support the SSHDP and CHP. The data used to carry out the analysis is appended at the end of this report which is archived from the state Ministry of Health, Ministry of budget and economic planning, Accountant General's office and Auditor General for LGAs' office, validated by HFG team and local officials.

2.1 STATE REVENUE STRUCTURE

The volume of revenue accruable to the state largely determines fiscal space available for government to spend on any sector including health. It is therefore, important to understand the volume, trend and composition of state government revenue (Table 2 and Figure 2). The five-year government revenue review shows there are various sources of revenue available to the government, this includes statutory allocation from the federation account (FAAC allocation and VAT), internally generated revenue (IGR), internal/external loans and other sources of revenue. The state's total revenue decreased from N357.4 billion in 2012 to N140.5 billion in 2016.

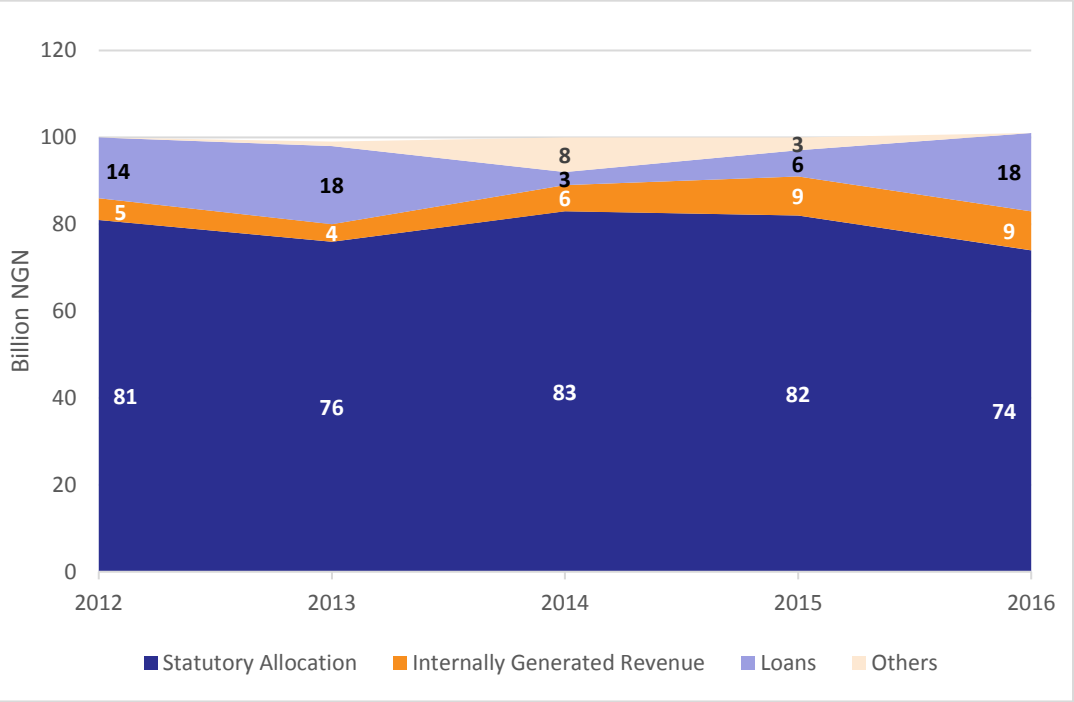
The Akwa Ibom Sstate revenue highly depended on statutory allocation from the federation account, as shown in the Figure 2. During the years under review, statutory allocation was decreasing from N289.1 billion in 2012 to N190.2 billion in 2016 and the share of statutory allocation was massive with proportion ranged from 74 percent to 83 percent; The reduction in the proportion of statutory allocation was as a result of increase in loan size. The contribution from internally generated revenue (IGR) increased from 4 percent in 2013 to 9 percent in 2016.

Table 2: Akwa Ibom State Revenue Profile 2012 – 2016

SOURCE	2012 NGN	2013 NGN	2014 NGN	2015 NGN	2016 NGN
Internally Generated Revenue	17,059,385,909	18,005,802,296	18,715,737,159	18,730,338,860	16,290,953,095
Statutory Allocation	289,097,295,829	326,897,070,796	270,416,063,953	174,101,262,960	140,486,856,535
External & Internal Loan	51,027,116,225	78,467,940,568	11,000,000,000	12,983,094,592	33,468,783,784
Others	250,000,000	5,000,000,000	25,366,070,414	7,100,000,000	0
TOTAL	357,433,797,963	428,370,813,660	325,497,871,526	212,914,696,411	190,246,593,414

Source: Akwa Ibom State Accountant General's report

FIGURE 2: AKWA IBOM STATE REVENUE COMPOSITION 2012-2016



2.2 STATE BUDGET AND EXPENDITURE REVIEW

The state total budget and expenditure declined in line with decreasing revenue during the period from N599.2 billion in 2013 to N423 billion in 2016 (29 percent decrease). Figure 3 shows that capital budget dominates the total budget allocation (57 percent to 70 percent of total state budget). The decline from capital budget from N421 billion in 2013 to N243 billion in 2016 accounts for the major reduction of state budget. The state budget for recurrent expenditure was reasonably constant which ranged from N166 billion to N209 billion over the review period.

The actual expenditure decreased from N398.43 billon in 2013 to N190.8 billon in 2016. The capital and recurrent mix reversed in 2014/2015. The capital expenditure was dominant in 2013-2014, and the share of capital expenditure was inferior than the recurrent expenditure in 2015-2016, which reduced from 66 percent to 48 percent during the review period.

FIGURE 3: STATE BUDGET AND EXPENDITURE

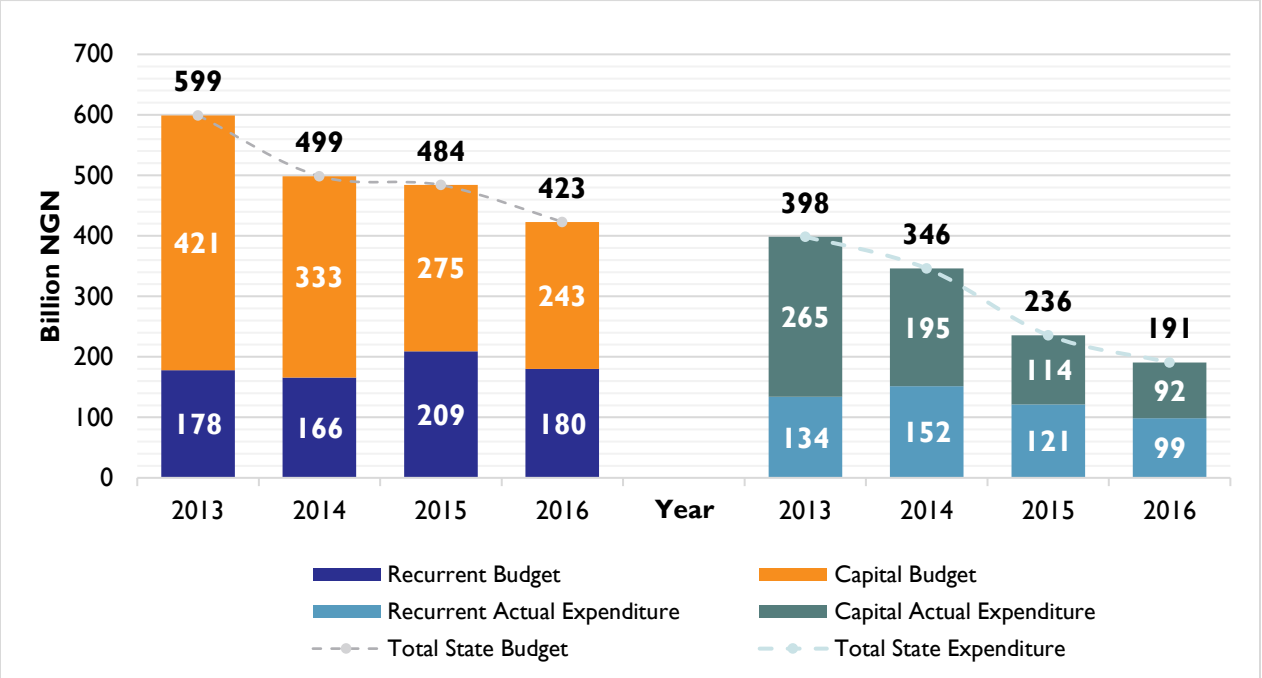
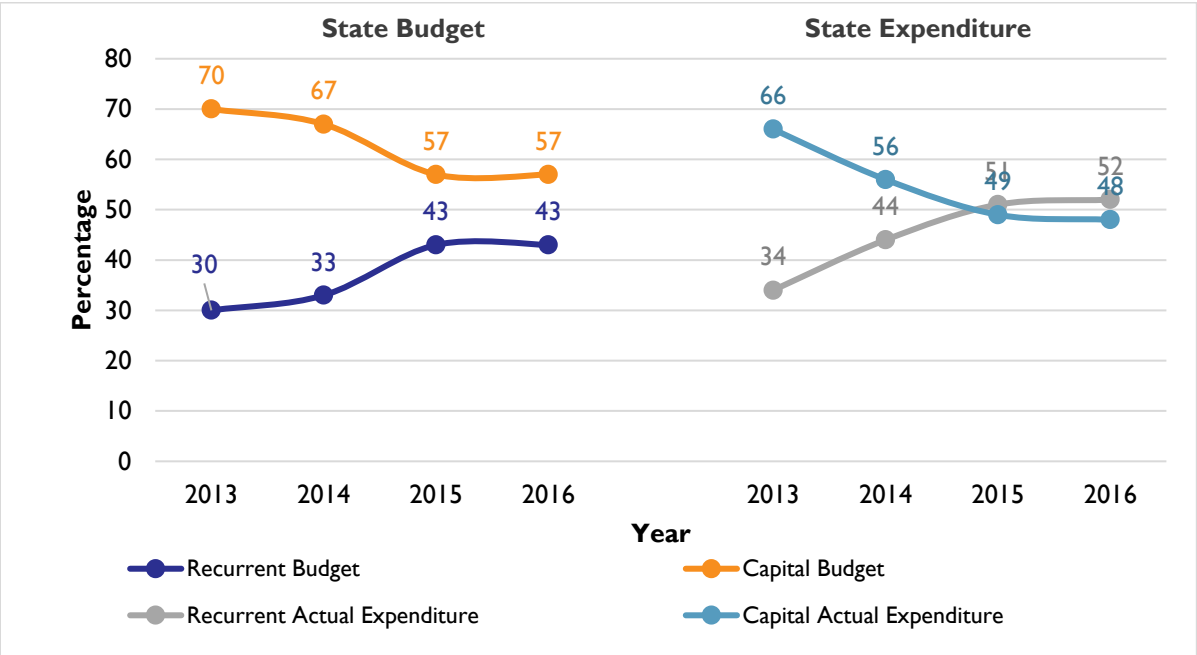


FIGURE 4: SHARE OF CAPITAL AND RECURRENT STATE BUDGET AND EXPENDITURE

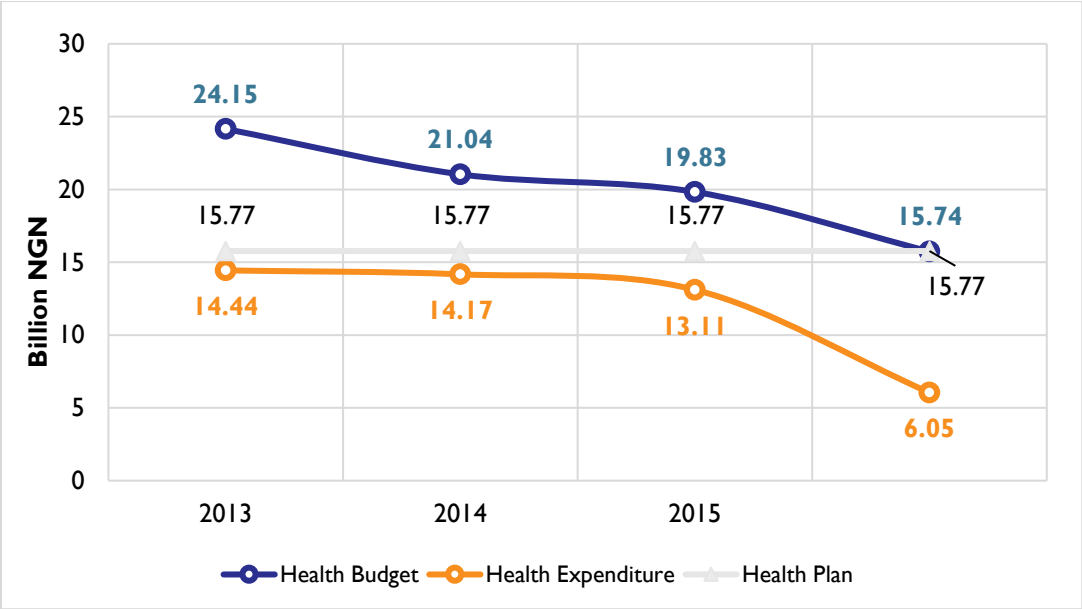


2.3 Total State Budget and Expenditure Allocated for Health

2.3.1 Total Public Health Budget and Expenditure

Despite government's commitment to achieve its health plan as highlighted in the SHDP (2010 – 2015), the current situation analysis of the health sector shows a contrary position. Health sector budgets decreased from N24.1 billion in 2013 to N15.7 billion in 2016 and the actual health expenditure dropped from N14.4 billion in 2013 N13.11 billion in 2015 and then nose-dived to N6 billion in 2016. Albeit expected support from other partners in the health sector, for the state to achieve its health plan, the actual health expenditure per year will be at least, N15.7billion.

FIGURE 5: TOTAL HEALTH BUDGET AND EXPENDITURE

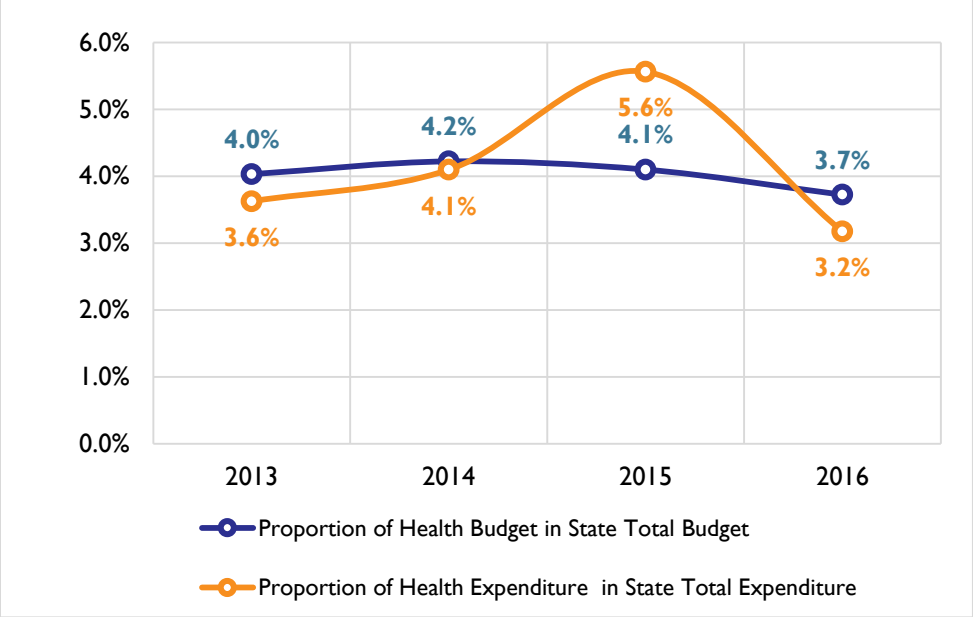


2.3.2 Share of Health Budget and Expenditure

From 2013 to 2016, health budget as a proportion of state budget was maintained at a constant 4 percent per annum. Despite the consistent percentage, monetary budget provisions declined over the 4 years. Health expenditure as a proportion of total government expenditure fluctuated between 3 percent and 6 percent, peaking at 6 percent in 2015. Though the actual expenditure is just a little below the planned N15.7 billion[4] per year (excluding 2016 expenditure), the current situation in the health sector revealed that a lot still needs to be done to achieve the desired goal.

[4] (SHDP 2010 – 2015)

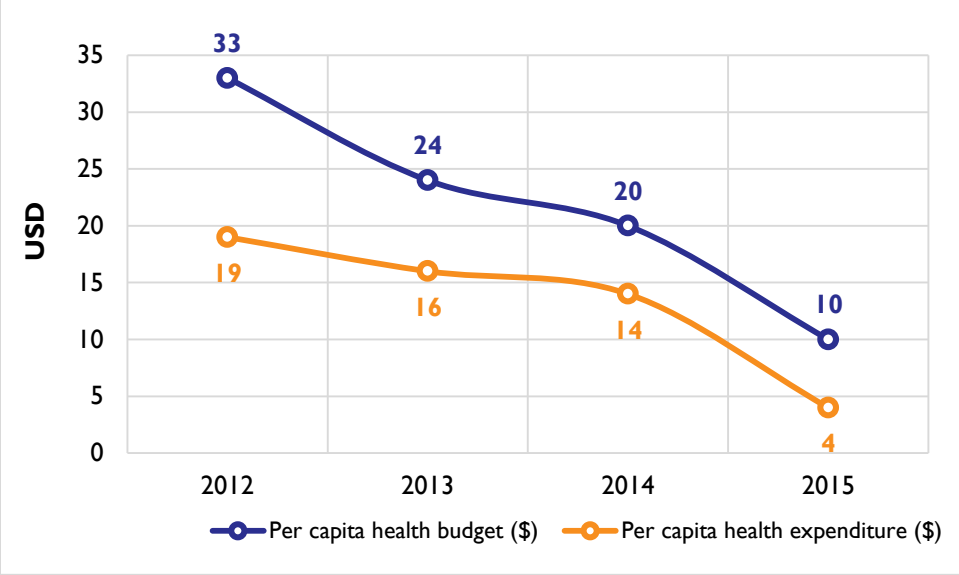
FIGURE 5: SHARE OF HEALTH IN STATE GOVERNMENT TOTAL BUDGET AND EXPENDITURE



2.3.3 Per capita Health Budget and Expenditure

Figure 7 presents trends in per capita public health budget and actual expenditure. It is worth noting that per capita health budget and expenditures declined consistently from 2013 to 2016. The per capita health budget was N4,878 ($33), N4,109 ($24), N3,743 ($20) and N2,872 ($10) respectively for each of the years under review. The per capita health expenditure was N2,917 ($19), N2,767 ($16), N2,475 ($13) and N1,104 ($4) in 2013, 2014, 2015 and 2016 respectively. In general, per capita health expenditure is very low and falls significantly short of the WHO recommended benchmark and may therefore not guarantee a healthy and productive population.

FIGURE 6: GOVERNMENT GENERAL EXPENDITURE PER CAPITA



2.3.4 Health Recurrent and Capital Budget and Expenditure

Capital budgeting for the health sector decreased dramatically from N18 billion to N7.6 billion from 2013 to 2016. The recurrent health budget increased from N6.2 billion in 2013 to N8.1 billion in 2016. Figure 9 shows their shares as the percentage of total health budget. Capital expenditure is the major driver of the health sector budgetary allocation; analysis of the health budget shows that more funds were allocated to capital expenditure though 2016 capital allocation is slightly lower than the recurrent.

Figure 8 shows that the actual capital expenditure was N8.8 billion in 2013, however, it shrank to N0.5 billion in 2016. The recurrent expenditure increased from N4.9 billion in 2014 to N5.6 billion in 2016; From 2013 to 2015, a huge proportion of the health spending went into capital expenditure. While in 2016, a higher allocation to recurrent expenditure with as high as 92% share of the total actual health expenditure. The trend from 2013 to 2015 is commendable as best practice dictates that a higher proportion of expenditure should be on development/capital activities to enhance a sustained health sector. However, the sudden shortage in capital investment in 2016 gives rise to concerns regarding capital projects' sustainability and efficiency.

FIGURE 7: HEALTH CAPITAL AND RECURRENT BUDGET AND EXPENDITURE

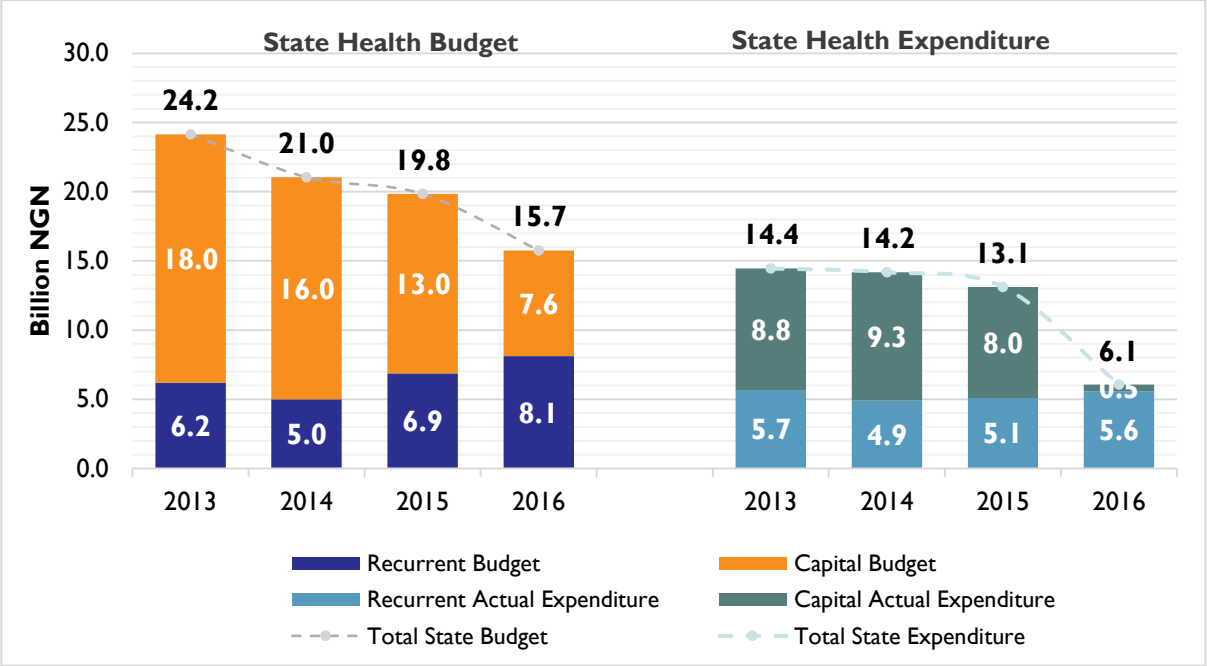
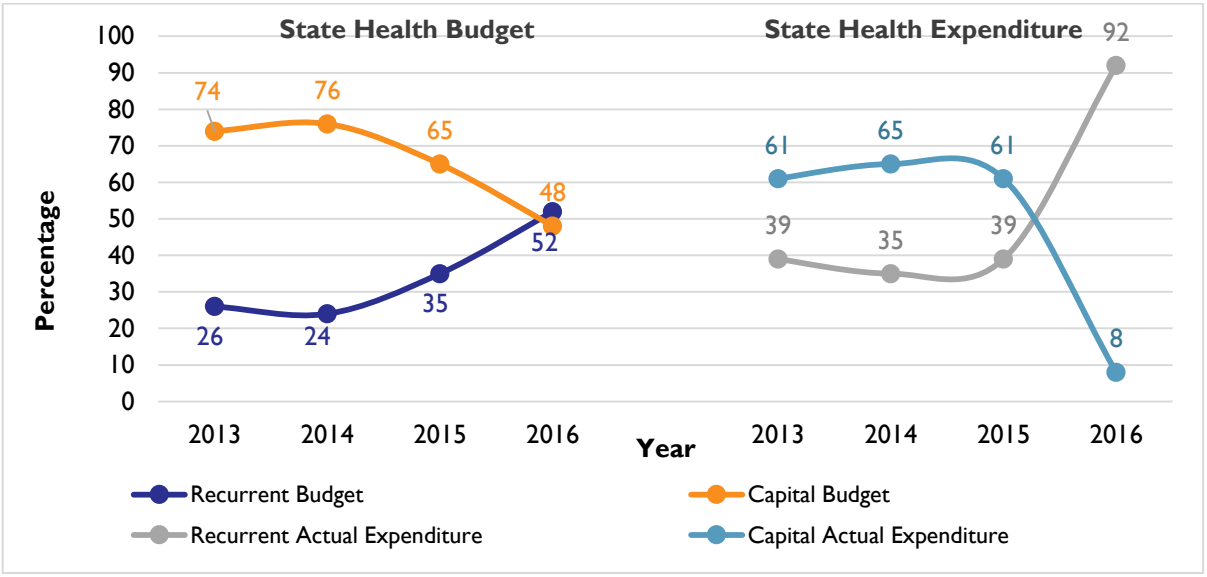


FIGURE 8: Share of health capital and recurrent budget and expenditure



2.4 KEY SECTORS BUDGET AND EXPENDITURE

The Works and Transport sector absorbed the highest share of state budget and expenditure. Allocations to health sector for the years reviewed remained at a steady 4% of government budget while

works and transport and education received as much as 24% and 13% respectively. The proportion of state government budget allocated to health is a far cry from the internationally recommended Abuja Declaration benchmark of 15% and still does not come close to the 7% benchmark set by the WHO recommended in the State SHDP (2010 – 2015). The evidence therefore, suggests that health sector is not accorded the same level of priority as other sectors in the state.

Actual expenditure shared similarities with the budget in terms of sectorial prioritization with the health sector which were having the low expenditure figures and percentages compared to education, and works and transport. Health expenditure peaked in 2015 at 6% of total Government expenditure, and had a low 3% in 2013 and 2016. Education in 2013 had its lowest expenditure for the years in review at 6%; while expenditure on education peaked in 2015 and 2016 at 9%. Works and Transport recorded the lowest percentages in 2014 and 2015 at 24%; while performing at 26% of total government expenditure in 2013 and 2016. Both budget and expenditure data paint a revealing picture on sectorial prioritization by the state government.

Figure 9: Budgetary Allocation to Key Sectors

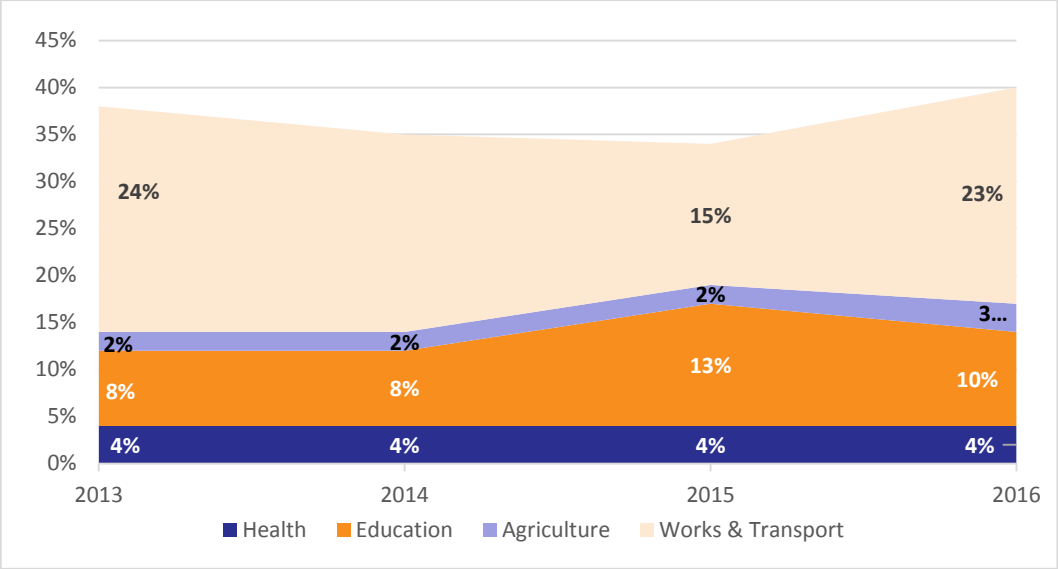
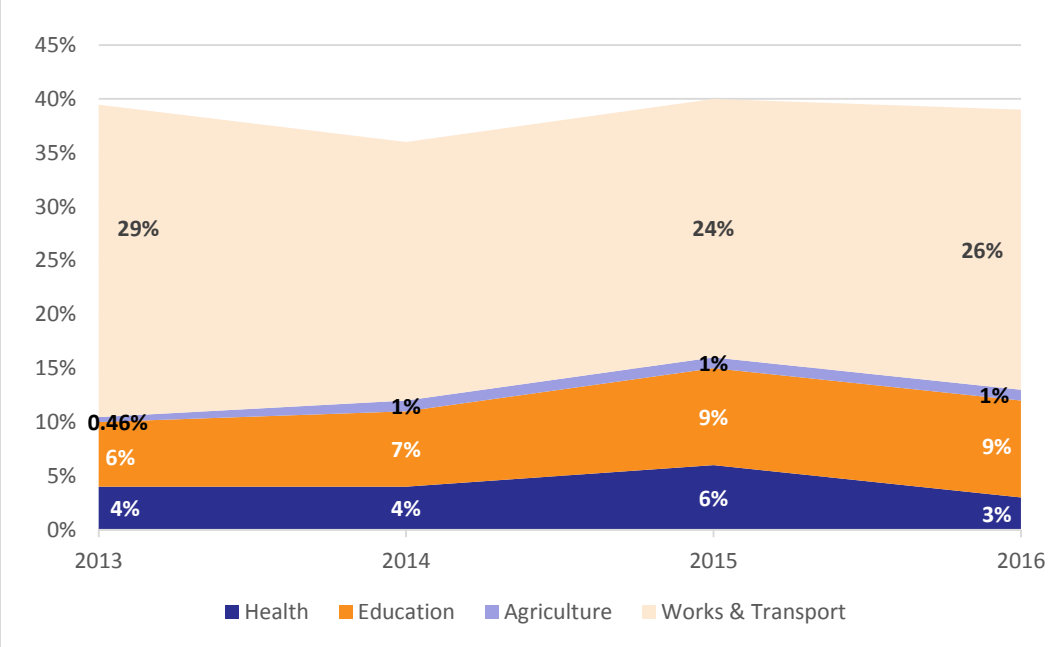


Figure 10: Key sectors' Actual Expenditure



2.4.1 Budget Implementation Review

Table 3 presents the budget implementation rates across all the major sectors from 2013 to 2016, summarized according to budget classification (recurrent and development budget). The overall state budget implementation ranged between 45% and a peak 69%; overall, recurrent budget performed better than the capital budget with highest implementation rate for the recurrent budget in 2014 at 92% and lowest at 55% in 2016. The capital budget on the other hand peaked in 2014 at 69% and fell as low as

45% in 2016. Across the key sectors, recurrent component of the budget performed better than the capital except for works and transport sector.

In general, performance of the health sector budget has been lower than is desirable throughout the review period, with an average annual execution rate of about 64 percent from 2013 to 2015. The implementation rate of the recurrent budget has consistently exceeded 60 percent from 2013 to 2015, and experienced a sharp decline in 2016, when implementation rate dropped to 38 percent only. The execution rate of the recurrent budget fell to 74 percent in 2015, and ended at 98 percent, in 2015. The execution performance of the capital budget has been generally lower than for the recurrent budget, attention is needed to address the causes of delays in the implementation of the health capital budget.

Comparing the implementation rate in health sector to that in other major sectors, health sector had higher implementation rate than that of sectors of agriculture and education. In all, it indicates the need to improve the budget efficiency in all the sectors, efforts should be scaled up to address possible impediments to ensure smooth implementation of the budget, especially the execution of the capital budget.

TABLE 3: Budget Execution Performance Indicators

Implementation Rates (%)	2013	2014	2015	2016
State Overall	66	69	49	45
Recurrent	75	92	58	55
Capital	63	58	42	38
Health	60	67	66	38
Recurrent	92	98	74	98
Capital	49	58	62	58
Works and Transport	79	82	77	50
Recurrent	63	93	23	47
Capital	79	82	80	50
Agriculture	18	18	17	22
Recurrent	95	94	82	47
Capital	6	8	1	17
Education	53	64	36	43
Recurrent	72	91	50	56
Capital	30	14	6	8

2.5 HEALTH FINANCING AT THE LOCAL GOVERNMENT

LGAs receive federal allocation through the Ministry for Local Government and Chieftaincy Affairs with the current structure being that the LGAs are responsible for expenditure and supervision at the PHCs; supervision over LGA services by the SMOH (where it happens) is based more upon goodwill and mutual respect than structured mandates and relationships. There is no accountability by the LGAs (to SMoH) to show the money it has received and spent for health.

The lack of data from the LGA precludes analysis of activities at the PHCs/LGA level; the validated account is only ready only up to 2014 and therefore not sufficient to arrive at a logical conclusion about the activities of the PHCs. However, a feature of LGA health expenditure is that bulk of the expenditure is on recurrent component with little on service provision.

3. AKWA IBOM STATE HEALTH SYSTEM'S PERFORMANCE AND EFFICIENCY REVIEW

The efficiency of state's health system is essential in meeting its health goals. State level efficiency of health system is concerned with understanding how well the state is using resources to accomplish the objectives of their health system. The need to develop reliable assessment of efficiency is important, given the state's responsibility to allocate funding where it might be optimally spent and identifying the factors of inefficient health delivery and provision. The assessment of efficiency can take many forms, however, challenged by limited information available at Akwa Ibom state and LGA level, a state health system comparison was adopted here to provide some indication of relative efficiency of health system. Over the period of PER review, selected indictors were identified in Akwa Ibom and compared across all the HFG funded states. This section reviews the following three aspects of Akwa Ibom state health indicators with respect to 1) general population health, especially the maternal, newborn and child health status; 2) health service delivery and provision; 3) health financing performance. Although there are variations in different state's current health system, the frameworks of state health systems are usually constructed similarly in terms of the goals they would like to archive, the dimensions of the health system they measure and the structure of health financing they relied on. Properly conducted state comparisons of performance could provide a rich source of evidence to identify the weakness and suggest relevant reforms. As more and better data are available in the state, analysis of the factors contributing to the discrepancy of health system performance becomes more feasible and the analysis of variation is more meaningful.

3.1 Akwa Ibom State Population Health

3.1.1 Akwa Ibom State Population Health Status

Overall maternal and children health status in Akwa Ibom state was getting severe from 2013 to 2016. The infant mortality rate was decreasing from 52 deaths per 100,000 live births to 10 deaths per 100,00 livebirths from 2013 to 2014 but the number increased again to 42 deaths per 100,000 live births in 2016. The children under five mortality rates had similar trend, the rate increased to 73 deaths per 100,00 livebirths. The maternal mortality rate increased 190% to 450 deaths per 100,00 livebirths in 2016.

The infectious disease became more prevalent during the review period. The prevalence rates of Tuberculosis (TB), malaria, HIV/AIDS and diarrhea are reminders that current health financing may not be enough to counter the threat of emerging infectious diseases and poor maternal and childhood conditions.

Table 4: Health Performance Indicators in Akwa Ibom States

Health Indicators	2013	2014	2015	2016
Infant Mortality Rate (MR)	52	10	15	42

Under five mortality Rate (U-SMR)	54	12	17	73
Maternal mortality Rate (MMR)	155	112	467	450
Children under 5 with fever receiving malaria treatment	11,044	142,209	83,880	88,500
Children 12-23months with full immunization coverage	29,719	145,415	117,599	126,547
Use of FP Modern method by married women 14-49	16,594	31,567	40,259	54,686
Malaria Prevalence	5,970	246,863	209,253	251,867
TB Prevalence	105	159	71	160
HIV Prevalence	2548	11440	17665	20126
Diarrhea in children	1232	4421	5142	5273

Source: Multiple Indicator Cluster Survey (MICS) 2016-2017 and State Ministry of Health

3.1.2 State Population Health Status Comparison Among HFG Selected States

Comparing the health status in Akwa Ibom state to other HFG investigated states, in general, Akwa Ibom state has better maternal and childhood conditions with lower maternal and children mortality rate. Table 5 below shows that the infant mortality rate and children under five mortality rates was much lower than the national average and its corresponding child under five malaria prevalence was 22.8%. Although the mortality rates remain low compared to other states, the maternal and childhood health conditions was getting worse over the review period (as indicated in the previous section). Therefore, a direction of health financing towards child and maternal health and a reform to improve intervention efficiency needs political attention.

Table 5: Selected Health Indicators across HFG slected states in 2016

State Name	Maternal Mortality Ratio Per 100,000 Live Births	Infant Mortality Rate Per 1,000 live births	Under 5 Mortality Rate Per 1,000 live births[5]	HIV Prevalence (%) [6]	Under 5 Malaria Prevalence (%)[7]
Akwa Ibom	450	42	73	6.5	22.8
Kogi	544	92	153	1.4	5.4
Osun	165	78	101	1.6	33.4
Oyo	108	59	73	5.6	19.2
Kebbi	490	111	174	0.8	63.6
Sokoto	1500	51	119	6.4	46.6
Bauchi	705	39	53	0.6	19.6
Ebonyi	576	47	62	0.9	30

[5] Multiple Indicator Cluster Survey (MICS) 2015-2016
[6] NARHS 2012 https://naca.gov.ng/nigeria-prevalence-rate/
[7] Percentage of children age 6-59 months tested using microscopy who are positive for malaria, MIS 2015

Benue	1318	70	82	5.6	44.5
National Average	814	70	120	3.4	42

Source: Multiple Indicator Cluster Survey (MICS) 2016-201

3.2 Akwa Ibom State Service Delivery

3.2.1 Akwa Ibom State Health Service Delivery/Provision

3.2.1.1 Maternal, Newborn and Child Health Service

Maternal and child service provision generally increased during the review period in Akwa Ibom state. Table below shows that, during the review period, 67.3 percent of women age 15-49 years with a live birth in the last two years received antenatal care by all kinds of skilled provider during the pregnancy in 2011-2012, then it increased to 80.5 percent in 2016. Similarly, the percentage of women age 15-49 years who delivered in the health facility was 47.7 percent in 2011-2012 and then increased to 76.3 percent in 2016. Children full immunization coverage was 30.6 percent in 2011-2012, then increased to 44.4 percent in 2016-2017. The percentage of children under five with fever receiving any antimalaria drugs was 45.8 percent and 37.3 percent in 2011-2012 and 2016-2017 respectively.

Table 6: Health Service Provision In Akwa Ibom state during the review period

Percentage	2011-2012	2016-2017
Women who received ANC by skilled health workers	67.3	80.5
Received HIV counselling During ANC	67.3	63.5
Skilled Attendant Assisted at delivery	39.7	40.0
Deliveries in health facilities	47.7	76.3
Children 12 – 23 months with full immunization coverage	30.6	44.4
Children under five with fever receiving malaria treatment (Any antimalarial drugs)	45.8	37.3

Source: Multiple Indicator Cluster Survey (MICS) 2012 and 2016

3.2.1.2 Facility utilization

There has been an improvement in facility utilization between 2013 and 2016; inpatient care increased from 5,440 visits per year to 58,602 visits per year while outpatient attendance increased from 30,982 visits per year to 1,067,417 visits per year in 2015 before declining to 530,892 visits per year in 2016. The decline in outpatient care between 2015 and 2016 was connected with the reduction in the number of health workers during this period.

3.2.2 State Health Service Provision Comparison Among HFG Selected States

Table 7 shows that, compared with the child and maternal service provision rates in other HFG selected states, the child and maternal service provision rates were high in Akwa Ibom state. In 2016, there were 80.5 percent of women age 15-49 years with a live birth in the last two years by antenatal care provider during the pregnancy for the last birth, 63.5 percent of them received HIV counselling during the antenatal care provision and 40.0 percent of them received assistance from skilled attendant during their delivery. There was 44.4 percent of children age 12-23 months who received all vaccinations recommended in the national immunization schedule by their first birthday. It is challenging to keep all the primary health services provided sustainable while the investment into public health sector remains low.

Table 7: Health service provison across HFG slected states in 2016

State Name	Antenatal Care Coverage [8]	Full immunization coverage[9]	Received HIV counselling During ANC [10]	Skilled Attendant Assisted at delivery [11]
Akwa Ibom	80.5	44.2	63.5	40.0
Kogi	80.4	29.9	36.9	78.4
Osun	95.6	43.0	56.9	84.7
Oyo	86.9	37.4	53.6	79.8
Kebbi	45.4	4.8	10.9	17.9
Sokoto	35.1	2.2	9.6	20.6
Bauchi	59.8	13.9	27.5	22.1
Ebonyi	75.0	35.0	45.7	72.6
Benue	67.5	37.0	57.6	62.8
National Average	65.8	22.9	41.0	43.0

Source: Multiple Indicator Cluster Survey (MICS) 2016-2017

3.3 Akwa Ibom State Health Financing

The Table 10 presents the share of health expenditure as a proportion of general state government expenditure and per capita public health expenditure among all the HFG selected states. Compared to

[8] Percent distribution of women age 15-49 years with a live birth in the last two years by antenatal care provider during the pregnancy for the last birth, Nigeria, 2016
[9] Percentage of children age 12-23 months who received all vaccinations recommended in the national immunization schedule by their first birthday (measles by second birthday) , Nigeria, 2016
[10] Percentage of women age 15-49 with a live birth in the last two years who received antenatal care from a health professional during the last pregnancy and received HIV counselling, Nigeria, 2016
[11] Percent distribution of women age 15-49 years with a live birth in the last two years by person providing assistance at delivery, Nigeria, 2016

most of the other states, on average, Akwa Ibom state spent 4.3 % of general government expenditure into health sectors which was lower than most states. The average per capita public health expenditure was $13.0 over the review period which is much lower than WHO recommended level. The lack of accountability in health expenditure is clearly an area that needs to be addressed if the state strategy and framework for maternal and child health is to have the desired impact.

Table 8: Selected Health Financing Indicators across HFG slected states during the review period

State Name	Gen. govt Expenditure on health as % of gen govt exp.	Govt Per Capita Expenditure on health at average $ exchange rate
Akwa Ibom	4.3	13.0
Kogi	5.4	7.7
Osun	7.8	10.8
Oyo	9.5	6.5
Kebbi	8.0	6.3
Sokoto	11.0	8.1
Bauchi	9.0	12.5
Ebonyi	8.5	8.0
Benue	8.5	6.3
National standard	15.0	97.0

In sum, although the health service provision expanded every year, the preventable mortality rate in Akwa Ibom state is getting higher during the review period. The incensement of preventable mortalities was partially due to the huge decline of health financing and low efficiency of the service implementation.

4. CONCLUSIONS AND RECOMMENDATION

One of the objectives of this assessment is to support the State Government to review their health public expenditure and identify areas for improvement; this will equally complement the findings from other various assessments necessary to provide useful information that will facilitate health financing reforms aimed at making progress towards Universal Health Coverage. Summary of the main findings and recommendations are highlighted below.

4.1 Highlights of PER Findings

4.1.1 General trend of health financing

Government funding remains the dominant source of health sector financing during the period under review. An analysis of Akwa Ibom state's fiscal profile indicates that the state revenue highly depended on statutory allocation from the federation account. During the years under review, contribution of statutory allocation ranges from 83 percent in 2014 to 74percent in 2016 while the contribution from Internally generated revenue (IGR) increased from 4 percent in 2013 to 9 percent in 2016.

In general, the public health sector financing gradually declined from 2013 to 2016, especially a sharp decline in the capital expenditure in 2016. Public health sector financing ranged between 3.7 percent -4.2 percent over the four-year period under review (2013-2016), and the share of the health budget in the total government budget remains below the 15 percent recommended under the Abuja Declaration. Although government committed to achieve its health plan as highlighted in the SHDP (2010 – 2015), health sector budget decreased from N24.1 billion in 2013 to N15.7billion in 2016 while the actual health expenditure dropped from N14.4 billion in 2013 N13.11 billion in 2015 and then nose-dived to N6 billion in 2016. Meanwhile, large share of public health sector expenditure had spent on capital investment from 2013-2015 but it sharply shrunk in 2016. The analysis shows that the actual capital expenditure was N8.8billion in 2013, however, it shrunk to N0.5billion in 2016. The recurrent expenditure increased from N4.9billion in 2014 to N5.6billion in 2016; From 2013 to 2015, a huge proportion of the health spending went into capital expenditure. While in 2016, a higher allocation to recurrent expenditure with as high as 92% share of the total actual health expenditure. The sudden shortage in capital investment in 2016 addressed the concerns for capital project's sustainability and efficiency.

4.1.2 Per capita expenditures

Per capita health budget and expenditures had declined consistently from 2013 to 2016. The per capita health budget was N4,878($33), N4,109($24), N3,743($20) and N2,872($10) respectively for each of the years under review. The per capita health expenditure was N2,917($19), N2,767($16), N2,475($13) and N1,104($4) in 2013, 2014, 2015 and 2016 respectively. In general, per capita health expenditure is very

low and falls significantly short of the WHO recommended benchmark and may therefore not guarantee a healthy and productive population.

4.1.3 Budget performance

In general, performance of the health sector budget has been lower than desirable throughout the review period, with an average annual execution rate of about 64 percent from 2013 to 2015. The implementation rate of the recurrent budget has consistently exceeded 60 percent from 2013 to 2015, and experienced a sharp decline in 2016, that implementation rate dropped to 38 percent only. The execution rate of the recurrent budget fell to 74 percent in 2015, and ended by 98 percent, in 2015. The execution performance of the capital budget has been generally lower than for the recurrent budget, where needs attention to address the causes of delays in the implementation of the health capital budget.

4.1.4 Health System Performance

Although the state health service provision expanded every year, the preventable mortality rose in Akwa Ibom state during the review period, especially, the maternal and childhood conditions care quality appears to be getting worse. The increase of preventable mortalities was partially due to the huge decline of health financing and low efficiency of the service implementation. When compared to other HFG selected states, the level of public financing is low while the provision of health services was high. However, the deteriorating health outcomes and downside trend of maternal and children health needs political attentions.

4.2 Recommendations

4.2.1 Macro Fiscal Context

Overreliance on statutory allocation as a main source of revenue for the state is inimical to the growth of the financial strength of the state due to volatility of oil revenue accruable to the country. Loan on the other hand increases government's future commitment hence reduction in amount available for planned interventions. Improved IGR will go a long way to expand the fiscal space for public health; although the proportion of IGR to the accrued revenue has been recognized to be better than that of few other states, it is advisable to improve on this. The average monthly IGR of N1.35billonn by the state calls for a review of the state revenue generation mechanism.

4.2.2 Increase Government expenditure on Health

Both budget and expenditure trend in the state show that health is not being accorded the priority it requires. The low prioritization of the health sector funding by the government is a threat to actualization of health goals set by the state as captured in the state health policy document. As a state with poor health indices, the state urgently needs to invest far more than 11 percent of its total expenditure on health. This low level of government investment on health is also a threat to the successful take-off of the proposed State Supported Health Care Scheme in the state. Both arms of government (state and LGA) should be effectively engaged to advocate for increased allocation to the health sector.

4.2.3 Improve the budget implementation capacity

The budget implementation rate was extremely low in the sectors with large share of budget especially in 2016. Execution of the development budget continues to be plagued by several impediments, such as the current practice of fragmented financing systems. The efforts should be addressed to those impediments to ensure the smooth implementation of the budget.

4.2.4 Strengthen the health financing capacity of local government authorities (LGA)

Although the delivery of primary health services is largely concentrated at the local government level, the largest share of health sector financing is still managed at the central level. During the review period, limited health financing information could be tracked at LGA level.

4.2.5 Institute mechanism to track allocation, expenditure and outcome

As stated earlier, expansion of fiscal space in the health sector requires efforts both at mobilizing more resources and also ensuring efficient use of available resources. It is highly recommended to institute adequate measures for timely and periodic review of the health systems efficiency. As in many developing countries, Akwa Ibom state government has very limited capacity to measure the developmental impact of public expenditure and most agencies are pre-occupied with reporting how inputs have been used rather than highlighting outcomes achieved. In view of this, the HMIS/M&E team needs to be better engaged and empowered in order to identify the most feasible way to link performance to productivity, one way to achieve this is to introduce performance-based financing. Increase the capacity of institutionalizing the PER and other resource tracking initiatives such as National Health Accounts (NHA) etc. is important for sustainable capacity build up.

4.2.6 Further Reviews

Further PFM assessment and problem solving is recommended to identify the cause of the current low absorptive capacity for capital funds within the health sector and to identify the necessary technical support should be sought to remove identified bottlenecks. The low capital investment is inimical to realization of investment needed to address the critical infrastructural gap being lamented by the populace. The capital budget execution rate is unacceptable and needs to be improved upon. Some of the findings of this PER suggest the need to conduct further studies that will produce additional evidence for decision making. Examples would include activities like the Service Availability and Readiness Assessments that HFG has conducted in Bauchi, Sokoto and Cross Rivers that have allowed those states to direct resources specifically where they are needed to support human resources for health training needs and infrastructure investments. In addition, it may be necessary to assess the capacity of the SHDP committee to ensure they possess the requisite capacity for domestic resource mobilization.

ANNEX

Annex 1: Indicators – State Budget and Expenditure

BUDGET	2013		2014		2015		2016	
	Amount	As a % of State Budget	Amount	As a % of State Budget	Amount	As a % of State Budget	Amount	As a % of State Budget
Total Recurrent	177,895,166,710	30	165,539,700,100	33	209,000,000,000	43	180,000,000,000	43
Capital	421,285,000,000	70	333,000,000,000	67	275,000,000,000	57	243,000,000,000	57
Total State Budget	599,180,166,710	100	498,539,700,100	100	484,000,000,000	100	423,000,000,000	100
EXPENDITURE	Amount	As a % of State Expenditure	Amount	As a % of State Expenditure	Amount	As a % of State Expenditure	Amount	As a % of State Expenditure
Total Recurrent	133,798,628,567	34	151,522,539,273	44	121,420,683,426	51	98,522,494,476	52
Capital	264,631,713,891	66	194,572,236,885	56	114,415,223,344	49	92,305,936,498	48
Total State Expenditure	398,430,342,458	100	346,094,776,158	100	235,835,906,770	100	190,828,430,974	100

Annex 2: Indicators - Health Budget and Expenditure

BUDGET	**2013**		**2014**		**2015**		**2016**	
	Amount	**As a % of Health Budget**	**Amount**	**As a % of Health Budget**	**Amount**	**As a % of Health Budget**	**Amount**	**As a % of Health Budget**
Total Recurrent	6,198,069,840	26	4,998,281,020	24	6,864,808,070	35	8,111,131,320	52
Capital	17,952,000,000	74	16,048,000,000	76	12,974,000,000	65	7,635,081,000	48
Total Health Budget	24,150,069,840	100	21,046,281,020	100	19,838,808,070	100	15,746,212,320	100
EXPENDITURE	**Amount**	**As a % of Health Expenditure**	**Amount**	**As a % of Health Expenditure**	**Amount**	**As a % of Health Expenditure**	**Amount**	**As a % of Health Expenditure**
Total Recurrent	5,676,051,711	39	4,913,555,426	35	5,095,872,569	39	5,580,104,648	92
Capital	8,767,475,612	61	9,260,373,705	65	8,021,135,575	61	475,128,573	8
Total Health Expenditure	14,443,527,323	100	14,173,929,131	100	13,117,008,144	100	6,055,233,221	100

Annex 3: Indicators - Key Sectors' Budget and Expenditure

BUDGET	2013		2014		2015		2016	
	Amount	As a % of State Budget	Amount	As a % of State Budget	Amount	As a % of State Budget	Amount	As a % of State Budget
Health	24,150,069,840	4	21,046,281,020	4	19,838,808,070	4	15,746,212,320	4
Education	47,323,333,130	8	38,307,305,780	8	60,611,613,460	13	41,641,958,610	10
Agriculture	10,365,012,110	2	11,944,286,360	2	8,920,469,460	2	11,674,013,190	3
Works and Transport	144,395,242,640	24	102,476,898,820	21	74,113,317,880	15	97,768,578,730	23
Others	372,946,508,990	62	324,764,928,120	65	320,515,791,130	66	256,169,237,150	61
Total State Budget	**599,180,166,710**	100	**498,539,700,100**	**100**	**484,000,000,000**	**100**	**423,000,000,000**	**100**
EXPENDITURE	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**
Health	14,443,527,323	4	14,173,929,131	4	13,117,008,144	6	6,055,233,221	3
Education	24,986,396,660	6	24,463,586,829	7	21,634,966,389	9	18,076,772,462	9
Agriculture	1,839,646,363	0.46	2,196,238,059	1	1,528,664,269	1	2,602,681,368	1
Works and Transport	114,243,749,281	29	83,919,563,763	24	56,866,723,368	24	48,799,313,215	26
Others	242,917,022,831	61	221,341,458,376	64	142,688,544,601	61	115,294,430,708	60
Total State Expenditure	**398,430,342,458**	100	**346,094,776,158**	**100**	**235,835,906,771**	**100**	**190,828,430,974**	**100**

Annex 4: Key Performance Indicators – Akwa Ibom State

DETAILS	2013	2014	2015	2016
	N	N	N	N
Health Budget	24,150,069,840	21,046,281,020	19,838,808,070	15,746,212,320
Health Expenditure	14,443,527,323	14,173,929,131	13,117,008,144	6,055,233,221
Projected Population	4,951,084	5,122,391	5,299,626	5,482,993
Exchange Rate (NGN/$)	150	170	190	300
Health budget per capita (NGN)	4,878	4,109	3,743	2,872
Health Budget per capita ($)	33	24	20	10
Health Expenditure per capita (NGN)	2,917	2,767	2,475	1,104
Health Expenditure per capita ($)	19	16	13	4

Annex 5: Recurrent and Capital Expenditure Implementation report

STATE

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	177,895,166,710	133,798,628,567	75	**165,539,700,100**	**151,522,539,273**	92	**209,000,000,000**	**121,420,683,426**	58	**180,000,000,000**	**98,522,494,476**	55
Capital Expenditure	421,285,000,000	264,631,713,891	63	333,000,000,000	194,572,236,885	58	275,000,000,000	114,415,223,344	42	243,000,000,000	92,305,936,498	38
Total	**599,180,166,710**	**398,430,342,458**	66	**498,539,700,100**	**346,094,776,158**	69	**484,000,000,000**	**235,835,906,770**	49	**423,000,000,000**	**190,828,430,974**	45

HEALTH

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	6,198,069,840	5,676,051,711	92	4,998,281,020	4,913,555,426	98	6,864,808,070	5,095,872,569	74	8,111,131,320	5,580,104,648	69
Capital Expenditure	17,952,000,000	8,767,475,612	49	16,048,000,000	9,260,373,705	58	12,974,000,000	8,021,135,575	62	7,635,081,000	475,128,573	6
Total	**24,150,069,840**	**14,443,527,323**	60	**21,046,281,020**	**14,173,929,131**	67	**19,838,808,070**	**13,117,008,144**	66	**15,746,212,320**	**6,055,233,221**	38

WORKS AND TRANSPORT

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	2,125,242,640	1,339,380,786	63	1,995,898,820	1,856,835,174	93	4,373,317,880	1,017,601,790	23	2,244,251,730	1,054,087,613	47
Capital Expenditure	142,270,000,000	112,904,368,494	79	100,481,000,000	82,062,728,589	82	69,740,000,000	55,849,121,578	80	95,524,327,000	47,745,225,602	50
Total	**144,395,242,640**	**114,243,749,280**	79	**102,476,898,820**	**83,919,563,763**	82	**74,113,317,880**	**56,866,723,368**	77	**97,768,578,730**	**48,799,313,215**	50

ARICULTURE

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	1,326,012,110	1,263,437,323	95	1,494,286,360	1,399,951,232	94	1,779,969,460	1,456,321,220	82	2,032,041,190	950,297,368	47
Capital Expenditure	9,039,000,000	576,209,040	6	10,450,000,000	796,286,827	8	7,140,500,000	72,323,049	1	9,641,972,000	1,652,384,000	17
Total	**10,365,012,110**	**1,839,646,363**	18	**11,944,286,360**	**2,196,238,059**	18	**8,920,469,460**	**1,528,644,269**	17	**11,674,013,190**	**2,602,681,368**	22

EDUCATION

DETAIL	2013	2014	2015	2016

	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	25,708,333,130	18,543,587,524	72	24,693,305,780	22,541,282,720	91	40,747,913,460	20,468,033,125	50	30,892,193,610	17,267,450,671	56
Capital Expenditure	21,615,000,000	6,442,809,137	30	13,614,000,000	1,922,304,109	14	19,863,700,000	1,166,933,264	6	10,749,765,000	809,001,791	8
Total	**47,323,333,130**	**24,986,396,661**	53	**38,307,305,780**	**24,463,586,829**	64	**60,611,613,460**	**21,634,966,389**	36	**41,641,958,610**	**18,076,452,462**	43

Annex 6: Budget by Health MDAs

2013

S/NO	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods			13,560,000	13,560,000		13,560,000
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)			35,208,680	35,208,680		35,208,680
3	Public Health Lab				-		-
4	State Committee on food and Nutrition			5,400,000	5,400,000		5,400,000
5	Hospital Management Board	4,144,942,530	43,470,000		4,188,412,530		4,188,412,530
6	Ministry of Health	1,592,738,630	87,570,000		1,680,308,630	17,952,000,000	19,632,308,630
7	CENTRAL DRUG STORE			1,750,000	1,750,000		1,750,000
8	CENTRAL LAB UNIT			4,630,000	4,630,000		4,630,000
9	OVERHEAD IN HOSPITALS/HEALTH CENTRES			268,800,000	268,800,000		268,800,000
	TOTAL	**5,737,681,160**	**131,040,000**	**329,348,680**	**6,198,069,840**	**17,952,000,000**	**24,150,069,840**

2014

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods	8,400,000	7,800,000		16,200,000		16,200,000
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	17,571,910	20,000,000		37,571,910		37,571,910
3	Public Health Lab		3,600,000		3,600,000		3,600,000
4	Monitoring of Government Hospitals		6,000,000		6,000,000		6,000,000
5	Drugs Revolving Committee		1,800,000		1,800,000		1,800,000
6	Christian Family Mission, Nkwot, Ikono		6,000,000		6,000,000		6,000,000
7	Comprehensive Health Centres		42,000,000		42,000,000		42,000,000
8	Cottage Hospitals		54,000,000		54,000,000		54,000,000
9	Dental Health Centre		12,000,000		12,000,000		12,000,000
10	General Hospitals		118,800,000		118,800,000		118,800,000
11	Hospital Management Board	3,344,947,490	60,040,000		3,404,987,490	1,728,000,000	5,132,987,490
12	Emmanuel General Hospital		8,400,000		8,400,000		8,400,000
13	Infectious Disease Hospital (IDH)		6,000,000		6,000,000		6,000,000
14	Leprosy Hospital		6,000,000		6,000,000		6,000,000
15	Mary Slessor Hospital		7,200,000		7,200,000		7,200,000
16	Methodist General Hospital		7,200,000		7,200,000		7,200,000

17	Ministry of Health	1,117,341,620	125,180,000		1,242,521,620	14,320,000,000	15,562,521,620
18	Mount Carmel Hospital		6,000,000		6,000,000		6,000,000
19	Psychiatric Hospital		6,000,000		6,000,000		6,000,000
20	Redeemer Hospital		6,000,000		6,000,000		6,000,000
	TOTAL	**4,488,261,020**	**510,020,000**		**4,998,281,020**	**16,048,000,000**	**21,046,281,020**

2015

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods	8,400,000	10,200,000		18,600,000		18,600,000
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	23,577,490	31,700,000		55,277,490	500,000,000	555,277,490
3	Public Health Lab			3,600,000	3,600,000		3,600,000
4	Monitoring of Government Hospitals			9,600,000	9,600,000		9,600,000
5	Drugs Revolving Committee			1,800,000	1,800,000		1,800,000
6	Comprehensive Health Centres		42,000,000		42,000,000		42,000,000
7	Cottage Hospitals		54,000,000		54,000,000		54,000,000
8	Dental Health Centre		12,000,000		12,000,000		12,000,000
9	General Hospitals		110,400,000		110,400,000		110,400,000
10	Hospital Management Board	4,271,664,690	76,040,000		4,347,704,690	1,569,000,000	5,916,704,690
11	Immanuel General Hospital		8,400,000		8,400,000		8,400,000
12	Infectious Disease Hospital (IDH)		6,000,000		6,000,000		6,000,000
13	Leprosy Hospital		6,000,000		6,000,000		6,000,000
14	Mary Slessor Hospital		7,200,000		7,200,000		7,200,000
15	Methodist General Hospital		7,200,000		7,200,000		7,200,000

16	Ministry of Health	2,108,505,890	13,720,000		2,122,225,890	10,905,000,000	13,027,225,890
17	Mount Carmel Hospital		6,000,000		6,000,000		6,000,000
18	Psychiatric Hospital		6,000,000		6,000,000		6,000,000
19	Redeemer Hospital		6,000,000		6,000,000		6,000,000
20	DIRECT INTERVENTION ON GOVT HOSPITAL			24,000,000	24,000,000		24,000,000
21	HEALTH RESEARCH & ETHICS COMMITTEE			3,600,000	3,600,000		3,600,000
22	MAT. & CHILD HEALTH COMMITTEE			3,600,000	3,600,000		3,600,000
23	MED DENTAL COUNCIL MONITORING COMMITTEE			3,600,000	3,600,000		3,600,000
	TOTAL	**6,412,148,070**	**402,860,000**	**49,800,000**	**6,864,808,070**	**12,974,000,000**	**19,838,808,070**

2016

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods	-	10,910,000		10,910,000		10,910,000
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	24,891,060	32,680,000		57,571,060	216,000,000	273,571,060
3	Public Health Lab	-		3,600,000	3,600,000		3,600,000
4	Monitoring of Government Hospitals			9,600,000	9,600,000		9,600,000
5	Drugs Revolving Committee			2,400,000	2,400,000		2,400,000
6	Christian Family Mission, Nkwot, Ikono	-	6,000,000		6,000,000		6,000,000
7	Comprehensive Health Centres	-	42,000,000		42,000,000		42,000,000
8	Cottage Hospitals	-	54,000,000		54,000,000		54,000,000
9	Dental Health Centre	-	12,000,000		12,000,000		12,000,000
10	General Hospitals	-	110,400,000		110,400,000		110,400,000

11	Hospital Management Board	6,012,105,570	81,080,000	24,000,000	6,117,185,570	959,500,000	7,076,685,570
12	Immanuel General Hospital	-	8,400,000		8,400,000		8,400,000
13	Infectious Disease Hospital (IDH)	-	6,000,000		6,000,000		6,000,000
14	Leprosy Hospital	-	6,000,000		6,000,000		6,000,000
15	Mary Slessor Hospital	-	7,200,000		7,200,000		7,200,000
16	Methodist General Hospital	-	7,200,000		7,200,000		7,200,000
17	Ministry of Health	1,434,274,690	161,190,000	12,000,000	1,607,464,690	6,459,581,000	8,067,045,690
18	Mount Carmel Hospital	-	6,000,000		6,000,000		6,000,000
19	Psychiatric Hospital	-	6,000,000		6,000,000		6,000,000
20	Redeemer Hospital	-	6,000,000		6,000,000		6,000,000
21	DIRECT INTERVENTION ON GOVT HOSPITAL			12,000,000	12,000,000		12,000,000
22	HEALTH RESEARCH & ETHICS COMMITTEE			3,600,000	3,600,000		3,600,000
23	MAT. & CHILD HEALTH COMMISION			3,600,000	3,600,000		3,600,000
24	MED DENTAL COUNCIL MONITORING COM			3,600,000	3,600,000		3,600,000
25	NIGERIAN RED CROSS			2,400,000	2,400,000		2,400,000
	TOTAL	**7,471,271,320**	**563,060,000**	**76,800,000**	**8,111,131,320**	**7,635,081,000**	**15,746,212,320**

Annex 7: Expenditure by Health MDAs

2013

S/NO	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods		13,560,000		13,560,000		13,560,000
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)		29,273,200		29,273,200		29,273,200
3	Public Health Lab				-		-
4	Food Committee on Nutrition			5,400,000	5,400,000		5,400,000
5	Hospital Management Board	4,071,480,974	32,498,330		4,103,979,304		4,103,979,304
6	Ministry of Health	1,196,170,958	71,772,250		1,267,943,208	8,767,475,612	10,035,418,820
7	CENTRAL DRUG STORE			780,000	780,000		780,000
8	CENTRAL LAB UNIT			-	-		-
9	OVERHEAD IN HOSPITALS/HEALTH CENTRES			255,116,000	255,116,000		255,116,000
	TOTAL	5,267,651,932	147,103,780	261,296,000	5,676,051,711	8,767,475,612	14,443,527,323

2014

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods	8,340,000	5,589,675		13,929,675		13,929,675
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	12,594,188	13,483,800		26,077,988		26,077,988
3	Public Health Lab			3,000,000	3,000,000		3,000,000
4	Monitoring of Government Hospitals			6,000,000	6,000,000		6,000,000
5	Drugs Revolving Committee			1,000,000	1,000,000		1,000,000
6	Christian Family Mission, Nkwot, Ikono		4,915,400		4,915,400		4,915,400
7	Comprehensive Health Centres		34,397,960		34,397,960		34,397,960
8	Cottage Hospitals		48,721,930		48,721,930		48,721,930
9	Dental Health Centre		10,179,750		10,179,750		10,179,750
10	General Hospitals		99,960,899		99,960,899		99,960,899
11	Hospital Management Board	3,339,115,928	46,452,345		3,385,568,273	698,734,942	4,084,303,215
12	Immanuel General Hospital		7,339,300		7,339,300		7,339,300
13	Infectious Disease Hospital (IDH)		5,640,650		5,640,650		5,640,650
14	Leprosy Hospital		5,593,350		5,593,350		5,593,350
15	Mary Slessor Hospital		6,727,400		6,727,400		6,727,400
16	Methodist General Hospital		5,528,250		5,528,250		5,528,250
17	Ministry of Health	1,116,884,652	116,665,219		1,233,549,871	8,561,638,762	9,795,188,633

18	Mount Carmel Hospital		5,475,130		5,475,130		5,475,130
19	Psychiatric Hospital		4,772,800		4,772,800		4,772,800
20	Redeemer Hospital		5,176,800		5,176,800		5,176,800
	TOTAL	**4,476,934,768**	**426,620,658**	**10,000,000**	**4,913,555,426**	**9,260,373,705**	**14,173,929,131**

2015

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods	4,865,000	4,099,880		8,964,880		8,964,880
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	8,550,189	7,794,500		16,344,689		16,344,689
3	Public Health Lab			1,950,000	1,950,000		1,950,000
4	Monitoring of Government Hospitals			4,050,000	4,050,000		4,050,000
5	Drugs Revolving Committee			975,000	975,000		975,000
6	Comprehensive Health Centres		6,647,500		6,647,500		6,647,500
7	Cottage Hospitals		22,279,050		22,279,050		22,279,050
8	Dental Health Centre		3,366,380		3,366,380		3,366,380
9	General Hospitals		76,211,175		76,211,175		76,211,175
10	Hospital Management Board	3,869,613,412	49,131,480		3,918,744,892	227,371,500	4,146,116,392
11	Immanuel General Hospital		5,234,320		5,234,320		5,234,320
12	Infectious Disease Hospital (IDH)		1,711,000		1,711,000		1,711,000
13	Leprosy Hospital		2,691,160		2,691,160		2,691,160
14	Mary Slessor Hospital		3,353,600		3,353,600		3,353,600
15	Methodist General Hospital		5,015,585		5,015,585		5,015,585
16	Ministry of Health	911,689,529	85,251,849		996,941,378	7,793,764,075	8,790,705,453
17	Mount Carmel Hospital		3,758,960		3,758,960		3,758,960
18	Psychiatric Hospital		2,120,500		2,120,500		2,120,500
19	Redeemer Hospital		1,662,500		1,662,500		1,662,500
20	DIRECT INTERVENTION ON GOVT HOSPITAL			10,250,000	10,250,000	-	10,250,000

21	HEALTH RESEARCH & ETHICS COMMITTEE			1,200,000	1,200,000	-	1,200,000
22	MAT. & CHILD HEALTH COMMITTEE			1,200,000	1,200,000	-	1,200,000
23	MED DENTAL COUNCIL MONITORING COMMITTEE			1,200,000	1,200,000	-	1,200,000
	TOTAL	**4,794,718,130**	**280,329,439**	**20,825,000**	**5,095,872,569**	**8,021,135,575**	**13,117,008,144**

2016

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
1	Task Force on Counterfeit and Fake Drugs and Unwholesome Processed Foods	-	6,000,000		6,000,000		6,000,000
2	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	14,719,152	2,000,000		16,719,152		16,719,152
3	Public Health Lab	-		600,000	600,000		600,000
4	Monitoring of Government Hospitals			1,500,000	1,500,000		1,500,000
5	Drugs Revolving Committee			300,000	300,000		300,000
6	Christian Family Mission, Nkwot, Ikono	-			-		-
7	Comprehensive Health Centres	-	1,496,500		1,496,500		1,496,500
8	Cottage Hospitals	-			-		-
9	Dental Health Centre	-	7,330		7,330		7,330
10	General Hospitals	-	18,736,865		18,736,865		18,736,865
11	Hospital Management Board	4,536,649,544	11,626,500	-	4,548,276,044	15,488,573	4,563,764,617
12	Immanuel General Hospital		2,454,370		2,454,370		2,454,370
13	Infectious Disease Hospital (IDH)				-		-
14	Leprosy Hospital				-		-
15	Mary Slessor Hospital		1,037,600		1,037,600		1,037,600

S/N	MDA	PERSONNEL	OVERHEAD	SUBVENTION	TOTAL RECURRENT	CAPITAL	TOTAL
16	Methodist General Hospital		2,874,535		2,874,535		2,874,535
17	Ministry of Health	948,076,769	26,732,483		974,809,252	459,640,000	1,434,449,252
18	Mount Carmel Hospital		93,000		93,000		93,000
19	Psychiatric Hospital				-		-
20	Redeemer Hospital				-		-
21	DIRECT INTERVENTION ON GOVT HOSPITAL			2,500,000	2,500,000		2,500,000
22	HEALTH RESEARCH & ETHICS COMMITTEE			900,000	900,000		900,000
23	MAT. & CHILD HEALTH COMMISION			900,000	900,000		900,000
24	MED DENTAL COUNCIL MONITORING COM			900,000	900,000		900,000
25	NIGERIAN RED CROSS				-		-
	TOTAL	**5,499,445,465**	**73,059,183**	**7,600,000**	**5,580,104,648**	**475,128,573**	**6,055,233,221**

Annex 8: Performance Indicators

DETAILS		2013	2014	2015	2016
NUMBER OF HEALTH WORKERS					
1	No of Nurses		94	135	193
2	No of Midwives		-	-	-
3	No of Nurse/Midwives		2,863	3,322	2,538
4	No of Doctors		201	201	193
5	Pharmacists		44	55	55
6	Med. Lab. Scientists/Tech.		148	77	68
7	Physiotherapists		2		
8	Radiographers		16		14
9	Medical Records Technologists/Technicians		201	145	126
	SERVICE UTILIZATION				
10	Outpatient	30,982	309,591	1,067,417	530,892
11	Inpatient	5,440	32,009	45,463	58,602
12	ANC provided by skilled health work	-	-	-	-
13	No of deliveries in Health Facilities	4,247	15,979	14,466	16,043
14	No of Live Births in Health Facilities	1,551	9,762	10,493	13,340
15	No of still Births in Health Facilities	17	273	413	443
16	Skilled attendant at birth	906	8,195	8,462	10,215
	HEALTH INDICATORS				
17	Infant Deaths	102	-	-	-
18	Infant Mortality Rate (MR)	52	10	15	5
19	Under five mortality Rate (U-SMR)	54	12	17	16
20	Under 5yrs deaths	20	77	65	64

DETAILS		2013	2014	2015	2016
21	Maternal Deaths	6	11	49	60
22	Maternal mortality Rate (MMR)	155	112	467	450
23	Malaria Prevalence	5,970	246,863	209,253	251,867
24	TB Prevalence	105	159	71	160
25	HIV Prevalence	2,548	11,440	17,665	20,126
	OTHER INDICATORS				
26	Diarrhea in children	1,232	4,421	5,142	5,273
27	Children under 5 with fever receiving malaria treatment	11,044	142,209	83,880	88,500
28	Children 12-23months with full imminization coverage	29,719	145,415	117,599	126,547
29	Comprehensive knowledge of TB	-	-	-	-
30	Deaths of TB	-	-	-	-
31	Comprehensive knowledge of HIV	-	-	-	-
32	Death due to HIV	-	-	-	-
33	Use of FP Modern method by married women 14-49	16,594	31,567	40,259	54,686

BOLD THINKERS DRIVING
REAL-WORLD IMPACT