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# BENUE STATE 2012-2016 PUBLIC EXPENDITURE REVIEW



August 2018

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It was prepared the Health Finance and Governance Project.

## **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.

## **August 2018**

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# BENUE STATE PUBLIC EXPENDITURE REVIEW 2012-2016

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# ACRONYMS

<b>AG</b>	Accountant General
<b>CSOs</b>	Civil Society Organizations
<b>FMoH</b>	Federal Ministry of Health
<b>GGE</b>	Government general expenditure
<b>HFG</b>	Health Finance and Governance
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
<b>HMB</b>	Hospital Management board
<b>HMOs</b>	Health Maintenance Organizations
<b>IGR</b>	Internally Generated revenue
<b>BENSACA</b>	Benue State Agency for the control of AIDS
<b>LGA</b>	Local Government Area
<b>MDAs</b>	Ministries Departments and Agencies
<b>MDG</b>	Millenium development goals
<b>MNCH</b>	Maternal, Neo-natal and Child health
<b>MoF</b>	Ministry of Finance
<b>MoLG</b>	Ministry of Local Government
<b>PER</b>	Public Expenditure Review
<b>PFM</b>	Public Financial Management
<b>PHC</b>	Primary Health Center
<b>SMoH</b>	State Ministry of Health
<b>SSHDP</b>	State strategic health development plan
<b>SSHIS</b>	State Supported Health Insurance Scheme
<b>UHC</b>	Universal Health Coverage
<b>USAID</b>	United States Agency for International Development
<b>VAT</b>	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 reduce the pressure and improve the current 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 suffering financial hardship<sup>1</sup>. Benue 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, 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. In order to understand the magnitude and flow of health resource which will enable the state to put available meagre resources into better utilization, USAID/HFG 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:

- Analyze state capital and recurrent budget and expenditure for 2013 to 2016
- Analyze of budget and expenditure trends for the four key sectors (Health, Education, Agriculture

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<sup>1</sup> (WHO 2017) Universal Health coverage



and works & transport) with a view to establishing the level of priority accorded the health sector

- Assess the allocative efficiency of the performance of health financing system
- 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, Bureau for Local Governments and Chieftaincy affairs, office of the Auditor General for LGAs, Benue State Agency for the Control of AIDS (BENSACA) and HFG. The team was led by the State Ministry of Health with technical support from the HFG project.

During the set-up of PER, A 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

One major challenge is the non-availability of complete documents required for the review, for instance approved state budget for 2014 and 2016 was not available as well as reports for Accountant General (AG) for 2016; for this reason, and only recurrent budget was recorded in 2014 for all the sectors. Also, LGA data is incomplete and this limits the extent of its analysis.

Health budget and financial statements were not segregated to 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 3.00% from 2006 population result<sup>2</sup>
2. Foreign Exchange Rate of N150, N170, N190 and N300 for 2013, 2014, 2015 and 2016 respectively
3. Data on 2016 key sectors' capital expenditure was not readily available hence the use of proxy to arrive at reported figures.

## Main Findings

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<sup>2</sup> Population by state and sex : population.gov.ng

**Government funding remains the dominant source of health sector financing during the period under review.** An analysis of Benue state's fiscal profile indicates that the Benue state revenue highly depended on statutory allocation from the federation account. During the years under review, contribution of statutory allocation was massive with a proportion as high as 82% in 2014; internally generated revenue (IGR) contributed as high as 16% of the total revenue available in 2012 but deteriorated to as low as 10 percent in 2016. The reduction in the proportion of statutory allocation reduced from 48 percent in 2012 to 36 percent in 2016.

**Public health sector financing ranged between 9 percent -11 percent over the four-year period under review, 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 increased from N12.5billion in 2013 to N13.7billion in 2016 while the actual health expenditure recorded a maximum of N7.1billion in 2015. Albeit expected support from other partners in the health sector, the state planned to spend at least N11.9billion for a period of six years (2010 – 2015) in order to achieve its desired objective.

**Small share of public health sector expenditure had spent on capital investment and large share of public health expenditure spent on health personnel.** Within the context of generally low spending in the health sector, share of capital investment as a proportion of general health spending is low as it represented only 1 percent to 6 percent of government health spending in the period under review. The capital expenditure budget was constantly lower than the recurrent expenditure. A large portion of health budget was allocated into human resources which ranged from 50 percent to 88 percent and human resources typically represent the single largest cost in total health expenditure. The exceptionally low capital investment is inimical to realization of investment needed to address the critical infrastructural gap in the health sector.

**Per capita public health allocations decreased between 2013 and 2016.** The per capita health budget was N2,379(\$16), N1,844(\$11)<sup>3</sup>, N1,943(\$10) and N2,379(\$8) respectively for each of the years under review. The per capita health expenditure was N1,180(\$8), N980(\$6), N1,280(\$7) and N1,135(\$4) in 2012, 2013, 2014 and 2015 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.** Health sector had an average annual execution rate of about 54 percent from 2013 to 2016. The implementation rate of the recurrent budget has consistently exceeded 50 percent from 2013 to 2016. The execution rate of the capital budget was extremely low, where needs attention to address the causes of delays in the implementation of the health capital budget.

## Recommendation

**Government and key stakeholders should be effectively engaged to advocate for increased allocation to the health sector.** The budget and expenditure trend in the state 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 far more than 5 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,

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<sup>3</sup> Recurrent expenditure budget only

the 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 under satisfaction in the sectors with large share of budget. 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 local government authorities (LGA) 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, 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 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 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 National Health Accounts (NHA) etc. is important for sustainable capacity build up.

**Further PFM 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 that will produce additional evidence for decision making.

# I. INTRODUCTION

## I.1 Background

Benue State, like many other states in Nigeria, is in the process of embracing health financing policy reform thrusts introduced at the national level to achieve more money for health and more health for the money. Benue 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, Revitalization of PHC for UHC policy and other laudable policy thrusts.

Benue state has made considerable progress towards introduction of state supported health insurance scheme as the legal framework is currently being reviewed by relevant stakeholders in preparation for its passage into law by the State House of Assembly.

In order to achieve context-appropriate and sustainable health financing reform in Benue State, USAID/HFG is supporting the state to conduct health financing diagnostic in a number of important areas including Public expenditure review (PER), public financial management and Fiscal Space analysis. 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.

Our expectation is that the Public Expenditure Review 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.

## I.2 Situation Analysis

### I.2.1 History

Benue State is one of the 36 States of the Federal Republic of Nigeria; Benue State is in the North Central geo-Political zone of the country with Makurdi as its capital. The population of the State was put at 4,253,641 by the 2006 census with a growth rate of 3.05% per annum; the State will have a projected population of 5,744,349 by the end of 2016. There are 23 LGAs in the state.

Benue State is one of the poorer states in Nigeria with approximately 14 percent of the population living in extreme poverty and 31.5 percent in moderately poor circumstance. The population structure conforms to a typical developing country profile with a high proportion of the population under 15 years of age and approximately 20 percent in the 15 – 24 years age group<sup>4</sup>.

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<sup>4</sup> Benue State SHDP II

## 1.2.2 Benue State Population Health

The demographics in Benue State shows that women of child bearing age and Under Five children, who are the most vulnerable, 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 malaria, Diarrhea, HIV/AIDS, TB. The disease profile is as a result of present wide spread of poverty and underdevelopment in the State and high rate of early marriage especially in the rural areas<sup>5</sup>.

**Table 1: Benue State Health Performance Indicators**

S/N	INDICATOR	NORTH-CENTRAL	BENUE	National
1	Infant Mortality rate (deaths/1000 live births)	72	70	70
2	Child mortality rate (deaths/1000 children surviving to age one)	33	14	54
3	Under-five mortality rate (deaths/1000 live births)	103	82	120
4	Estimated % of children 12 – 23 months with full immunization coverage by first birthday (measles by second birthday)	31	38	23
5	Use of FP modern method by married women 15-49 (%)	14	15	10.8
6	ANC provided by skilled Health workers (% of women with a live birth in the last two years)	62.5	67.5	65.8
7	No of deliveries in health facilities (% of women with a live birth in the last two years)	44.4	61.6	37.5
8	Skilled attendants at birth (% of women with a live birth in the last two years)	50.3	62.8	43

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

## 1.2.3 Overview of the Benue State Health System

Nigeria is a Federal state 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

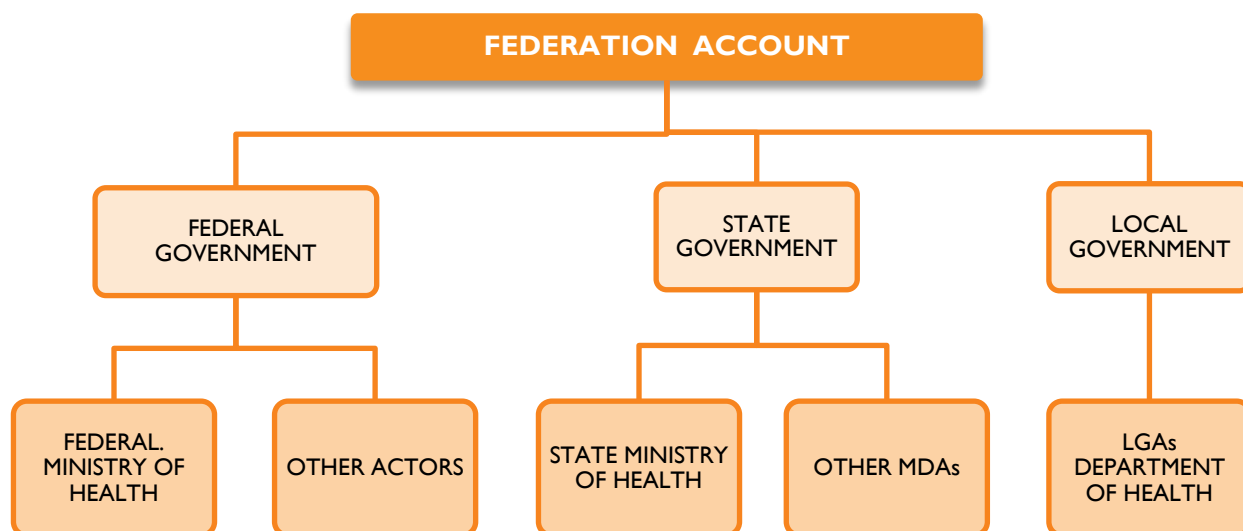
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<sup>5</sup> Benue state SHDP 2010 - 2015

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

The Nigerian government financial system operates a structure where funds flow to the three tiers of government from what is termed the federation account. the federation account serves as the central pocket through which government – federal, State and Local government – fund developmental 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 Benue State Strategic health development plan (2010 – 2015)

As contained in the SSHDP, the state is committed to developing and implementing appropriate policies and program that will strengthen the health system by providing quality, accessible and affordable healthcare services to its citizens<sup>6</sup>. 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

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<sup>6</sup> Benue State Strategic health development plan 2010 - 2015

## 8. Research for health

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

- Partnership with donors and philanthropist to rehabilitate the health facilities
- Implementation of DRF (mark-up and recycle)
- Implementation of deferral and exemption (D&E) program – under deferral, patients are allowed payment of hospital bill to a later date; exemption policy allows carefully selected indigent patient to enjoy free health care services.
- Introduction of the free medical service initiative (Supported by Eunice spring of life initiative of the wife of the state Governor)
- Provision of free ANC drugs

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

### 2.1 State Revenue

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). The five-year government revenue review shows there are various sources of revenue available to the government which includes statutory allocation from the federation account (FAAC allocation and VAT), internally generated revenue, excess crude oil, internal/external loans and other sources of revenue. The state's total revenue decreased from N96.1billion in 2012 to N88.9billion in 2016.

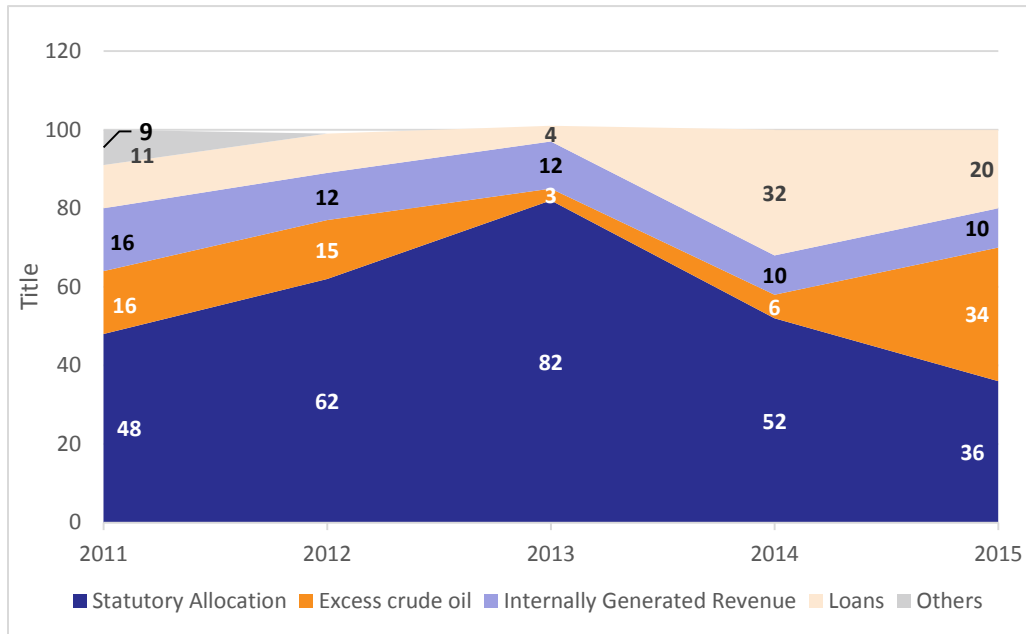
**Table 2: Benue State Revenue Profile 2013 – 2016**

SOURCE	2012 NGN	2013 NGN	2014 NGN	2015 NGN	2016 NGN
Statutory allocation	46,055,074,955	56,588,755,185	55,392,033,695	40,307,466,012	32,057,598,150
Internally generated revenue	15,520,851,781	10,976,603,745	8,164,424,381	7,633,317,031	8,744,826,924
Excess crude oil	15,405,822,201	13,958,037,998	1,823,350,125	4,628,890,500	30,655,388,358
Loans (internal and external)	10,896,979,196	8,953,818,487	2,500,000,000	25,060,986,677	17,500,000,000
Others	8,239,027,651	415,018,487	0	0	0
<b>TOTAL</b>	<b>96,117,755,784</b>	<b>90,892,233,901</b>	<b>67,879,808,200</b>	<b>77,630,660,220</b>	<b>88,957,813,432</b>

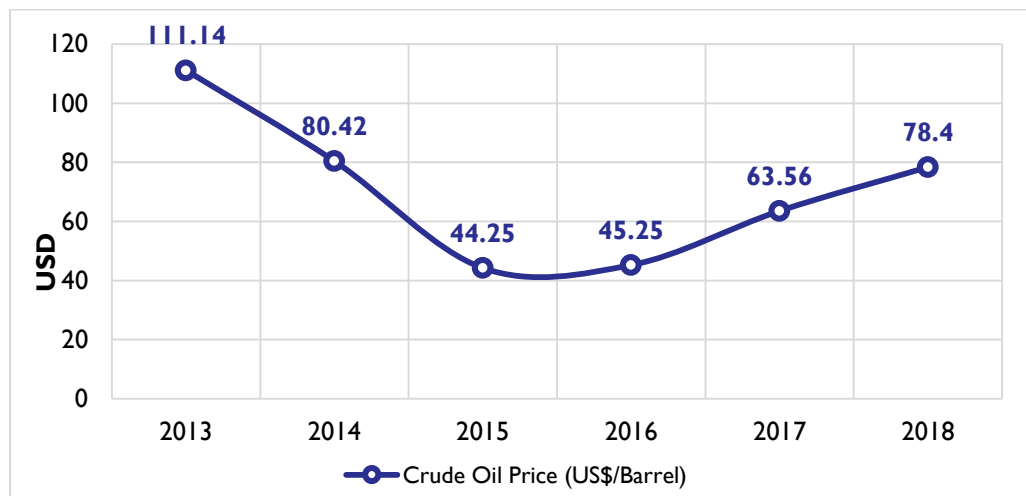
Source: Benue State Accountant General's report

The Benue state revenue highly depended on statutory allocation from the federation account, as shown in the figure 2, during the years under review, contribution of statutory allocation was very significant with a proportion as high as 82% in 2014; internally generated revenue (IGR) contributed as high as 16% of the total revenue available in 2012 but deteriorated to as low as 10 percent in 2016. The reduction in the proportion of statutory allocation reduced from 48 percent in 2012 to 36 percent in 2016 and this was as a result of increase in loan size and excess crude oil. As shown in figure 3, the price of crude oil reduced from 111 dollar to 45 dollar from 2013 to 2016.

**Figure 2: Benue State Revenue Composition 2012-2016**



**Figure 3: Trend of Crude Oil Price 2013-2018**

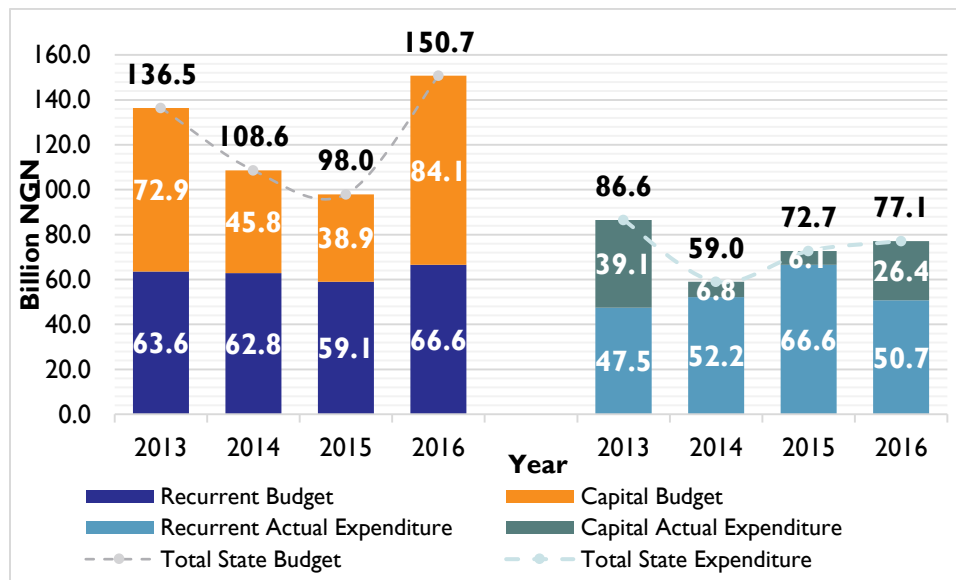


## 2.2 State Budget and Expenditure Review

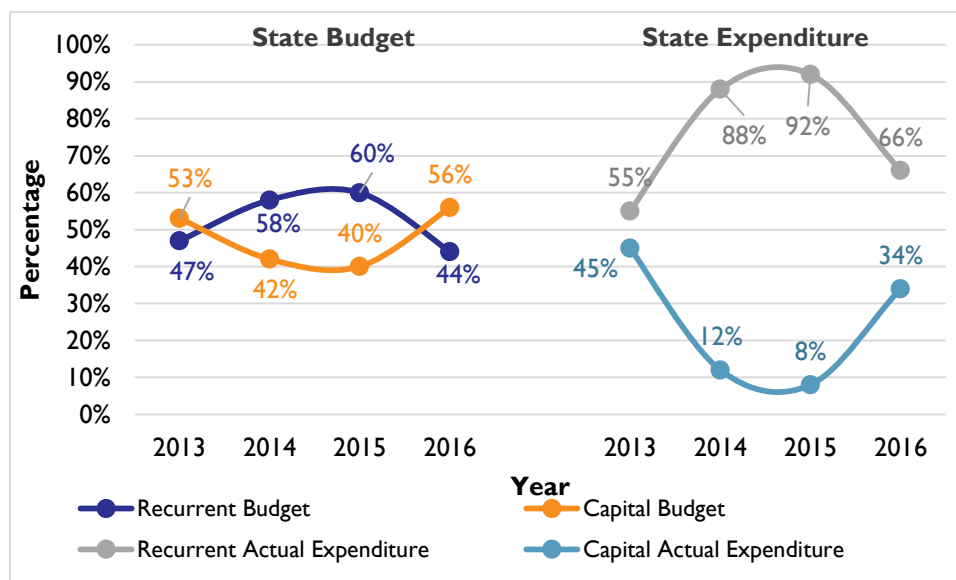
The state total budget declined from N136.5billion in 2013 to N98.0 billion in 2015 (28 percent decrease) and thereafter there was a sharp increase to N150.74bn in 2016. The capital budget followed the same trend as total budget, it decreased from N72.9billion in 2013 to N38.9billion in 2015 and then increased 1 in 2015 and then increased 116 percent to N84.1billion in 2016. The recurrent budget was stable during the review period which ranged from N59.1billion to N66.6billion. There was no clear pattern in the allocation between capital and recurrent heads; capital budget enjoyed higher proportion in 2013 and 2016 while recurrent budget recorded higher proportion in 2014 and 2015.

Total Government expenditure dwindled because of reduced revenue. The state total actual expenditure decreased from N86.6billion in 2013 to N77.1billion in 2016. The capital actual expenditure shrunk from N39.1billion in 2013 to N6.1billion in 2015 then increased back to N26.4billion. In general, the actual expenditure clearly favors recurrent expenditure as it had higher proportion throughout the period under review. The state recurrent expenditure accounted for 55 percent to 98 percent of total state expenditure.

**Figure 4: State Budget and Expenditure**



**Figure 5: State Budget and Expenditure**

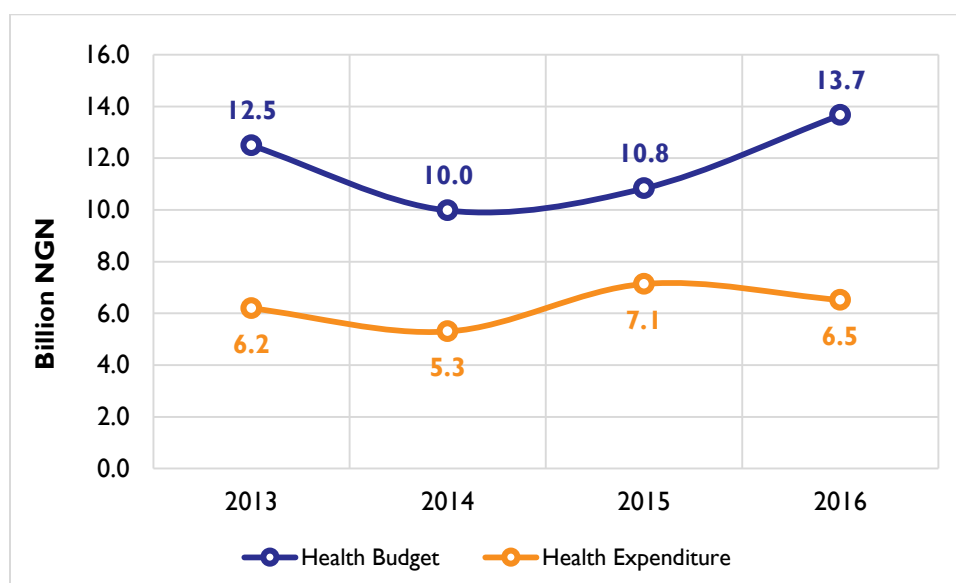


## 2.3 Total State Budget and Expenditure Allocated for Health

### 2.3.1 Total Public Health Budget and Expenditure

Although the health budget trend reflects government's commitment to achieve its health plan as highlighted in the SHDP (2010 – 2015), actual expenditure shows a contrary view; Health sector budget increased from N12.5billion in 2013 to N13.7billion in 2016 while the actual health expenditure recorded a maximum of N7.1billion in 2015. Albeit expected support from other partners in the health sector, the state planned to spend at least N11.9billion for a period of six years (2010 – 2015) in order to achieve its desired objective.

**Figure 6: Health Budget and Expenditure Trend**

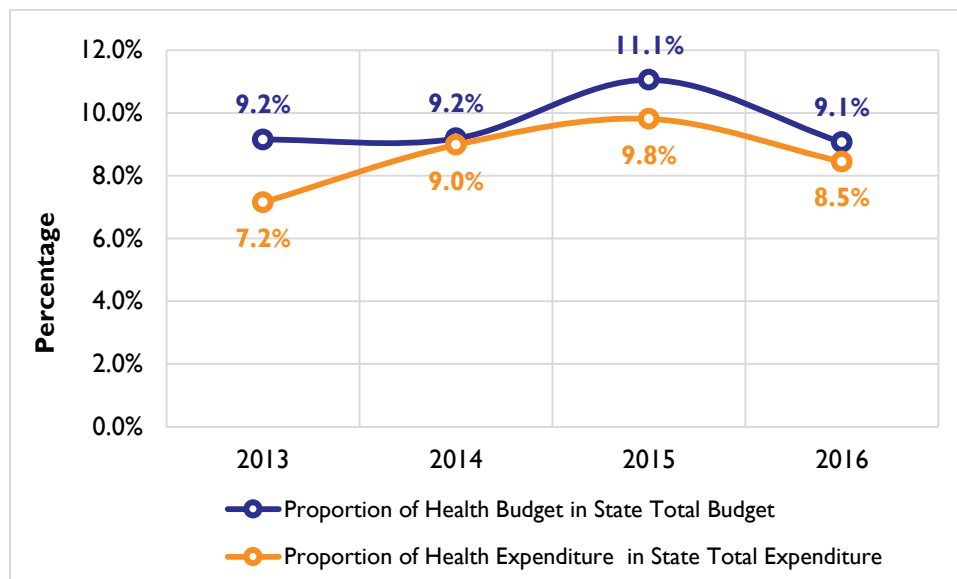


### 2.3.2 Share of Health Budget and Expenditure

The share of health budget in total state government budget ranged between 9 percent and 11 percent for the period under review; the recommendation from the Abuja declaration of 2001 requires government to allocate at least 15 percent of its total annual budget for the development of the health sector and as revealed from the available data, the current practice in the state is not in line with the recommendation.

Although the increase in actual health expenditure is not so significant, the proportion of health expenditure to total state government expenditure increased during the period and ranged between 7 percent and 10 percent; the low investment in the health sector needs to be reversed to pave way for actualization of health objectives.

**Figure 7: Share Of Health In State Government Total Budget And Expenditure**

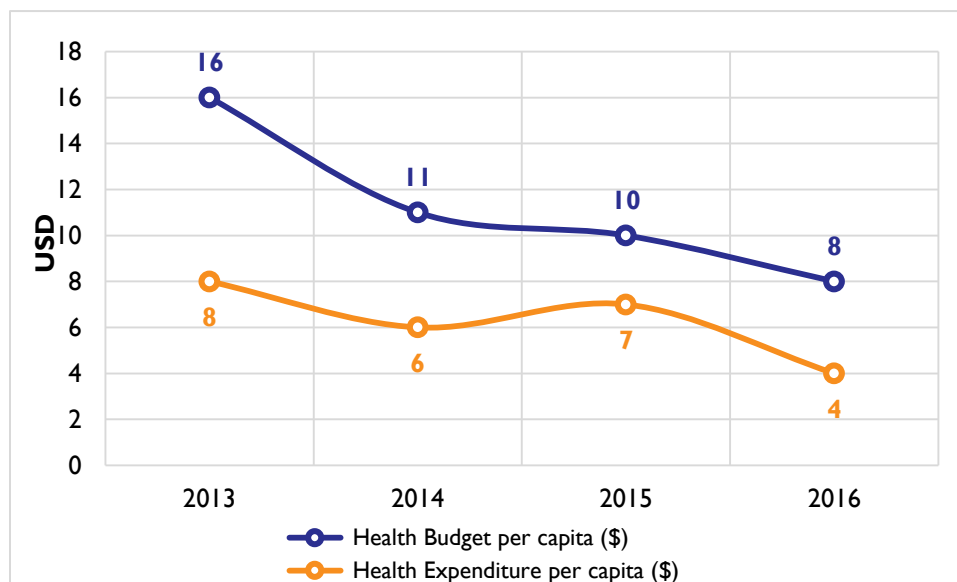


### 2.3.3 Per capita Health Budget and Expenditure

Figure 7 presents trends in per capita public health budget and actual expenditure. The per capita health budget was N2,379(\$16), N1,844(\$11)<sup>7</sup>, N1,943(\$10) and N2,379(\$8) respectively for each of the years under review. The per capita health expenditure was N1,180(\$8), N980(\$6), N1,280(\$7) and N1,135(\$4) in 2012, 2013, 2014 and 2015 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.

<sup>7</sup> Recurrent expenditure budget only

Figure 8: Per Capita Health Expenditure and Budget <sup>8</sup>



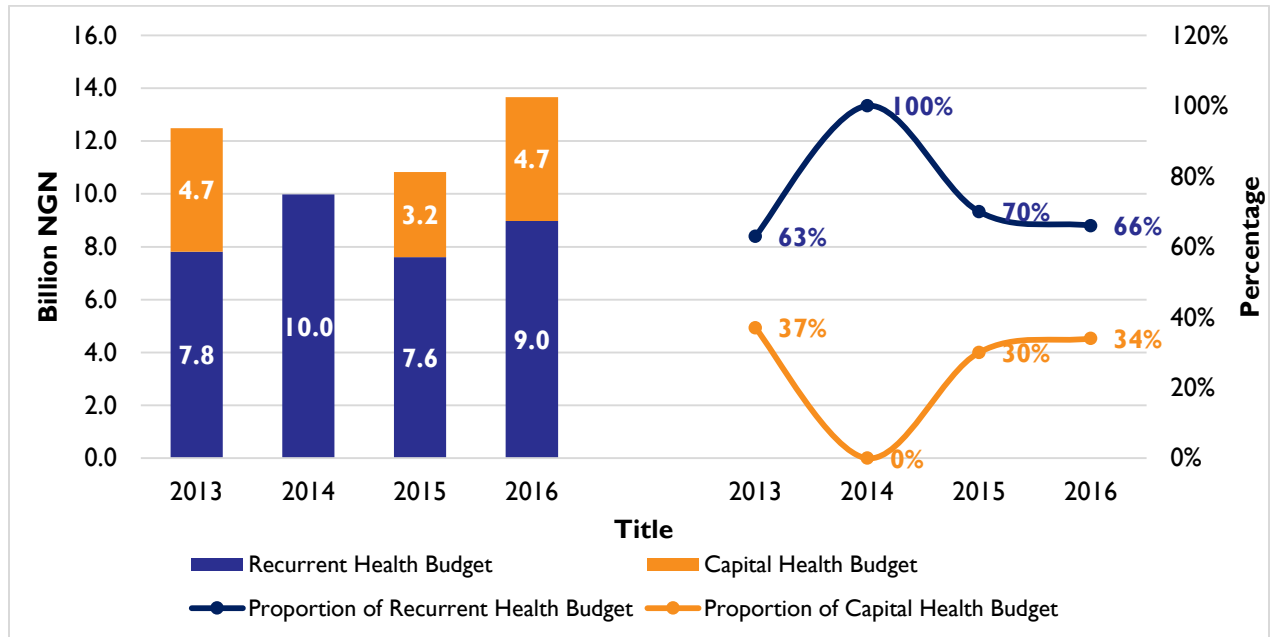
### 2.3.4 Health Recurrent and Capital Budget and Expenditure

Recurrent expenditure is the major driver of the health sector allocation; the recurrent health budget increased from N7.8billion in 2013 to N9.0billion in 2016. Capital budget for health sector ranged from N3.2billion to N4.7Billion and the information was missing for 2014. Figure 8 shows their shares as the percentage of total health budget which shows that more funds were allocated to recurrent expenditure though capital recording highest proportion of 70 percent in 2015. This trend is worrisome as best practice dictates that a higher proportion of expenditure should be on developmental activities to enhance a sustained health sector.

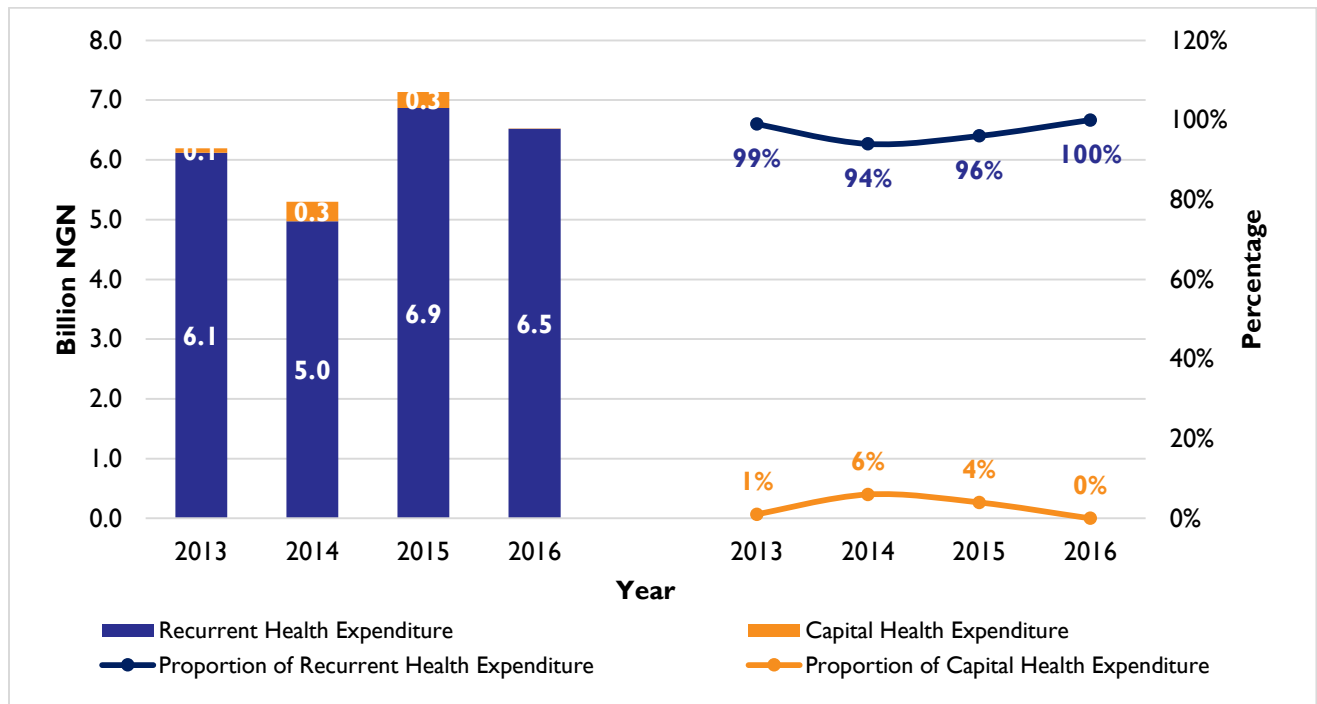
Figure 9 shows that the actual capital expenditure was extremely low which ranged from N0.1billion to N0.3billion. The recurrent expenditure increased from N5.0billion in 2014 to N6.9billion in 2016; From 2013 to 2016, a huge proportion of the health spending went into capital expenditure. The trend from 2013 to 2016 is commendable as best practice dictates that a higher proportion of expenditure should be on developmental/capital activities to enhance a sustained health sector. However, the sudden shortage in capital investment in 2016 addressed the concerns for capital project's sustainability and efficiency.

<sup>8</sup> (WHO 2012) Spending on health: A Global overview

**Figure 9: Health Capital and Recurrent Budget Trends**



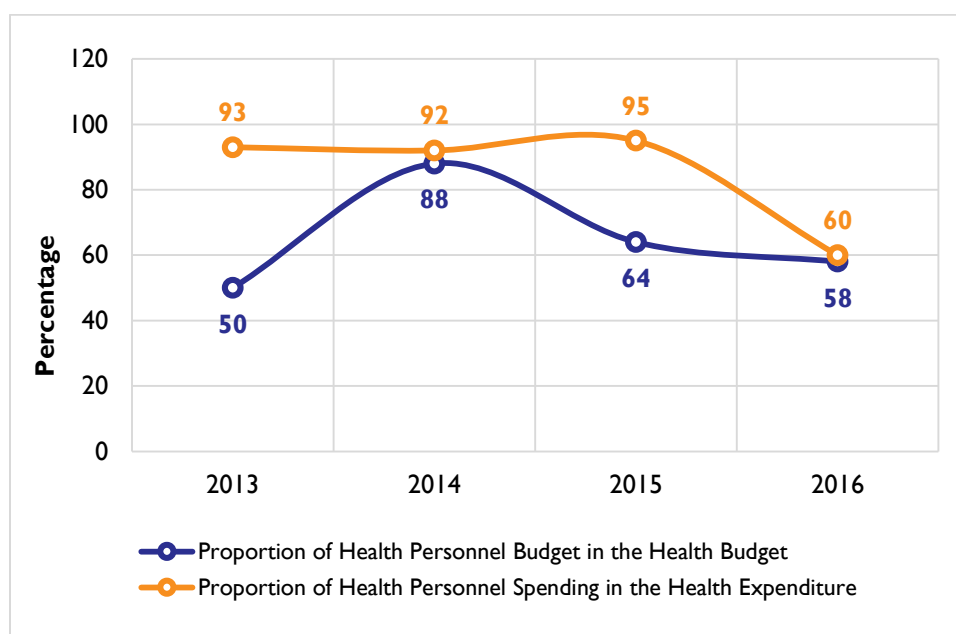
**Figure 10: Capital and Recurrent Actual Expenditure Trends**



### 2.3.5 Health Personnel Expenditure

Figure 11 shows that large portion of health budget was allocated into human resources which ranged from 50 percent to 88 percent and human resources typically represent the single largest cost in total state health expenditure and therefore management of health personnel cost have an important impact on overall efficiency. Available information revealed a decreasing number of human resources during the period albeit the large portion of human resources financial investment. (Annex 9) In general, excessive spending on wages and salaries suggests an imbalance in the use of inputs and translates into less resources being available for other health programs and activities. The share of employment costs to total state expenditure was consistently as high as 92 percent to 95 percent from 2013 to 2015, then declined to 60 percent in 2016. Reducing excessive expenditures on wages and salaries could free up resources for other health activities. Since the gains from addressing health worker absenteeism alone would create a lot of financial opportunities for other health activities in Benue state. It needs to be ensured that services for which these payments are made, are being carried out. Routine workers biometric verification exercises, for example, to screen out ghost workers, and spot checks in health facilities to ensure presence of crucial health professionals is important in increasing efficiency savings.

**Figure 11: The trends of health personnel budget and expenditure**



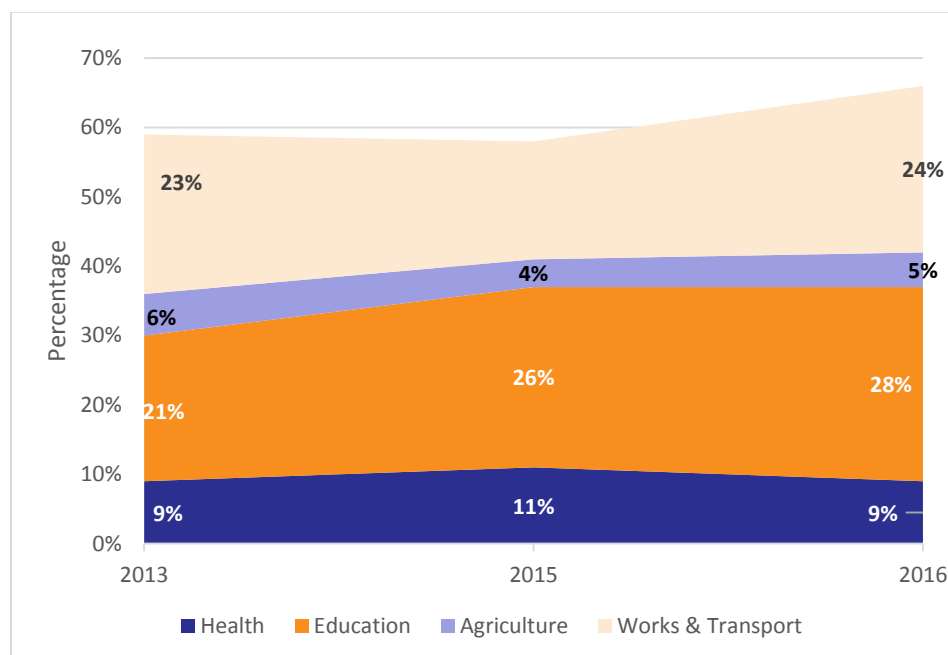
## 2.4 Budget and Expenditure in the other key sectors

Works & Transport sector absorbed the highest share of State budget and expenditure. Allocation to health sector ranged between 9 percent and 11 percent of state government budget in the years under review while works and transport and Education got as high as 24 percent and 28 percent respectively. The proportion of state government budget allocated to health is a far cry from the internationally



recommended Abuja Declaration benchmark of 15 percent<sup>9</sup>. The level of prioritization accorded health sector is not encouraging especially when compared alongside some other states in the country; this could constitute obstacle to achieving health sector developmental objectives.

**Figure 12: Budgetary Allocation to Key Sectors in Benue State <sup>10</sup>**

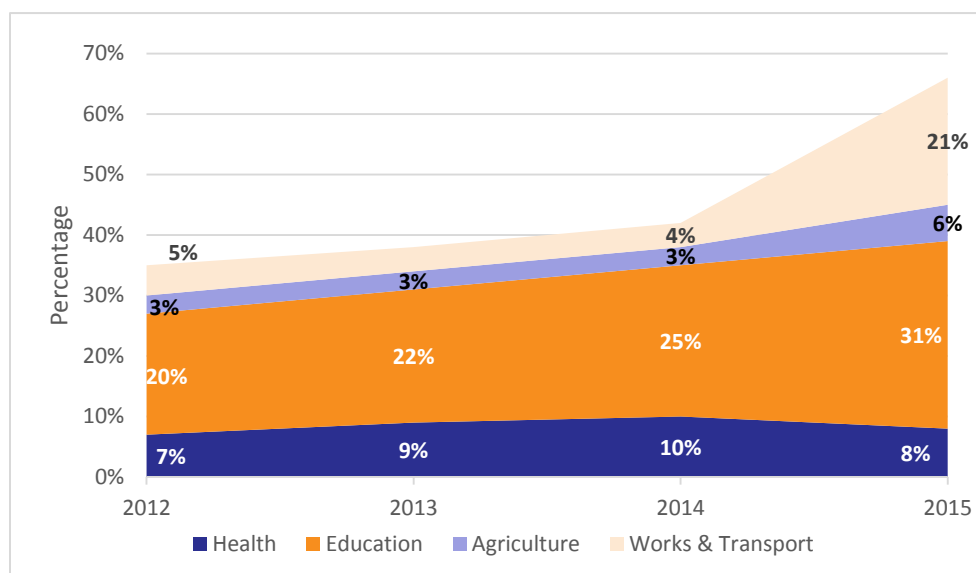


Actual state government expenditure on the other hand shows a little deviation from the budget pattern as health allocation ranged between 7 percent and 10 percent in 2013 and 2015; the least (7 percent) was recorded in 2013. Works & Transport was at its high point in 2016 with a share of 21 percent while the previous years averaged 4 percent. Education consistently got the highest proportion of the state total expenditure. The budget and expenditure data confirmed the priority accorded the education by the state government; prioritizing health sector over and above works and transport in 2014 and 2015 is a laudable development.

<sup>9</sup> WHO (2011) The Abuja declaration: Ten years on

<sup>10</sup> 2014 not reported for lack of capital budget data

**Figure 13: 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 rate for the period ranged between 46 percent and 74 percent; when broken down, the recurrent budget performed better than the capital budget with the highest implementation rate of 113 percent (overspend) in 2015. Capital budget on the other hand had an implementation rate that ranged between 15 percent and 54 percent with the lowest occurring in 2014. Budget performance across the key sectors calls for urgent intervention especially with the capital budget implementation rate; the recurrent expenditure performed far better than the capital expenditure.

In general, performance of the health sector budget has been lower than satisfaction throughout the review period, with an average annual execution rate of about 54 percent from 2013 to 2016. The implementation rate of the recurrent budget has consistently exceeded 50 percent from 2013 to 2016. The execution rate of the capital budget was extremely low, where needs attention 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 works and transport. In all, it indicates the need to improve the budget efficiency in the sector, 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: The performance rate across all the key sectors**

Implementation Rates (%)	2013	2014	48	2016
State Overall	63	54	74	46
Recurrent	75	83	113	76
Capital	54	15	16	22
Health	50	53	66	48

Recurrent	78	50	90	73
Capital	2	0	8	0
Works and Transport	14	250	18	45
Recurrent	48	34	85	36
Capital	12	0	16	45
Agriculture	36	68	48	
Recurrent	86	64	70	78
Capital	12	0	5	45
Education	61	80	70	56
Recurrent	72	78	87	72
Capital	21	0	14	0

## 2.5 LGA level Health Financing

LGAs receive federal allocation through the Bureau for Local Government and Chieftaincy Affairs, the structure is such that the LGAs are responsible for expenditure and supervision at the PHCs; supervision over LGA services by the SMOH (where it exists) 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.

A feature of LGA health expenditure is that over 90 percent of expenditure is on human resources with little or nothing on service provision (annex 10). Although the health professionals are relatively well paid, they are demotivated by other poor working conditions which results in high level of absenteeism; with the full operation of the PHCUOR, all identified inefficiencies will be addressed.

### 3. BENUE 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 analysis 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 a reliable assessment of efficiency is important, given the state policy direction of deciding where the limited health fund could 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 Benue state and LGA level, a state health system comparison was adopted here to measure the efficiency of health system. Over the period of PER review, selected indicators were identified in Benue and compared across all the HFG funded states. This section reviews the following three aspects of Benue 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 State Population Health

##### 3.1.1 Benue State Population Health Status

Overall children health in Benue state was getting severe from 2012 to 2016. The infant mortality rate was decreasing from 97 deaths per 100,000 live births to 70 deaths per 100,000 livebirths from 2012 to 2016. The children under five mortality rates had similar trend, the rate reduced from 158 deaths per 100,000 livebirths to 80 deaths per 100,000 livebirths. The maternal mortality rate increased from 548 deaths per 100,000 livebirths to 576 deaths per 100,000 live births in 2016.

**Table 4: Preventable mortality rates in Benue State in 2012 and 2016**

Indicators	2012	2016
Maternal Mortality Rate Per 100,000 Live Births	548	576 <sup>11</sup>
Infant Mortality Rate Per 1,000 live births	97	70
Under 5 Mortality Rate Per 1,000 live births	158	82

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

### 3.1.2 State Population Health Status Comparison Among HFG Selected States State Service Delivery

Comparing the health status in Benue state to other HFG investigated states, in general, Benue state has worse maternal and childhood conditions with higher maternal and children mortality rate. Table 5 shows that the infant mortality rate and children under five mortality rates was much higher than the national average and its corresponding child under five malaria prevalence was 44.5%. 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 selected 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 <sup>12</sup>	HIV Prevalence (%) <sup>13</sup>	Under 5 Malaria Prevalence (%) <sup>14</sup>
Benue	1318	70	82	5.6	44.5
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	108.4	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
National Average	814	70	120	3.4	42

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

<sup>11</sup> This is the maternal mortality rate estimated in 2015

<sup>12</sup> Multiple Indicator Cluster Survey (MICS) 2016

<sup>13</sup> NARHS 2012 <https://naca.gov.ng/nigeria-prevalence-rate/>

<sup>14</sup> Percentage of children age 6-59 months tested using microscopy who are positive for malaria, MIS 2015

## 3.2 Benue State Service Delivery

### 3.2.1 Benue State Health Service Delivery/Provision

#### 3.2.1.1 Maternal, Newborn and Child Health Service

Maternal and child service provision was generally increased during the review period in Benue state. Table 6 shows that, during the review period, the percentage of women age 15-49 years who delivered in the health facility was 43.8 percent in 2012 and then increased to 57.6 percent in 2016. Children with full immunization coverage was 13.1 percent in 2011-2012, then increased to 37.0 percent in 2016-2017. And there was 69.2 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 2012, then it slightly declined to 67.5 percent in 2016. Similarly, the percentage of children under five with fever receiving any antimalaria drugs was 56.4 percent and 37.8 percent in 2012 and 2016 respectively.

**Table 6: Health Service Provision In Benue state during the review period**

Percentage	2012	2016
<b>Women who received ANC by skilled health workers</b>	69.2	67.5
<b>Received HIV counselling During ANC</b>	43.8	57.6
<b>Skilled Attendant Assisted at delivery</b>	59.6	62.8
<b>Children 12 – 23 months with full immunization coverage</b>	13.1	37.0
<b>Children under five with fever receiving malaria treatment (Any antimalarial drugs)</b>	56.4	37.8

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

#### 3.2.1.2 Facility utilization

The limited DHIS data provided by the HMIS unit (annex 8) revealed government effort at reforming the health sector has resulted in significant improvement in the performance indices in the state. For instance, between 2012 and 2015, outpatient facility attendance increased from 309,581 to 1,062,982 while inpatient care increased from 32,657 to 498,908; the improved performance is partly due to strengthened reporting system as well as increased service utilization. The scope of the review does not cover assessment of quality of care provided from the facilities, therefore, we are not able to confirm if the incensement of facility utilization is an improvement of service delivery.

### 3.2.2 State Health Service Provision Comparison Among HFG Selected States

The 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 moderate in Benue state. In 2016, there were 67.5 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, 57.6 percent of them received HIV counselling during the antenatal care provision and 62.8 percent of them received assistance from skilled attendant during their delivery. There was 37.0 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 provision across HFG selected states in 2016**

State Name	Antenatal Care Coverage <sup>15</sup>	Full immunization coverage <sup>16</sup>	Received HIV counselling During ANC <sup>17</sup>	Skilled Attendant Assisted at delivery <sup>18</sup>
Benue	67.5	37.0	57.6	62.8
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
National Average	65.8	22.9	41.0	43.0

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

### 3.3 Benue State Health Financing

The Table 8 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 most of the other states, on average, Benue state spent 8.5 percent of general government expenditure into health sectors which was moderate among most states. The average per capita public health expenditure was \$6.3 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 selected 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
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<sup>15</sup> 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

<sup>16</sup> 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

<sup>17</sup> 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

<sup>18</sup> 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

<b>Benue</b>	8.5	6.3
<b>Akwa Ibom</b>	4.3	13.0
<b>Kogi</b>	5.4	7.7
<b>Osun</b>	7.8	10.8
<b>Oyo</b>	9.5	6.5
<b>Kebbi</b>	8.0	6.3
<b>Sokoto</b>	11.0	8.1
<b>Bauchi</b>	9.0	12.5
<b>Ebonyi</b>	8.5	8.0
<b>National standard</b>	15.0	97.0



## 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 Findings

#### 4.1.1 General trend of health financing

Federal government funding remains the dominant source of health sector financing during the period under review. An analysis of Benue state's fiscal profile indicates that the Benue state revenue highly depended on statutory allocation from the federation account. During the years under review, contribution of statutory allocation was massive with a proportion as high as 82% in 2014; internally generated revenue (IGR) contributed as high as 16% of the total revenue available in 2012 but deteriorated to as low as 10 percent in 2016. The reduction in the proportion of statutory allocation reduced from 48 percent in 2012 to 36 percent in 2016.

Public health sector financing ranged between 9 percent -11 percent over the four-year period under review, and the share of the health budget in the total government budget remains below the 15 percent recommended under the Abuja Declaration. Health sector budget increased from N12.5 billion in 2013 to N13.7billion in 2016 while the actual health expenditure recorded a maximum of N7.1 billion in 2015.

#### 4.1.2 Per capita health budget and expenditure

The per capita health budget was N2,379(\$16), N1,844(\$11)<sup>19</sup>, N1,943(\$10) and N2,379(\$8) respectively for each of the years under review. The per capita health expenditure was N1,180(\$8), N980(\$6), N1,280(\$7) and N1,135(\$4) in 2012, 2013, 2014 and 2015 respectively. In general, per capita health expenditure is very low and falls significantly short of the WHO recommended benchmark (\$34) and therefore does not support the development of a healthy and productive population.

#### 4.1.3 Health Expenditure

A small share of public health sector expenditure had spent on capital investment and large share of public health expenditure spent on health personnel. Within the context of generally low spending in the health sector, share of capital investment as a proportion of general health spending is low as it

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<sup>19</sup> Recurrent expenditure budget only

represented only 1 percent to 6 percent of government health spending in the period under review. The capital expenditure budget was constantly lower than the recurrent expenditure. A large portion of health budget was allocated into human resources which ranged from 50 percent to 88 percent and human resources typically represent the single largest cost in total health expenditure. The exceptionally low capital investment is inimical to realization of investment needed to address the critical infrastructural gap in the health sector.

#### 4.1.4 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 54 percent from 2013 to 2016. The implementation rate of the recurrent budget has consistently exceeded 50 percent from 2013 to 2016. The execution rate of the capital budget was extremely low, where needs attention to address the causes of delays in the implementation of the health capital budget.

#### 4.1.5 Health System Performance

Compared to other HFG selected states in Nigeria, Benue health system has poor maternal and child health indicators, the preventable mortality rate was higher than most of compared states. The service provision and coverage and level of public health financing was moderate during the comparison.

### 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. Loans on the other hand increase government's future commitment hence reduction in amount available for planned interventions. Improved IGR will go a long way to expand the fiscal space of the state as a whole and is expected to filter down to the health sector; 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 N0.73 bn by the state calls for a review of the state revenue generation mechanism.

#### 4.2.2 Prioritization of Health

Both budget and expenditure trend in the state show that health is not being accorded the priority it deserves. 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 considerably poor health indices, the state urgently needs to invest far more than 10 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 Increase the capital Investment

Within the context of generally low investment in the health sector, capital investment as a proportion of general health budget and spending is unacceptably low. The low capital investment is inimical to realization of investment needed to address the critical infrastructural gap in the health sector. Further PFM assessment is recommended to identify the cause of the current low performance level of capital budget within the health sector and necessary technical support should be sought to remove identified bottlenecks.

### 4.2.4 Improve the budget implementation capacity

As in many developing countries, Benue state government has very limited capacity to measure the development 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.

### 4.2.5 Build up health financing coordination

The state will benefit immensely from the effort of a multi-sectorial coordination platform (or reorganization of health stakeholders' forum currently present in the state) to coordinate all the players/stakeholders in the health sector and the external ones, e.g. the legislature, who can positively or negatively impact health sector financing. There is need to align the programs of donors with that of the state government to prevent duplication of effort; this will eliminate wastages of scarce resources.

### 4.2.6 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 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, Benue 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 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 development.

### 4.2.7 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.

### 4.2.8 Conduct further reviews

Further PFM 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. Some of the findings of this Public Expenditure Review (PER) suggest the need to conduct further studies that will produce additional evidence for decision making. In addition, it may be necessary to assess the capacity of the SHDP committee to ensure they possess the requisite capacity; with the current level of health expenditure, the state should come close to achieving its goal as stated in the plan but unfortunately, the current situation analysis depicts the opposite.

# 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	63,600,917,935	47	62,827,072,284	58	59,075,170,280	60	66,593,996,470	44
Capital	72,850,374,811	53	45,777,749,619	42	38,876,956,023	40	84,148,877,582	56
<b>Total State Budget</b>	<b>136,451,292,746</b>	<b>100</b>	<b>108,604,821,903</b>	<b>100</b>	<b>97,952,126,303</b>	<b>100</b>	<b>150,742,874,052</b>	<b>100</b>
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	47,484,396,180	55	52,173,458,350	88	66,579,139,882	92	50,742,123,137	66
Capital	39,097,756,537	45	6,824,443,608	12	6,147,269,955	8	26,396,201,743	34
<b>Total State Expenditure</b>	<b>86,582,152,717</b>	<b>100</b>	<b>58,997,901,958</b>	<b>100</b>	<b>72,726,409,837</b>	<b>100</b>	<b>77,138,324,880</b>	<b>100</b>

## 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						
Personnel	6,278,278,986	50	8,807,972,340	88	6,924,440,000	64	7,965,527,730	58
Overhead	1,534,591,110	12	1,169,493,120	12	678,660,000	6	1,014,245,000	7
Total Recurrent	7,812,870,096	63	9,977,465,460	100	7,603,100,000	70	8,979,772,730	66
Capital	4,677,338,829	37	0	0.00	3,227,571,000	30	4,686,082,600	34
Total Health Budget	12,490,208,925	100	9,977,465,460	100	10,830,671,000	100	13,665,855,330	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
Personnel	5,742,477,919	93	4,863,070,397	92	6,807,163,013	95	3,908,885,690	60
Overhead	375,709,511	6	107,952,783	2	60,660,240	1	2,609,494,805	40
Total Recurrent	6,118,187,429	99	4,971,023,180	94	6,867,823,253	96	6,518,380,494	100
Capital	76,051,989	1	328,965,574	6	269,135,150	4	72,868	0.0011
Total Health Expenditure	6,194,239,418	100	5,299,988,754	100	7,136,958,403	100	6,518,453,363	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	12,490,208,925	9	9,977,465,460	9	10,830,671,000	11	13,665,855,330	9
Education	29,086,900,470	21	16,348,060,873	15	25,774,613,569	26	42,070,449,679	28
Agriculture	8,198,988,670	6	2,604,628,970	2	4,028,330,000	4	8,284,729,500	5
Works and Transport	31,900,781,311	23	1,015,675,550	1	16,557,045,584	17	36,387,408,862	24
Others	54,774,413,370	40	78,658,991,050	72	40,761,466,150	42	50,334,430,681	33
<b>Total State Budget</b>	<b>136,451,292,746</b>	<b>100</b>	<b>108,604,821,903</b>	<b>100</b>	<b>97,952,126,303</b>	<b>100</b>	<b>150,742,874,052</b>	<b>100</b>
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	6,194,239,418	7	5,299,988,754	9	7,136,958,403	10	6,518,453,363	8
Education	17,623,976,377	20	13,067,216,433	22	18,158,319,539	25	23,586,103,166	31
Agriculture	2,971,571,099	3	1,766,287,902	3	1,922,774,162	3	4,595,512,108	6
Works and Transport	4,410,667,860	5	2,534,142,386	4	2,999,994,640	4	16,375,210,157	21
Others	55,381,697,963	64	36,330,266,483	62	42,508,363,093	58	26,063,046,087	34
<b>Total State Expenditure</b>	<b>86,582,152,717</b>	<b>100</b>	<b>58,997,901,958</b>	<b>100</b>	<b>72,726,409,837</b>	<b>100</b>	<b>77,138,324,881</b>	<b>100</b>

## Annex 4: Key Performance Indicators - State

DETAILS	2013	2014	2015	2016
	N	N	N	N
Health Budget	12,490,208,925	9,977,465,460	10,830,671,000	13,665,855,330
Health Expenditure	6,194,239,418	5,299,988,754	7,136,958,403	6,518,453,363
Projected Population	5,249,245	5,409,347	5,574,332	5,744,349
Exchange Rate (NGN/\$)	150	170	190	300
Health budget per capita (NGN)	2,379	1,844	1,943	2,379
Health Budget per capita (\$)	16	11	10	8
Health Expenditure per capita (NGN)	1,180	980	1,280	1,135
Health Expenditure per capita (\$)	8	6	7	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	63,600,917,935	47,484,396,180	75	62,827,072,284	52,173,458,350	83	59,075,170,280	66,579,139,882	113	66,593,996,470	50,742,123,137	76
Capital Expenditure	72,850,374,811	39,097,756,537	54	45,777,749,619	6,824,443,608	15	38,876,956,023	6,147,269,955	16	84,148,877,582	18,700,945,023	22
<b>Total</b>	<b>136,451,292,746</b>	<b>86,582,152,717</b>	63	<b>108,604,821,903</b>	<b>58,997,901,958</b>	54	<b>97,952,126,303</b>	<b>72,726,409,837</b>	74	<b>150,742,874,052</b>	<b>69,443,068,160</b>	46

### HEALTH

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	7,812,870,096	6,118,187,429	78	9,977,465,460	4,971,023,180	50	7,603,100,000	6,867,823,253	90	8,979,772,730	6,518,380,494	73
Capital Expenditure	4,677,338,829	76,051,989	2	0	328,965,574		3,227,571,000	269,135,150	8	4,686,082,600	72,868	0
<b>Total</b>	<b>12,490,208,925</b>	<b>6,194,239,418</b>	50	<b>9,977,465,460</b>	<b>5,299,988,754</b>	53	<b>10,830,671,000</b>	<b>7,136,958,403</b>	66	<b>13,665,855,330</b>	<b>6,518,453,363</b>	48

## WORKS AND TRANSPORT

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	1,218,226,960	581,906,000	48	1,015,675,550	348,419,430	34	624,055,000	530,001,483	85	635,060,000	227,363,542	36
Capital Expenditure	30,682,554,351	3,828,761,860	12	0	2,185,722,956		15,932,990,584	2,469,993,157	16	35,752,348,862	16,147,846,615	45
<b>Total</b>	<b>31,900,781,311</b>	<b>4,410,667,860</b>	14	<b>1,015,675,550</b>	<b>2,534,142,386</b>	250	<b>16,557,045,584</b>	<b>2,999,994,640</b>	18	<b>36,387,408,862</b>	<b>16,375,210,157</b>	45

## AGRICULTURE

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	2,729,768,520	2,336,677,099	86	2,604,628,970	1,657,174,279	64	2,656,830,000	1,849,262,986	70	2,632,489,500	2,042,630,760	78
Capital Expenditure	5,469,220,150	634,894,000	12	0	109,113,623		1,371,500,000	73,511,176	5	5,652,240,000	2,552,881,348	45
<b>Total</b>	<b>8,198,988,670</b>	<b>2,971,571,099</b>	36	<b>2,604,628,970</b>	<b>1,766,287,902</b>	68	<b>4,028,330,000</b>	<b>1,922,774,162</b>	48	<b>8,284,729,500</b>	<b>4,595,512,108</b>	



## EDUCATION

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	22,482,263,373	16,234,367,059	72	16,348,060,873	12,828,213,548	78	19,990,008,000	17,320,326,940	87	32,797,660,479	23,585,958,975	72
Capital Expenditure	6,604,637,097	1,389,609,318	21	0	239,002,885		5,784,605,569	837,992,599	14	9,272,789,200	144,192	0
<b>Total</b>	<b>29,086,900,470</b>	<b>17,623,976,377</b>	61	<b>16,348,060,873</b>	<b>13,067,216,433</b>	80	<b>25,774,613,569</b>	<b>18,158,319,539</b>	70	<b>42,070,449,679</b>	<b>23,586,103,166</b>	56

## Annex 6: Budget by Health MDAs

2013

S/NO	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	613,399,850	104,140,189	717,540,039	3,815,879,525	4,533,419,564
2	HMB	3,073,470,390	41,400,000	3,114,870,390	-	3,114,870,390
3	BSUTH	1,605,969,906	953,704,921	2,559,674,827	180,000,000	2,739,674,827
4	COLLEGE OF HEALTH SCIENCES	978,598,840	283,974,000	1,262,572,840	52,000,000	1,314,572,840
5	BENSACA	6,840,000	151,372,000	158,212,000	-	158,212,000
6	MDG	-	-	-	629,459,304	629,459,304
	TOTAL	6,278,278,986	1,534,591,110	7,812,870,096	4,677,338,829	12,490,208,925

2014

S/NO	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	984,487,650	64,416,199	1,048,903,849		1,048,903,849
2	BSUTH	1,526,715,310	953,704,921	2,480,420,231		2,480,420,231
3	HMB	3,252,171,170	-	3,252,171,170		3,252,171,170
4	BENSACA	6,840,000	151,372,000	158,212,000		158,212,000
5	COLLEGE OF HEALTH SCIENCES	3,037,758,210	-	3,037,758,210		3,037,758,210
6	MDG	-	-		-	-
	TOTAL	8,807,972,340	1,169,493,120	9,977,465,460	-	9,977,465,460



## 2015

S/NO	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	1,030,000,000	25,810,000	1,055,810,000	2,539,371,000	3,595,181,000
2	HMB	3,325,000,000	29,690,000	3,354,690,000	-	3,354,690,000
3	BSUTH	1,862,600,000	497,650,000	2,360,250,000	90,700,000	2,450,950,000
4	COLLEGE OF HEALTH SCIENCES	700,000,000	105,000,000	805,000,000	307,500,000	1,112,500,000
5	BENSACA	6,840,000	20,510,000	27,350,000	-	27,350,000
6	MDG	-	-	-	290,000,000	290,000,000
	<b>TOTAL</b>	<b>6,924,440,000</b>	<b>678,660,000</b>	<b>7,603,100,000</b>	<b>3,227,571,000</b>	<b>10,830,671,000</b>

## 2016

S/NO	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	1,423,000,000	42,600,000	1,465,600,000	3,855,482,600	5,321,082,600
2	HMB	3,110,060,000	45,400,000	3,155,460,000	-	3,155,460,000
3	BSUTH	2,247,567,730	723,780,000	2,971,347,730	708,100,000	3,679,447,730
4	COLLEGE OF HEALTH SCIENCES	1,184,900,000	157,875,000	1,342,775,000	122,500,000	1,465,275,000
5	BSPHCB	-	31,140,000	31,140,000	-	31,140,000
6	BENSACA	-	13,450,000	13,450,000	-	13,450,000
7	MDG			-	-	-
	<b>TOTAL</b>	<b>7,965,527,730</b>	<b>1,014,245,000</b>	<b>8,979,772,730</b>	<b>4,686,082,600</b>	<b>13,665,855,330</b>

## Annex 7: Expenditure by Health MDAs

2013

S/NO	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	1,083,724,735	18,761,793	1,102,486,528	76,051,989	1,178,538,517
2	HMB	2,992,680,433	3,117,718	2,995,798,151		2,995,798,151
3	BSUTH	1,170,145,678	265,000,000	1,435,145,678		1,435,145,678
4	COLLEGE OF HEALTH SCIENCES	495,927,073	81,000,000	576,927,073		576,927,073
5	BENSACA	-	7,830,000	7,830,000		7,830,000
6	MDG	-	-	-		-
	TOTAL	5,742,477,919	375,709,511	6,118,187,429	76,051,989	6,194,239,418

2014

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	699,189,423	23,452,783	722,642,206	328,965,574	1,051,607,780
2	BSUTH	1,343,719,000	47,000,000	1,390,719,000		1,390,719,000
3	HMB	2,045,718,921	-	2,045,718,921		2,045,718,921
4	BENSACA	-	2,500,000	2,500,000		2,500,000
5	COLLEGE OF HEALTH SCIENCES	774,443,053	35,000,000	809,443,053		809,443,053
6	MDG	-	-	-	-	-
	TOTAL	4,863,070,397	107,952,783	4,971,023,180	328,965,574	5,299,988,754



## 2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	1,097,689,310	10,873,090	1,108,562,400	269,135,150	1,377,697,551
2	HMB	3,296,666,094	1,787,150	3,298,453,244		3,298,453,244
3	BSUTH	1,243,300,000	15,000,000	1,258,300,000		1,258,300,000
4	COLLEGE OF HEALTH SCIENCES	1,169,007,609	30,500,000	1,199,507,609		1,199,507,609
5	BENSACA	500,000	2,500,000	3,000,000		3,000,000
6	MDG	-	-	-	-	-
	TOTAL	6,807,163,013	60,660,240	6,867,823,253	269,135,150	7,136,958,403

## 2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	SMOH & HS	581,333,272	19,577,354	600,910,626	72,868	600,983,495
2	HMB	1,506,302,439	626,878,145	2,133,180,584	-	2,133,180,584
3	BSUTH	824,064,397	1,445,739,886	2,269,804,282	-	2,269,804,282
4	COLLEGE OF HEALTH SCIENCES	997,185,581	514,299,420	1,511,485,001	-	1,511,485,001
5	BSPHCB				-	
6	BENSACA		3,000,000	3,000,000	-	3,000,000
7	MDG				-	
		3,908,885,690	2,609,494,805	6,518,380,494	72,868	6,518,453,363

## Annex 8: Performance Indicators

DETAILS		2012	2013	2014	2015
<b>SERVICE UTILIZATION</b>					
1	Outpatient	309,581	375,017	951,798	1,062,982
2	Inpatient	32,657	26,661	51,967	498,908
3	ANC provided by skilled health work	20,493	87,595	124,195	130,219
4	No of deliveries in Health Facilities	977	26,777	36,106	35,885
5	No of Live Births in Health Facilities	69/1,000 Lb	69/1,000 Lb	69/1,000 Lb	
6	No of still Births in Health Facilities				
7	Skilled attendant at birth	13,220	34,906	47,987	
<b>HEALTH INDICATORS</b>					
8	Infant Mortality Rate (IMR)	69/1000	69/1000	69/1000	
9	Under 5yrs deaths	128 /1000 Lb	128 /1000 Lb	128 /1000 Lb	
10	Maternal Deaths				
11	Maternal mortality Rate(MMR)	548/100,000 Lb	576/100,000 Lb	576/100,000 Lb	
12	Use of FP Modern method by married women 15-49	5,279	16,751	23,673	34,596





## Annex 9: Key Human Resources for Health

	2010 <sup>20</sup>	2016 <sup>21</sup>
CADRE OF PERSONNEL	NUMBER	NUMBER
Doctors	368	545
Nurses & Midwives	2,172	1,491
PHC Educators	-	11
CHO	897	92
CHEWS	2,803	2,932
JCHEW	-	152
Environmental Health Tutors	-	7
Environmental Health Officers	-	6
Medical Lab Scientist	-	105
Medical Lab. Technicians	88	320
Medical Lab Assistants	46	30
Pharmacists	127	170
Pharmacy Technicians	13	13
Health Records Officers & Technicians	125	78
Radiologists	5	5
Epidemiologist	1	10
Dental Therapists	5	23
Dental Health Technician	9	1
TBAs	64	-
No. of Midwives trained on LSS	468	-
No of CHEWS trained on LSS	69	-
No. of Doctors trained on LSS	42	-
Others (not in this list)	1,786	1, 786
<b>Total</b>	<b>9,088</b>	<b>5,991</b>

<sup>20</sup> SSHDP 2010 - 2015

<sup>21</sup> SSHDP 2017 – 2021 (Draft)



## Annex 10: Health Expenditure by LGA

S/N	LGA	2013			2014			2015		
		TOTAL LGA EXPENDITURE	HEALTH EXPENDITURE		TOTAL LGA EXPENDITURE	HEALTH EXPENDITURE		TOTAL LGA EXPENDITURE	HEALTH EXPENDITURE	
1	ADO	1,923,460,517	73,998,000	3.85	1,898,600,724	48,136,059	2.54	1,550,200,593	10,990,000	0.71
2	AGATU	1,662,730,813	46,267,000	2.78	1,740,423,520	9,500,000	0.55	1,624,768,212	7,300,000	0.45
3	APA	1,635,050,580	28,000,000	1.71	1,650,952,857	15,955,000	0.97	1,305,131,483	9,450,000	0.72
4	BURUKU	1,708,654,849	16,040,000	0.94	2,078,128,000	30,850,000	1.48	1,318,626,462	12,470,000	0.95
5	GBOKO	2,523,696,052	47,119,200	1.87	2,473,368,944	64,233,000	2.60	2,325,505,061	50,320,500	2.16
6	GUMA	1,991,227,641	46,000,000	2.31	2,007,613,259	8,595,000	0.43	1,484,442,345	500,000	0.03
7	GWER EAST	1,745,604,574	50,275,391	2.88	1,989,333,229	29,680,000	1.49	1,721,729,126	3,500,000	0.20
8	GWER WEST	1,719,555,159	61,251,315	3.56	1,660,746,511	123,401,589	7.43	1,526,395,521	16,169,000	1.06
9	KATSINA ALA	2,133,193,657	21,842,705	1.02	2,133,548,000	19,302,000	0.90	1,583,440,000	34,336,000	2.17
10	KONSHISHA KWANDE	1,968,439,345	45,605,300	2.32	2,009,269,383	2,529,000	0.13	1,705,543,562	21,367,000	1.25
11	LOGO	2,395,277,710	106,672,905	4.45	2,477,269,925	28,897,790	1.17	2,832,238,152	28,810,000	1.02
12	MAKURDI	1,816,834,767	140,335,930	7.72	1,774,625,500	98,303,000	5.54	1,348,597,951	6,400,000	0.47
13	OBI	1,039,159,204	28,502,600	1.40	2,215,385,047	17,670,500	0.80	1,808,559,003	6,808,500	0.38
14	OGBADIBO	1,530,040,501	31,611,280	2.07	1,552,911,377	24,396,209	1.57	1,188,568,108	1,125,000	0.09
15		1,667,144,644	35,300,000	2.12	1,651,437,445	7,400,000	0.45	144,331,400,340	8,100,000	0.01



16	OHIMINI	1,981,653,000	48,790,000	2.46	1,981,553,000	48,790,000	2.46	1,285,008,000	41,000,000	3.19
17	OJU	2,287,656,000	29,960,000	1.31	1,884,606,000	4,200,000	0.22	2,273,632,000	99,105,000	4.36
18	OKPOKWU	1,862,841,439	150,000,000	8.05	1,782,678,938	35,338,600	1.98	1,741,212,699	85,486,850	4.91
19	OTUPKO	2,753,956,037	239,632,669	8.70	2,540,228,919	111,730,400	4.40	1,992,835,466	4,350,000	0.22
20	TARKA	1,588,702,561	75,305,000	4.74	1,366,678,618	75,120,187	5.50	1,116,515,818	7,505,478	0.67
21	UKUMA	2,134,971,963	86,860,000	4.07	1,980,284,451	30,262,000	1.53	1,763,353,245	3,190,000	0.18
22	USHONGO	1,923,094,853	38,756,947	2.02	1,835,194,753	40,550,700	2.21	1,825,674,726	10,450,000	0.57
23	VANDEIKYA	1,985,533,065	15,410,000	0.78	2,020,583,871	2,317,350	0.11	1,560,802,943	400,000	0.03
	<b>TOTAL</b>	<b>44,978,478,930</b>	<b>1,463,536,242</b>	<b>3.25</b>	<b>44,705,422,269</b>	<b>877,158,384</b>	<b>1.96</b>	<b>181,214,180,816</b>	<b>469,133,328</b>	<b>0.26</b>







BOLD THINKERS DRIVING  
REAL-WORLD IMPACT