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# KEBBI STATE PUBLIC EXPENDITURE REVIEW 2013-2016



August 2018

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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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# CONTENTS

<b>Acronyms.....</b>	<b>iii</b>
<b>Acknowledgments .....</b>	<b>v</b>
<b>Executive Summary .....</b>	<b>vii</b>
<b>I. Introduction .....</b>	<b>11</b>
1.1 Background.....	11
1.2 Situation Analysis of Kebbi State.....	11
<b>2. State Health budget and expenditure analysis .....</b>	<b>15</b>
2.1 Introduction .....	15
2.2 State Revenue .....	15
2.3 State budget and actual expenditure review .....	16
2.4 Public Health budget and actual expenditure review .....	17
2.5 Share of state budget and actual expenditure in other key sectors.....	23
<b>3. KEBBI STATE HEALTH SYSTEM'S PERFORMANCE REVIEW ....</b>	<b>25</b>
3.1 Kebbi State Population Health .....	25
3.2 Kebbi State Health Service Delivery/Provision .....	27
3.3 Kebbi State Health Financing.....	28
<b>4. RECOMMENDATION .....</b>	<b>30</b>
4.1 Macro Fiscal Context .....	30
4.2 Prioritization of Health.....	30
4.3 Capital Investment.....	30
4.4 Prioritize Preventive care at the PHCs over Curative care at the secondary facilities .....	30
4.5 Measurement of health systems efficiency.....	31
4.6 Further Reviews .....	31
<b>Annex A .....</b>	<b>33</b>
Annex 1: Five Year Financial Highlights .....	33
Annex 2: Indicators – State Budget and Expenditure.....	34
Annex 4: Indicators - Key Sectors' Budget and Expenditure .....	35
Annex 5: Key Performance Indicators - State.....	36
Annex 6: Recurrent and Capital Expenditure Implementation report.....	36
Annex 7: Budget by Health MDAs.....	41
Annex 8: Expenditure by Health MDAs .....	43
Annex 9: Performance Indicators.....	45



## List of Tables

Table 1: Maternal, Newborn and Child Health Facts .....	12
Table 2: Utilization of Maternal and Child Health Service in Kebbi State .....	12
Table 3: Kebbi State Revenue Profile 2012 – 2016.....	15
Table 4: Health Budget Execution Performance Indicators.....	22
Table 5: State Population Health Indicators.....	25
Table 6: State Population Health Status Comparison Among HFG Selected States .....	26
Table 7: State Health Service Provision Comparison Among HFG Selected States .....	28
Table 8: State Health Financing Indicators Comparison Among HFG Selected States .....	28

## List of Figures

Figure 1: Funds Flow from Federation Account.....	13
Figure 2: Kebbi State Revenue Composition 2012-2016.....	16
Figure 3: Kebbi State Budget and Actual Expenditure.....	17
Figure 4: Trend of Health Budget and Expenditure.....	18
Figure 5: Health Shares in Government Budget and Actual Expenditure .....	18
Figure 6: Trend of Health Recurrent and Capital Budget.....	19
Figure 7: Capital and Recurrent Actual Expenditure Trends.....	20
Figure 8: Trends of Per Capita Health budget and expenditure.....	20
Figure 9: Health Personnel Budget and expenditure.....	22
Figure 10: Budgetary Allocation to Key Sectors in Kebbi State.....	23
Figure 11: Key sectors' Actual Expenditure.....	24

# 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>KBSACA</b>	Kebbi 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>MoBEP</b>	Ministry of Budget and Economic Planning
<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>UNDP</b>	United Nations Development Project
<b>USAID</b>	United States Agency for International Development
<b>VAT</b>	Value Added Tax





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# EXECUTIVE SUMMARY

## Introduction

Nigeria and many countries have subscribed to the principle of Universal Health Coverage (UHC) which aims to ensure equitable access to needed health care without suffering financial hardship. Kebbi State, like many other states, is in the process of embracing health financing policy reforms introduced at the national level to achieve more money for health and more health for the money. The state has keyed in to health financing policy reforms including decentralization of health insurance scheme that will usher in State Supported Health Insurance Scheme, PHC management integration policy called PHCOUR, Revitalization of PHC for UHC policy and other laudable policy thrusts.

It is increasingly recognized that the sufficient public health funding and efficient health funding management play a crucial role towards achieving UHC, 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 PER analyzes government budgetary allocations and expenditures over a period of years to assess their consistency with policy priorities, and what results had been 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:

- 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 health financing system in the state, its efficiency and performance
- 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, office of the Auditor General for LGAs, Kebbi State Agency for the Control of AIDS (KBSACA), Ministry of Finance, the State Bureau of Statistics and USAID's Health Financing Governance (HFG) project. The team was led by the State Ministry of Health with technical support from the HFG project. 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 data collection tools were 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 the Kebbi state officials.

## Limitations

One major challenge is the lack of data from the local government area (LGA) level even though relevant officials from the office of the Auditor General for LGAs were contacted for this purpose. We gathered that the LGA report are not presented/disaggregated in a format that will reveal expenditure of the various department and as such resulted in the exclusion of the LGAs from the report.

Budgets were not linked to expected output and outcome/target, which makes it a challenge to assess the effectiveness of health expenditure.

Budget and financial statements were not disaggregated into program and intervention areas making it difficult to map out expenditure allocated based on this criterion; this problem is more profound under recurrent expenditure.

The lack of adequate data on sector performance/health outcome made it difficult to measure the development impact of health spending. Accuracy and completeness of available data could not be confirmed.

## Assumption

- Annual population growth rate of 3.15% from 2006 population result
- 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, and the share of external and internal loans has increased noticeably during the period under review.** Government contribution (statutory/federal allocation) counts for the major proportion of state budget reaching 51 percent in 2012, and declining to 36 percent of the 2016 budget. The share of external and internal loans increased from 1 percent in the 2014 budget to a maximum of 36 percent in the 2016 budget. The internally generated revenue (IGR) contributed an average of 5 percent throughout the period, the absolute value of IGR consistently reduced during the period while it is maintaining a constant share of the total revenue.

**Public health sector financing allocation was stable ranged between 7% - 9% 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), the health sector budget had a slight decline in nominal terms from N10.6 billion in 2013 to N9.9 billion in 2016. The shares of public health allocation in the total government budget increased from 8 percent in the 2013 budget to 9 percent in the 2016 budget. Within the context of generally low investment in the

health sector, capital investment as a proportion of general health spending is very low as it represented only 9 percent to 25 percent of government health spending in the period under review. The exceptionally low capital investment is detrimental to realizing the investment needed to address the critical infrastructural gaps in the health sector noted in the SHDP.

### **Large share of public health sector expenditure spent personnel and overhead**

**expenditure.** The share of public spending on health out of total government expenditure increased from 7 percent to 10 percent from 2013 to 2015, the declined to 7 percent in 2016; The actual capital expenditure was N1.06 billion in 2013, had its peak in 2014 at N1.36 billion before declining to N364 million in 2016. Personnel and overhead cost accounted for 75 percent to 91 percent of the state government health spending in the period under review. This expenditure should be reviewed vis-à-vis productivity of labor in the state and any source of inefficiency including 'ghost' worker syndrome, moonlighting and absenteeism should be identified and addressed.

### **Per capita public health allocations have almost declined over 50% in nominal terms**

**between 2013 and 2016.** Further, per capita health spending is still low, and falls significantly short of the recommended target of USD86<sup>1</sup> to address health challenges. Kebbi State had an average health expenditure per capita at USD 6.25; the trend remained constant in 2013 and 2014 and then consistently dropped in the two subsequent years to USD 3 in 2016.

**The performance of the health sector budget implementation was concerning throughout the review period, it remains vulnerable to persistent challenges in the implementation of the capital budget.** The implementation rate of the state total budget was ranged from 27 percent and 60 percent, the capital budget implementation rate was generally lower than the recurrent budget implementation rate across all the key sectors including the public health sectors. In general, performance of the health sector budget had an average annual execution rate of about 47 percent. The implementation rate of the recurrent budget has consistently exceeded 70 percent throughout the review period, and in 2013 and 2014 the performance was 89 percent and 83 percent respectively.

## **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 requires. As a state with a considerably high burden of disease, Kebbi urgently needs to invest far more than 6 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, 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 extremely low 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.

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<sup>1</sup> \$86 (expressed in 2012 terms) being the estimate of per capita resource requirements for providing a minimum level of key health services in low-income countries. *Fiscal Space for Domestic Funding of Health and Other Social Services*. Di McIntyre and Filip Meheus. March 2014

**Improve the capital investment in the health sector** The current share of capital health investment and capital budget execution rate was low in Kebbi state. 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.

**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, 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 development impact of its public expenditures 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 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 lack of absorptive capacity for capital funds within the health sector and necessary technical support should be sought to remove identified bottlenecks. 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

Kebbi State, like many other states in Nigeria, is in the process of embracing health financing policy reforms introduced at the national level to achieve more money for health and more health for the money. Kebbi state has therefore keyed in to health financing policy reforms including decentralization of health insurance scheme that will usher in State Supported Health Insurance Scheme, PHC management integration policy called PHCOUR, Revitalization of PHC for UHC policy and other laudable policy thrusts.

Kebbi State has been given support to conduct health care financing training for main stakeholders in the state aimed at building technical capacity of the stakeholders to understand the basic health care financing functions, and be acquainted with necessary policy, legal and institutional frameworks needed to implement the aforementioned policy thrust. The state has made 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 Kebbi State, USAID/HFG is supporting the state to conduct health financing diagnostic in a number of important areas including Governance/Political Economy and Fiscal Space analysis. Moreover, 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.

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.

## I.2 Situation Analysis of Kebbi State

### I.2.1 History of Kebbi State

Kebbi State is one of the 36 States of the Federal Republic of Nigeria; it was created in 1991 with its capital at Birni Kebbi. The population of the State was put at 3,256,541 by the 2006 census with a growth rate of 3.15% per annum; the State will have a projected population of 4,440,674 by the end of 2016. There are 21 LGAs in the state, the principal occupation of the people of Kebbi state are trading and agriculture, animal rearing and fishing are also common.

### I.2.2 Maternal, Newborn and Child Health in Kebbi State

Kebbi was recorded as one of the states with the highest burden of maternal, infant and children under five mortality rates in Nigeria from 2012 to 2015. In Kebbi State, pregnant women and children under five, who are the most vulnerable to virus infection, constitute 23% and 20% of the population

respectively. The infant mortality rate hit 111 deaths per 1,000 live birth annually which was over 50 percent higher than the national average. Under five mortality rate was 174 deaths per 1,000 live births which is much higher than the average of north west region and Nigeria. In 2016/2017, the maternal mortality rate was reduced to 490 deaths per 100,000 live birth compared to national average of 800 deaths per 100,000 live birth annually. Malaria during pregnancy remains a serious public health problem, with substantial risks for the mother, her fetus and the newborn. According to malaria indicator survey 2015, the percentage of children age 6-59 months who were having malaria was 64 percent compared to a region average of 37 percent and a national average of 42 percent; the percentage of children age 6-59 months who were having anemia was 84 percent compared to a region average of 80 percent and a national average of 68 percent

**Table 1: Maternal, Newborn and Child Health Facts**

Indicator	North West	Kebbi	National
Infant Mortality rate (deaths/1000 live births) <sup>1</sup>	87	111	70
Child mortality rate (deaths/1000 children surviving to age one) <sup>1</sup>	83	70	54
Under-five mortality rate (deaths/1000 live births) <sup>1</sup>	162	174	120
Maternal mortality rate (deaths/100,000 live births)	1026	490	800
Percentage of children age 6-59 months classified as having malaria <sup>2</sup>	37	64	42
Percentage of children age 6-59 months classified as having anaemia <sup>2</sup>	80	84	68

Sources:

1. Nigeria Multiple Indicator Cluster Survey (MICS) 2016/2017, UNICEF, [https://www.unicef.org/statistics/index\\_24302.html](https://www.unicef.org/statistics/index_24302.html)
2. Nigeria DHS Malaria Indicator Survey 2015, USAIDS, <https://dhsprogram.com/pubs/pdf/MIS20/MIS20.pdf>

Poor maternal and child health performance have been a public health challenge in Kebbi state. Many interventions were instituted to ensure that Kebbi achieves the relevant Millennium Development Goals (MDGs). Nevertheless, the maternal, newborn and child health utilization statistics have shown the challenges as well as threats to the attainment of MDGs 4 and 5 (child and maternal mortality reduction, respectively.) Table 2 indicates the utilization rates of selected maternal, newborn and child health service in the state which were generally lower than the region average and national average. The findings addressed the need for financing commitment into health interventions for the vulnerable population of pregnant women and children.

**Table 2: Utilization of Maternal and Child Health Service in Kebbi State**

Indicator	North West	Kebbi	National
Estimated % of children 12 – 23 months with full immunization coverage by first birthday (measles by second birthday)	16	13	14.3
Use of FP modern method by married women 15-49 (%)	7.4	5	23
ANC provided by skilled Health workers (% of women with a live birth in the last two years)	53.6	45.4	10.8
No of deliveries in health facilities (% of women with a live birth in the last two years)	17.8	12.2	65.8



Skilled attendants at birth (% of women with a live birth in the last two years)	23.6	17.9	37.5
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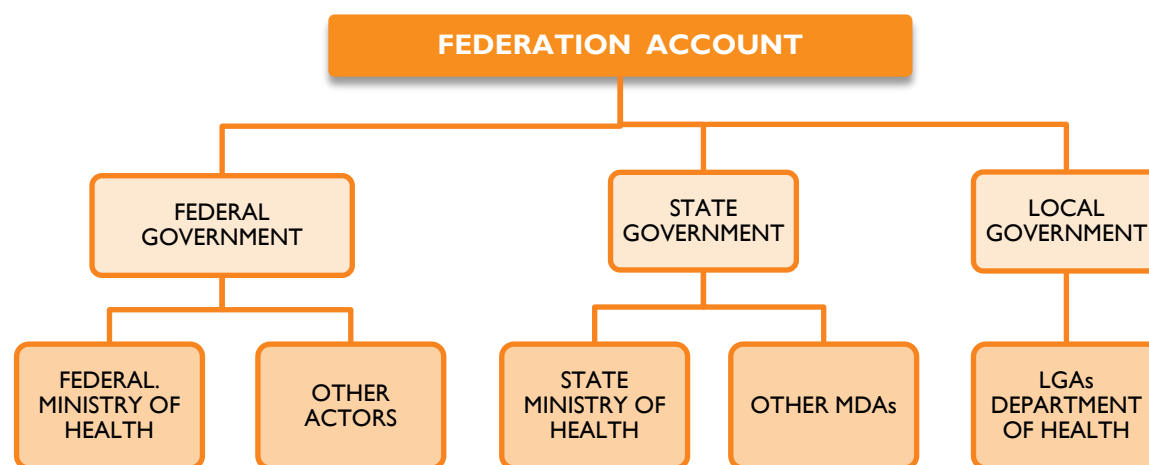
### 1.2.3 Overview of the State Health Financing System

Nigeria is a Federal country 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 centers (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 specialized 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 Kebbi 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 Kebbi State Strategic Health Development Plan (2010 – 2015)

As contained in the SSHDP, the state is committed to providing quality, accessible and affordable healthcare services to its citizens by 2015. The state strategic plan was structured after the strategic framework which has 8 priority areas as listed below:

- I. 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:

- Provision of free drugs to pregnant women and children under five
- Provision of subsidy on surgical consumables
- Introduction of waivers to indigent patients under the DRF program
- Free treatment for some ailments which includes TB, HIV and leprosy
- Provision of free catering services to selected patients based on their economic status

Other steps taken include rehabilitation of existing facilities and provision of additional ones to ensure fairly equitable distribution across the state. The state also, following the national health policy on sustainable health services with full and active participation of people at the grass root level, introduced the ward health system. This policy is relevant in ensuring community participation in PHC delivery.

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.

After two years of implementation of the state strategic plan, the Kebbi Health Sector PER 2013 to 2016 provides a hands-on tool to immediately track the progress made in key health financing indicators, identify challenges, and make relevant recommendations for successful implementation of the strategy.

The Kebbi health system PER is organized in four chapters. After the introduction, Chapter 2 summarizes trends in overall public health spending (trends in the total public health budget and expenditures) and various subsector trends, with some detailed analysis of recurrent expenditure items and the development budget. Budget execution at different levels, expenditure by different departments. Chapter 3 gives a health system efficiency review by comparing the population health, health service delivery and health financing condition to other HFG states. Chapter 4 points out key messages from the analysis and provides recommendations for the way forward.

## 2. STATE HEALTH BUDGET AND EXPENDITURE ANALYSIS

### 2.1 Introduction

This chapter presents an assessment of public health budget and expenditure trends between 2012 and 2016. The chapter also evaluates the health sector budgetary absorptive capacity and resource allocation to key priority areas to support the SSHDP. 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.

### 2.2 State Revenue

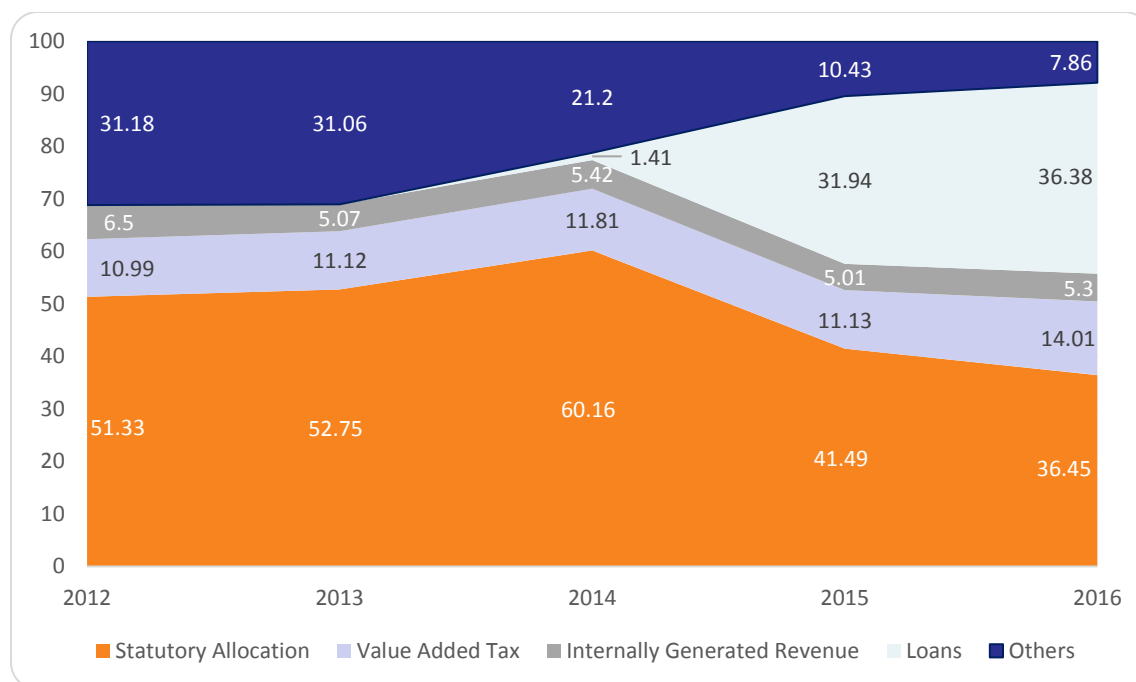
During the years under review, the state total revenue decreased from N68 billion in 2012 to N59 billion in 2016. There are various sources of revenue to the state government which includes statutory allocation from the federation account, internally generated revenue, value added tax, internal/external loans and other sources of revenue. The Kebbi state revenue was highly dependent on the statutory allocation from the federation account, as shown in the Figure 2, the share of statutory allocation from the federal government accounts for almost half of the state revenue, which ranges from 36 percent to 60 percent. The proportion of statutory allocation reduced from 51 percent in 2012 to 36 percent in 2016, this was due to the large loans (external and internal) secured by the state government to cushion the effect of reduced statutory allocation. The internal and external loans contributed to the state revenue since 2014, jumped from N1 billion in 2014 to N21 billion in 2016 which accounts for 36 percent of total state revenue. The internally generated revenue (IGR) contributed an average of 5 percent throughout the period, the absolute value of IGR consistently fell during the period while maintaining a constant share of the total revenue.

**Table 3: Kebbi State Revenue Profile 2012 – 2016**

SOURCE	2012 NGN	2013 NGN	2014 NGN	2015 NGN	2016 NGN
Statutory allocation	34,959,861,607	39,500,233,891	42,554,064,451	29,720,531,782	21,525,225,499
Value Added Tax	7,484,809,323	8,324,347,332	8,351,241,585	7,972,089,995	8,270,639,957
Internally generated revenue	4,424,015,849	3,798,260,682	3,834,143,642	3,592,406,108	3,132,343,262
External and Internal loan	0	0	1,000,000,000	22,880,460,000	21,482,804,383
Others	21,237,661,122	23,258,413,304	14,992,826,543	7,469,173,794	4,643,193,877

TOTAL	68,106,347,900	74,881,255,210	70,732,276,220	71,634,661,680	59,054,206,978
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**Figure 2: Kebbi State Revenue Composition 2012-2016**



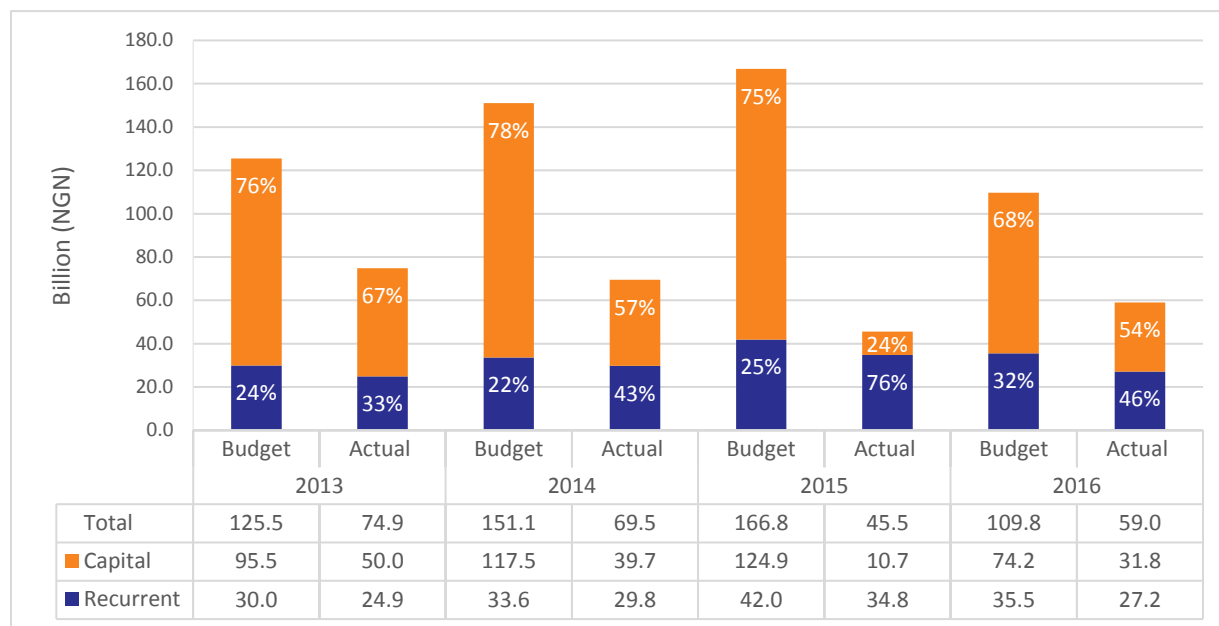
Source: Kebbi State 2016 Accountant General's report

## 2.3 State budget and actual expenditure review

The state total budget increased from N125.5 billion in 2013 to N166.8 billion in 2015 (33 percent increment) and thereafter there was a sharp decline to N109.8 billion in 2016. The recurrent budget developed steadily from N30.0 billion in 2013 to N35.5 billion in 2015 and accounts for 22 percent to 32 percent of total state budget. The capital budget consistently had a larger share of the total state budget with almost equal proportions (around 68-78 percent) for the four years in view. It reflects the trend of total budget change, the recurrent budget increased from N95.5 billion in 2013 to N124.9 billion in 2015 and thereafter dropped to N74.2 billion in 2016 (Figure 3).

The state total actual expenditure declined from N74.9 billion in 2013 to N59.0 billion in 2016. It is noticeable that since 2015, while the state total budget experience significant growth, the actual expenditure kept diminishing – suggesting a lack of budget realism and serious flaws in the budgeting process beyond/above the ministry of health. Figure 3 shows the share of capital and recurrent actual expenditure reversed in 2015. The capital expenditure was the major spending in 2013, 2014 and 2016, the share of capital expenditure ranged from 54 percent to 67 percent. In 2015, the share of capital actual expenditure shrank into only 24 percent.

**Figure 3: Kebbi State Budget and Actual Expenditure**



## 2.4 Public Health budget and actual expenditure review

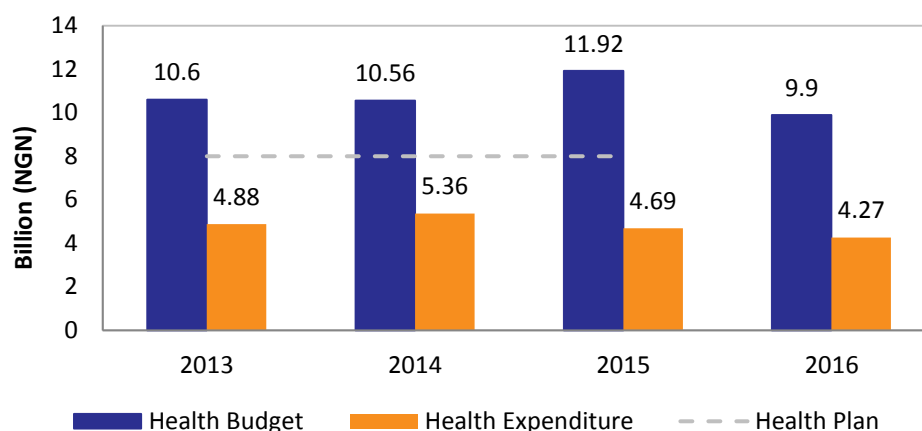
### 2.4.1 Total Public Health Budget and Expenditure

Total public health budget declined from N10.6 billion in 2013 to N9.9 billion in 2016; analysis of the budget shows that more funds were allocated to capital expenditure than recurrent budget with the exception of 2016 where the recurrent budget is slightly higher than the capital budget. Notwithstanding the slight deviation, this trend (recurrent and capital expenditure mix) was in line with best practices.

The actual public health expenditure dropped from N4.88 billion in 2013 to N4.27 billion in 2016. However contrary to what is obtainable with the public health budget, the recurrent expenditure had the larger share of the total health expenditure with a proportion as high as 91 percent in 2016. This trend is worrisome as best practice dictates that a higher proportion of expenditure should be on developmental activities (capital expenditure) to enhance a strong health sector capable of delivering quality care.

While 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; the state planned to spend at least N8 billion for a period of six years (2010 – 2015) in order to achieve its desired objective.

**Figure 4: Trend of Health Budget and Expenditure**

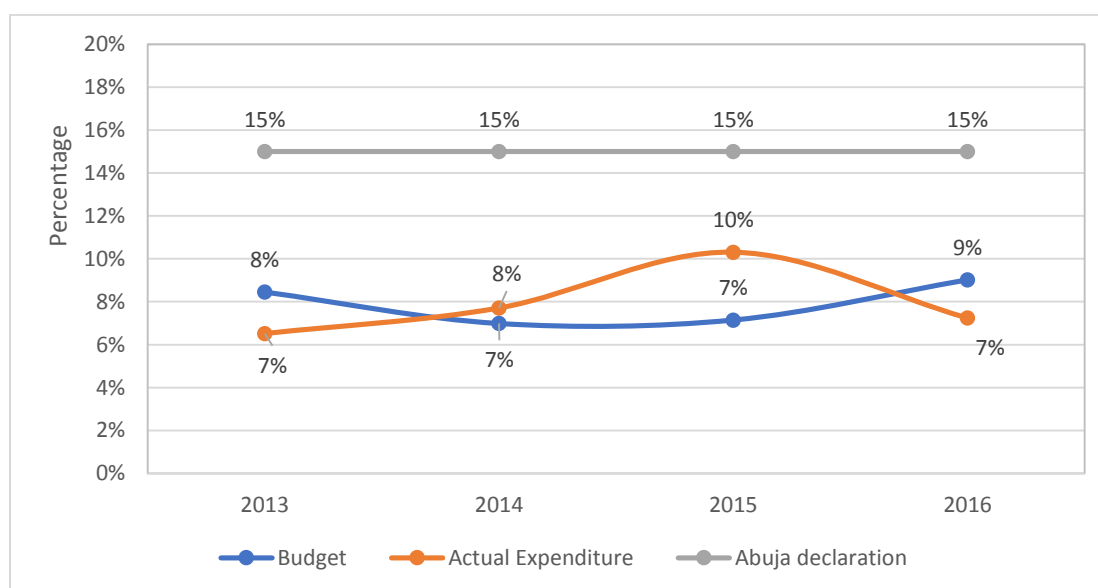


## 2.4.2 Health Share in State Government Budget and Expenditure

The share of the health budget in total state government budget ranged between 7% and 9% for the period under review; the recommendation from the Abuja declaration of 2001 suggests that governments allocate at least 15% 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 this recommendation.

The share of health expenditure in total state government expenditure ranged between 7% and 10%; the low investment in the health sector has given rise to a lot of challenges (according to anecdotal information shared during data collection) which include an upsurge in establishment of private health facilities and increased patronage at the traditional medical centers.

**Figure 5: Health Shares in Government Budget and Actual Expenditure**



### 2.4.3 Trend of Health Recurrent and Capital Budget and Actual Expenditure

Although the health capital budget experienced a fall in absolute value and proportion of total health budget, it remains the major driver of the health sector budget allocation. The capital budget for the health sector had a slight drop from N6.34 billion in 2013 to N5.73 billion in 2014; it increased again to N6.51 billion in 2015 and then ended up at N4.63 billion in 2016; figure 6 shows its share as a percentage of total health budget also followed same trend. The share of health capital budget in total health budget decreased from 60 percent in 2013 to 47 percent in 2016.

Recurrent budget in health sector increased from N4.27 billion in 2013 to N5.41 billion in 2015 and had a fall to N4.62 billion in 2016. Similarly, the share of health recurrent budget in total health budget increased from 40 percent in 2013 to 53 percent in 2016.

For health sector figure 6 shows the share of recurrent budget was constantly lower than the capital budget except in 2016 where it was slightly higher.

**Figure 6: Trend of Health Recurrent and Capital Budget**

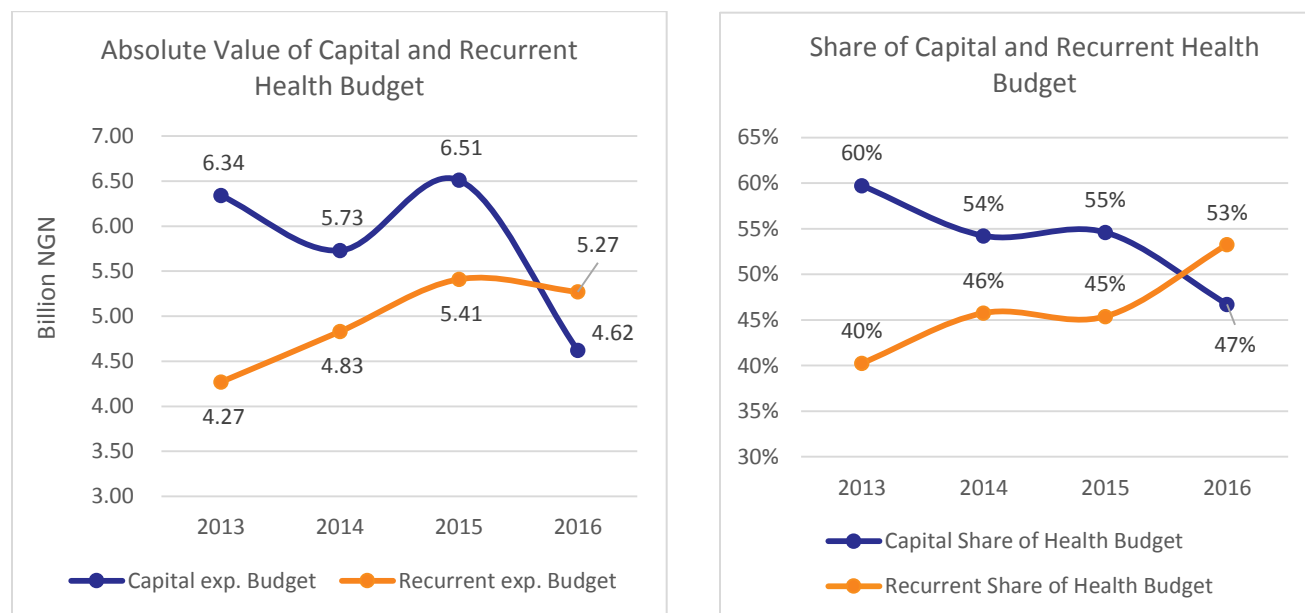
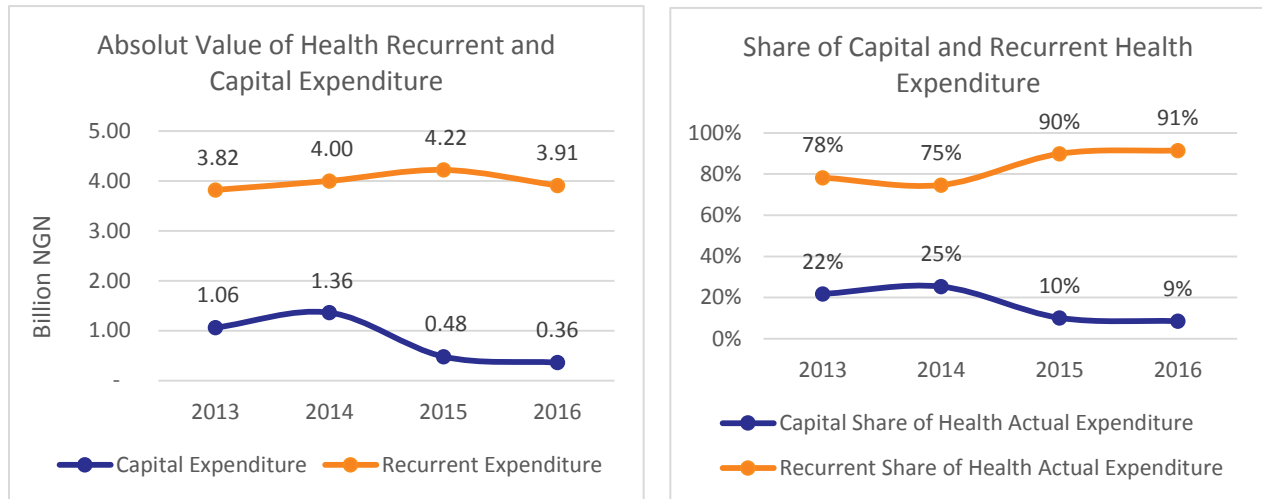


Figure 7 shows that the actual capital expenditure was N1.06 billion in 2013, had its peak in 2014 at N1.36 billion before declining to N364million in 2016. The recurrent expenditure increased from N3.82 billion in 2013 to N4.22 billion in 2015 and declined to N3.91 billion in 2016; the share of recurrent expenditure was consistently higher than the capital expenditure among total health actual expenditure during the period under review which runs contrary to the recommended mix.

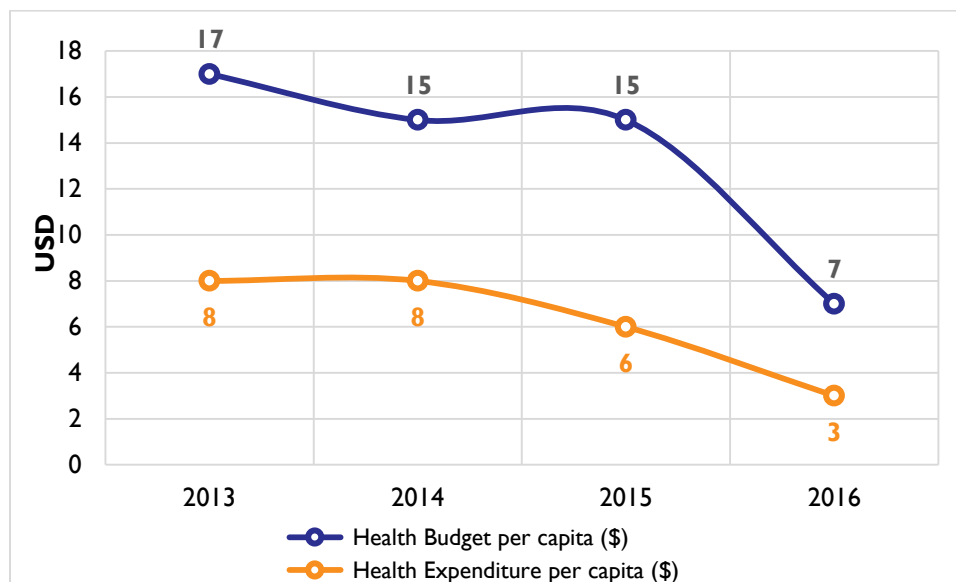
**Figure 7: Capital and Recurrent Actual Expenditure Trends**



## 2.4.4 Per Capita Public Health Budget and Expenditure

Figure 8 presents trends in per capita public health budget and actual expenditure. It is worth noting that per capita health budget and expenditures had declined consistently from 2013 to 2016. The per capita health budget was \$17, \$15, \$15, \$7 respectively for each of the years under review. The per capita health expenditure was \$8, \$8, \$6, \$3 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.

**Figure 8: Trends of Per Capita Health budget and expenditure**



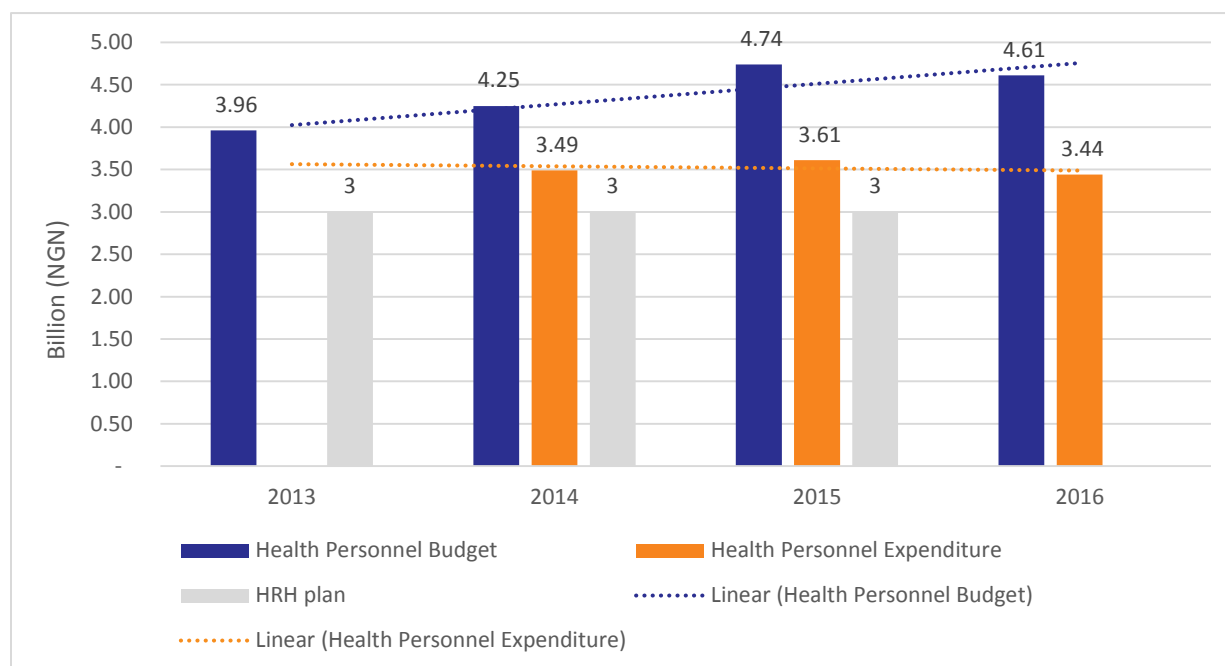


## 2.4.5 Health Personnel Budget and Expenditure

A large share of public health sector expenditure had spent on capital investment, especially the personnel and overhead expenditure. Personnel and overhead cost accounted for 75% to 91% of the state government health spending in the period under review, as this represents a very large proportion of government spending. The absolute value of health personal expenditure remained almost constant during the period while a noticeable upsurge in aggregate number of health workers was observed. Figure 9 shows that the health personal budget increased from N3.96 billion in 2014 to N4.61 billion in 2016 by 16 percent. The actual health personnel expenditure recorded a decrease from N3.49 billion in 2014 to N3.43 billion in 2016 by 2 percent. As contained in the SSHDP (2010 – 2015), the state desires to spend an annual average of N3 billion on Human Resources for Health (HRH) from 2010 to 2015, all things being equal, the Kebbi state had operated at its optimum as it relates to HRH.

Examining the efficiency of health personnel spending, the increased investment on HRH didn't produce high quality of health services. First, the common sources of inefficiency of human resources management, including 'ghost' worker syndrome, moonlighting and absenteeism need to be identified and addressed. This high HRH expenditure could be reviewed vis-à-vis productivity of labor in the state. Second, information gathered from selected respondents (within the PER team) indicates the inequality in the distribution and skill mix of health workers in Kebbi state. The interviewed respondents were concerned that most skilled health workers concentrated in the urban areas and private sectors, especially the state capital cities. The data from HIMS unit of SMOH indicates that health workers' skill mix in the rural area (or disadvantaged districts) and primary facilities was marked by few skilled health workers and high numbers of health workers with low-level skills. It appears that better working and living conditions, as well as higher remuneration draw skilled health workers to urban area and the private sector. The disparity of skilled workers distribution and funding support resulted in poor performance at the PHC level.

**Figure 9: Health Personnel Budget and expenditure**



## 2.4.6 Performance of the health sector budget

Table 4 presents budget performance indicators over the period 2013–2016, summarized according to budget classification (recurrent and development budget). In general, performance of the health sector budget has been lower than satisfactory throughout the review period, with an average annual execution rate of about 47 percent. The implementation rate of the recurrent budget has consistently exceeded 70 percent throughout the review period, and in 2013 and 2014 the performance was 89 percent and 83 percent respectively. The execution of the recurrent budget fell to 78 percent in 2015, and even lower, to 74 percent, in 2016. The execution performance of the capital budget has been generally lower than for the recurrent budget, which fell to only 8 percent in 2016 from 17 percent in 2013, which needs attention to address the causes of delay in the implementation of the capital budget.

**Table 4: Health Budget Execution Performance Indicators**

Implementation Rate (%)	2013	2014	2015	2016
Recurrent	89	83	78	74
Capital	17	24	7	8
Total Budget	46	51	39	43

## 2.5 Share of state budget and actual expenditure in other key sectors

Works and transports and education sectors absorbed the highest share of state budget. The proportion of state government budget allocated to health is below the internationally recommended Abuja Declaration benchmark of 15 percent. Figure 10 shows that the allocation to health sector ranged between 7 percent and 9 percent of state government budget in the years under review while works and transport and education received as much as 33 percent and 26 percent respectively. The level of prioritization to health sector is not promising especially when compared with some other states in the country given its high level of disease burden in the state; this could constitute obstacle to achieving health sector development objectives.

**Figure 10: Budgetary Allocation to Key Sectors in Kebbi State**

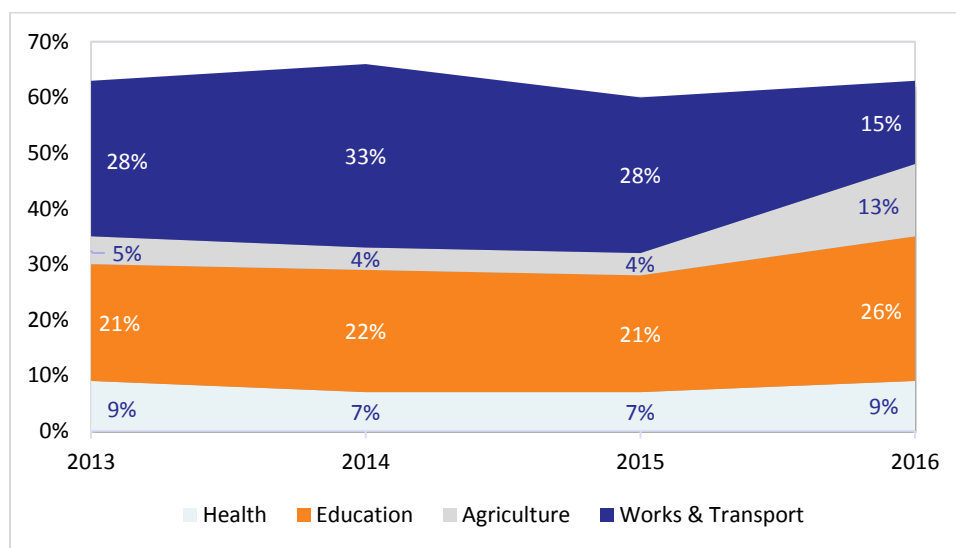
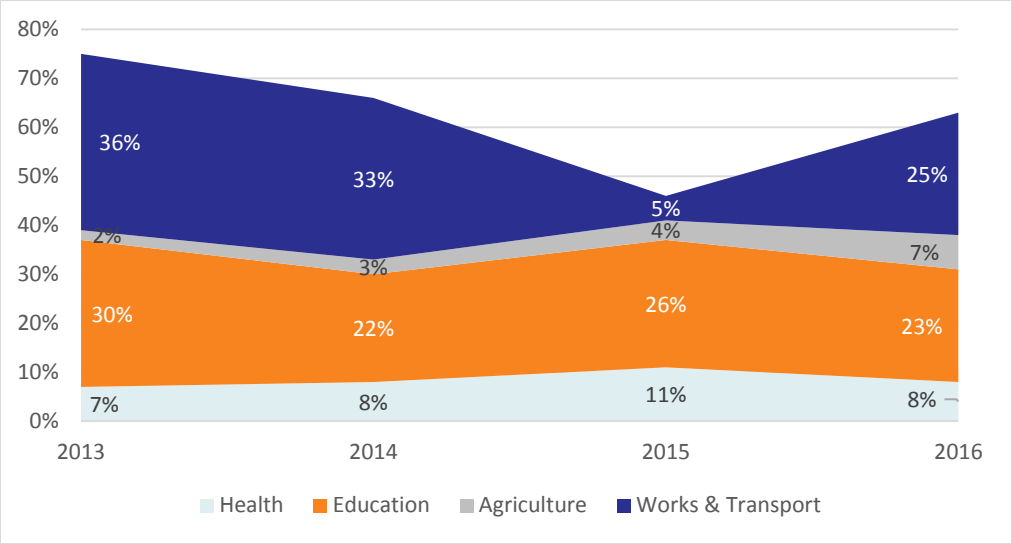


Figure 11 shows that actual state government expenditure had a similar pattern as the proportion distribution in the state government budget. Works and transports, education sectors were the major sectors consumed state government expenditure. Health sector spending was allocated as high as 11 percent in 2015 with the least 7 percent recorded in 2013 and 8 percent in 2016. Works & Transport was at its high point in 2013 with a share of 36 percent while Education also got the highest proportion of 30 percent in 2013. In 2015 the works and transport share of state actual expenditure shrunk to only 5 percent. The budget and expenditure data confirmed the priority accorded the education and the works & transport sector by the state government.

Figure 11: Key sectors' Actual Expenditure



### 3. KEBBI STATE HEALTH SYSTEM'S PERFORMANCE 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 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 Kebbi 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 Kebbi and compared across all the HFG funded states. This section reviews the following three aspects of Kebbi state health system 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. Efficiency is understood as how well the outcomes of health care provision are distributed among the population (allocative efficiency). 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 that points to 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 Kebbi State Population Health

##### 3.1.1 State Population Health Status

Available data revealed an overwhelming improvement in child care (Table 5 and more details in Annex 9). Infant and under-five mortality rate dropped significantly. However, reported cases of diarrhea in children are on the increase and require urgent attention (likely improvement in reporting notwithstanding.) Records also shows that malaria prevalence is on the rise as the number of cases reported moved upward from 18,786 to 417,396; this is alarming especially with the realization that malaria is the leading cause of ill health and death in the Kebbi state.

**Table 5: State Population Health Indicators**

Year	2012	2013	2014	2015
Infant Mortality Rate (IMR)	24.4	142.2	19.2	8.2
Under five mortality Rate (U-5MR)	43.7	158.3	26.2	18.2
Maternal mortality rate (MMR)	1520	1054	788	490
Malaria Prevalence	18,786	360,030	268,733	417,396

TB Prevalence	338/100,000	N/A	N/A	N/A
HIV Prevalence	1.00%	0.80%	0.80%	1.40%

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

Table 6 compares selected Kebbi state key health indicators with that of other HFG supported states. In Kebbi state, the children under five mortality rate was among the highest which hit 174 cases per 1,000 live births annually, compared to the national average of 120 cases per 1,000 live births; and the infant mortality rate was the highest which was 111 cases per 1,000 live births annually, compared to the national average of 70 cases per 1,000 live births. Maternal mortality rate and HIV prevalence was moderate among the selected states. These indicators may partially indicate an outcome of high health expenditure occurred in the Kebbi state and support an argument for gains being achieved with investment public health.

**Table 6: State Population Health Status Comparison Among HFG Selected States**

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>2</sup>	HIV Prevalence (%) <sup>3</sup>
<b>Kebbi</b>	<b>490</b>	<b>111</b>	<b>174</b>	<b>0.8</b>
<b>Zamfara</b>	N/A	104	210	0.4
<b>Plateau</b>	N/A	55	80	2.3
<b>Nasarawa</b>	N/A	81	121	8.1
<b>Ebonyi</b>	576	47	62	0.9
<b>Akwa Ibom</b>	450	42	73	6.5
<b>Kogi</b>	544	92	153	1.4
<b>Osun</b>	165	78	101	1.6
<b>Oyo</b>	108.4	59	73	5.6
<b>Sokoto</b>	1500	51	119	6.4
<b>Bauchi</b>	705	39	53	0.6
<b>Benue</b>	1318	70	82	5.6
<b>National Average</b>	<b>814</b>	<b>70</b>	<b>120</b>	<b>3.4</b>

Source: Multiple Indicator Cluster Survey (MICS) 2016-2017 and Malaria Indicator Survey (MIS) 2015

<sup>2</sup> Multiple Indicator Cluster Survey (MICS) 2015-2016

<sup>3</sup> NARHS 2012 <https://naca.gov.ng/nigeria-prevalence-rate/>

## 3.2 Kebbi State Health Service Delivery/Provision

### 3.2.1.1 Maternal, Newborn and Child Health Service

According to the information from HIMS, the indicators of maternal care indicates a progress during the period (Annex 9); for instance, ANC provided by skilled health workers increased from 25,282 in 2013 to 209,067 in 2016. consequently, the number of deliveries in health facilities and skilled attendants at birth followed same trend. There was also a sharp increase in the number of married women between the age of 15 and 49 using modern method of family planning from 3,219 to 37,315. Again, improved reporting and actual service utilization are both responsible for the observed advancement in performance; this is giant stride in the face of the critical attitude of women in this part of the country towards hospital attendance/utilization, which is greatly influenced by religious and cultural belief.

### 3.2.1.2 Facility utilization

There has been an increase in health facility utilization, especially the utilization of maternal care. The data provided by the HMIS unit (annex 9) 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 53,427 to 701,522 while inpatient care increased from 6,780 to 48,775 annually; the increased health facility utilization is partly due to strengthened reporting system as well as increased service utilization. State Health Service Provision Comparison Among HFG Selected States

The following table shows that, compared with the child and maternal service provision rates in other HFG selected states, the child and maternal service provision rates were pretty low in Kebbi state. In 2016, there were 45.4 % 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, 10.9 % of them received HIV counselling during the antenatal care provision and 17.9 % of them received assistance from skilled attendant during their delivery. In addition, there was only 4.8 % 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: State Health Service Provision Comparison Among HFG Selected States**

State Name	Antenatal Care Coverage <sup>4</sup>	Full immunization coverage <sup>5</sup>	Received HIV counselling During ANC <sup>6</sup>	Skilled Attendant Assisted at delivery <sup>7</sup>
Kebbi	45.4	4.8	10.9	17.9
Plateau	61.3	30.6	40.4	47.3
Nasarawa	67.9	21.4	49.9	48.4
Zamfara	42.2	4.9	10.4	16.4
Ebonyi	75.0	35.0	45.7	72.6
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
Sokoto	35.1	2.2	9.6	20.6
Bauchi	59.8	13.9	27.5	22.1
Benue	67.5	37.0	57.6	62.8
<b>National Average</b>	<b>65.8</b>	<b>22.9</b>	<b>41.0</b>	<b>43.0</b>

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

### 3.3 Kebbi State Health Financing

Table 8 shows that, on average, the share of health expenditure in Kebbi state is among the highest state which was 8% of general state government expenditure. And on average, the per capita public health expenditure in Kebbi state is moderate which was 6.3USD.

**Table 8: State Health Financing Indicators Comparison Among HFG Selected States**

State Name	Gen. govt Expenditure on health as % of gen govt exp.	Govt Per Capita Expenditure on health at average \$ exchange rate
Kebbi	8.0	6.3
Plateau	4.8	6.5

<sup>4</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>5</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>6</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>7</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>Nasarawa</b>	8.5	10.8
<b>Zamfara</b>	6.0	5.0
<b>Ebonyi</b>	8.5	8.0
<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>Sokoto</b>	11.0	8.1
<b>Bauchi</b>	9.0	12.5
<b>Benue</b>	8.5	6.3
<b>National standard</b>	15.0	97.0

## 4. 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 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. The major recommendations are highlighted below.

### 4.1 Macro Fiscal Context

Over-reliance on statutory allocation as a main source of revenue for the state is detrimental 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 increases government's future commitment hence reduction in future funding 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; therefore the average monthly IGR of N261 million by the state calls for a review of the state revenue generation mechanism.

### 4.2 Prioritization of 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 considerably high burden of disease, the state urgently needs to invest far more than 7% 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.

### 4.3 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 relatively low. 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. 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.

### 4.4 Prioritize Preventive care at the PHCs over Curative care at the secondary facilities

Though health activities at the LGA level could not be ascertained due to lack of data, it was gathered during interaction with stakeholders that activities at the PHCs are unacceptable. In order to move from

the current trend of concentrating spending on curative care at the secondary facilities, Government spending needs to be re-directed to preventive care at the PHCs which has been identified as the key to UHC<sup>8</sup>. The state needs to spend more at the PHCs level in order to reduce the prevalence of preventable diseases; the current effort by the State Government to ensure PHCUOR policy is fully operational is a right step in the right direction at achieving UHC.

## 4.5 Measurement of health systems efficiency

As stated earlier, expansion of fiscal space in the health sector requires efforts both at mobilising 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.

### 4.5.1 Budget effectiveness

As in many developing countries, Kebbi 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 in order to identify the most feasible way to link performance to productivity.

### 4.5.2 Health financing coordination

It will be highly beneficial if a multi-sectorial coordination platform is introduced in the state to coordinate all the players in the health sector. 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.

## 4.6 Further Reviews

Some of the findings of this Public Expenditure Review suggest the need to conduct further studies that will produce additional evidence for decision making, for instance it will be necessary to conduct additional PFM to determine the cause of low capital budget execution rate. LGAs, private sector and donor agencies should be further engaged for release of health expenditure data in order to expand the scope of this review.

The review revealed that despite having a higher GGHE per capita, the average consultation per person per year as well as the GGE per facility utilization is higher in Kebbi state; this calls for a review to unravel the reason behind this with a view to eliminate it.

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<sup>8</sup> (WHO) Declaration of Alma-Ata 1978



# ANNEX A

## Annex I: Five Year Financial Highlights

SOURCE	2012 NGN	%	2013 NGN	%	2014 NGN	%	2015 NGN	%	2016 NGN	%
Statutory allocation	34,959,861,607	51	39,500,233,891	53	42,554,064,451	60	29,720,531,782	41	21,525,225,499	36
Grant reimbursement	0	0	2,000,000,000	3	2,000,000,000	3	1,685,382,883	2	0	0
Value Added Tax	7,484,809,323	11	8,324,347,332	11	8,351,241,585	12	7,972,089,995	11	8,270,639,957	14
Internally generated revenue	4,424,015,849	6	3,798,260,682	5	3,834,143,642	5	3,592,406,108	5	3,132,343,262	5
External and Internal loan	0	0	0	0	1,000,000,000	1	22,880,460,000	32	21,482,804,383	36
Other income	19,896,382,691	29	18,562,720,157	25	10,168,548,977	14	5,742,483,766	8	4,612,359,742	8
Sure P	1,341,278,431	2	2,695,693,147	4	2,761,374,576	4	0	0	0	0
Dividend Received from companies	0	0	0	0	62,902,990	0	41,307,145	0	30,834,135	0
<b>TOTAL</b>	<b>68,106,347,900</b>	<b>100</b>	<b>74,881,255,210</b>	<b>100</b>	<b>70,732,276,220</b>	<b>100</b>	<b>71,634,661,680</b>	<b>100</b>	<b>59,054,206,978</b>	<b>100</b>



## Annex 2: 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	29,989,831,959	24	33,620,899,948	22	41,951,413,038	25	35,521,339,299	32
Capital	95,504,934,490	76	117,479,100,352	78	124,873,635,054	75	74,231,181,201	68
<b>Total State Budget</b>	<b>125,494,766,449</b>	100	<b>151,100,000,300</b>	100	<b>166,825,048,092</b>	100	<b>109,752,520,500</b>	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	24,872,442,857	33	29,818,052,184	43	34,813,204,546	76	27,165,419,841	46
Capital	50,012,411,436	67	39,658,738,965	57	10,704,766,036	24	31,849,706,285	54
<b>Total State Expenditure</b>	<b>74,884,854,293</b>	<b>100</b>	<b>69,476,791,149</b>	<b>100</b>	<b>45,517,970,582</b>	<b>100</b>	<b>59,015,126,126</b>	<b>100</b>

## Annex 3: Indicators - Key Sectors' Budget and Expenditure

	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
<b>BUDGET</b>								
Health	10,604,509,073	8	10,555,473,205	7	11,921,808,584	7	9,900,598,866	9
Education	25,521,814,176	20	32,661,405,534	22	35,166,894,815	21	28,401,310,475	26
Agriculture	5,770,782,007	5	6,791,455,531	4	6,604,976,123	4	14,594,990,398	13
Works and Transport	34,451,985,655	27	49,812,110,799	33	46,330,988,458	28	16,011,500,000	15
Others	49,145,675,538	39	51,279,555,231	34	66,800,380,112	40	40,844,120,761	37
<b>Total State Budget</b>	<b>125,494,766,449</b>	<b>100</b>	<b>151,100,000,300</b>	<b>100</b>	<b>166,825,048,092</b>	<b>100</b>	<b>109,752,520,500</b>	<b>100</b>
<b>EXPENDITURE</b>		As a % of State Expenditure	Amount	As a % of State Expenditure	Amount	As a % of State Expenditure	Amount	As a % of State Expenditure
Health	4,880,216,117	7	5,356,463,859	8	4,692,972,499	10	4,274,191,273	7
Education	22,522,559,887	30	15,053,455,939	22	10,923,562,037	24	12,541,012,148	21
Agriculture	1,530,861,522	2	2,067,196,396	3	1,837,988,847	4	3,745,318,244	6
Works and Transport	26,812,221,962	36	22,042,944,468	32	2,211,764,006	5	13,972,858,244	24
Others	19,138,994,805	26	24,956,730,487	36	25,851,683,194	57	24,481,746,217	41
<b>Total State Expenditure</b>	<b>74,884,854,293</b>	<b>100</b>	<b>69,476,791,149</b>	<b>100</b>	<b>45,517,970,583</b>	<b>100</b>	<b>59,015,126,126</b>	<b>100</b>



## Annex 4: Key Performance Indicators - State

DETAILS	2013	2014	2015	2016
	N	N	N	N
Health Budget	10,604,509,073	10,555,473,205	11,921,808,584	9,900,598,866
Health Expenditure	4,880,216,117	5,356,463,858	4,692,872,500	4,274,191,273
Projected Population	4,046,143	4,173,596	4,305,064	4,440,674
Exchange Rate (NGN/\$)	150	170	190	300
Health budget per capita (NGN)	2621	2529	2769	2230
Health Budget per capita (\$)	17	15	15	7
Health Expenditure per capita (NGN)	1206	1283	1090	963
Health Expenditure per capita (\$)	8	8	6	3

## 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	29,989,831,959	24,872,442,857	83	33,620,899,948	29,818,052,184	89	41,951,413,038	34,813,204,546	83	35,521,339,299	27,165,419,841	76
Capital Expenditure	95,504,934,490	50,012,411,436	52	117,479,100,352	39,658,738,965	34	124,873,635,054	10,704,766,036	9	74,231,181,201	31,849,706,285	43
<b>Total</b>	<b>125,494,766,449</b>	<b>74,884,854,293</b>	<b>60</b>	<b>151,100,000,300</b>	<b>69,476,791,149</b>	<b>46</b>	<b>166,825,048,092</b>	<b>45,517,970,582</b>	<b>27</b>	<b>109,752,520,500</b>	<b>59,015,126,126</b>	<b>54</b>

## HEALTH

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	4,269,509,073	3,818,750,015	89	4,830,473,205	4,000,047,222	83	5,411,808,584	4,216,105,632	78	5,274,210,425	3,909,315,671	74
Capital Expenditure	6,335,000,000	1,061,466,102	17	5,725,000,000	1,356,416,636	24	6,510,000,000	476,766,867	7	4,626,388,441	364,875,603	8
<b>Total</b>	<b>10,604,509,073</b>	<b>4,880,216,117</b>	<b>46</b>	<b>10,555,473,205</b>	<b>5,356,463,858</b>	<b>51</b>	<b>11,921,808,584</b>	<b>4,692,872,499</b>	<b>39</b>	<b>9,900,598,866</b>	<b>4,274,191,274</b>	<b>43</b>

## WORKS AND TRANSPORT



DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	283,200,516	355,531,085	126	347,416,940	369,569,722	106	610,500,000	499,473,790	82	466,500,000	439,095,351	94
Capital Expenditure	34,168,785,139	26,456,690,876	77	49,464,693,859	21,673,374,746	44	45,720,488,458	1,712,290,217	4	15,545,000,000	13,533,762,893	87
<b>Total</b>	<b>34,451,985,655</b>	<b>26,812,221,961</b>	<b>78</b>	<b>49,812,110,799</b>	<b>22,042,944,468</b>	<b>44</b>	<b>46,330,988,458</b>	<b>2,211,764,007</b>	<b>5</b>	<b>16,011,500,000</b>	<b>13,972,858,244</b>	<b>87</b>

## AGRICULTURE

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	885,374,007	1,014,224,032	115	973,147,531	903,481,542	93	1,010,312,123	784,036,574	78	961,332,655	920,986,894	96
Capital Expenditure	4,885,408,000	516,637,490	11	5,818,308,000	1,163,714,855	20	5,594,664,000	1,053,952,273	19	13,633,657,743	2,824,331,350	21
<b>Total</b>	<b>5,770,782,007</b>	<b>1,530,861,522</b>	<b>27</b>	<b>6,791,455,531</b>	<b>2,067,196,397</b>	<b>30</b>	<b>6,604,976,123</b>	<b>1,837,988,847</b>	<b>28</b>	<b>14,594,990,398</b>	<b>3,745,318,244</b>	<b>26</b>

## EDUCATION

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	9,123,572,825	7,521,575,409	82	11,695,307,041	7,733,247,256	66	12,888,172,219	8,665,456,718	67	11,637,310,475	7,974,068,321	69
Capital Expenditure	16,398,241,351	15,000,984,478	91	20,966,098,493	7,320,208,683	35	22,278,722,596	2,258,105,318	10	16,764,000,000	4,566,943,827	27
<b>Total</b>	<b>25,521,814,176</b>	<b>22,522,559,887</b>	88		<b>15,053,455,939</b>	46	<b>35,166,894,815</b>	<b>10,923,562,036</b>	31	<b>28,401,310,475</b>	<b>12,541,012,148</b>	44





## Annex 7: Budget by Health MDAs

**2013**

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Hospital Management	0	78,000,000	78,000,000	0	78,000,000
2	Sir Yahaya Memorial Hospital	405,415,488	31,500,000	436,915,488	0	436,915,488
3	Kebbi State Health System Development Project II	3,267,048	1,050,000	4,317,048	0	4,317,048
4	Community Direct Treatment Review	0	525,000	525,000	0	525,000
5	School of Nursing and midwifery	154,378,584	15,750,000	170,128,584	0	170,128,584
6	School of Health Jega	123,078,912	21,610,425	144,689,337	0	144,689,337
7	Kebbi State Agency for the Control of AIDS	0	0	0	0	0
8	Agency for Health Care Development	0	21,000,000	21,000,000	350,000,000	371,000,000
9	Ministry of Health	3,271,966,212	141,967,404	3,413,933,616	5,985,000,000	9,398,933,616
	<b>TOTAL</b>	<b>3,958,106,244</b>	<b>311,402,829</b>	<b>4,269,509,073</b>	<b>6,335,000,000</b>	<b>10,604,509,073</b>

**2014**

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	3,500,000,000	309,000,000	3,809,000,000	5,375,000,000	9,184,000,000
2	Sir Yahaya Memorial Hospital	450,000,000	37,000,000	487,000,000	0	487,000,000
3	H.S.D.P(2)	3,134,196	1,200,000	4,334,196	0	4,334,196
4	Community Direct Treatment Review	0	600,000	600,000	0	600,000
5	School of Nursing and midwifery	154,378,584	20,000,000	174,378,584	0	174,378,584
6	School of Health Jega	130,950,000	21,610,425	152,560,425	0	152,560,425
7	S A C A	0	0	0	0	0
8	Agency for Health Care Development	10,000,000	24,000,000	34,000,000	350,000,000	384,000,000
9	Hospitals Management Board	0	168,600,000	168,600,000	0	168,600,000

	<b>TOTAL</b>	<b>4,248,462,780</b>	<b>582,010,425</b>	<b>4,830,473,205</b>	<b>5,725,000,000</b>	<b>10,555,473,205</b>
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## 2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	4,000,000,000	366,500,000	4,366,500,000	6,000,000,000	<b>10,366,500,000</b>
2	State Primary Health care Development Agency	5,000,000	29,000,000	34,000,000	510,000,000	<b>544,000,000</b>
3	State Agency for the Control of AIDS	0	0	0	0	<b>0</b>
4	community direct treatment and review	0	600,000	600,000	0	<b>600,000</b>
5	School of Health, Jega	130,950,000	25,000,000	155,950,000	0	<b>155,950,000</b>
6	School of Nursing and midwifery	154,378,584	24,000,000	178,378,584	0	<b>178,378,584</b>
7	Kebbi state health system development project	3,180,000	1,200,000	4,380,000		<b>4,380,000</b>
8	Sir Yahaya Memprial Hospital	450,000,000	42,000,000	492,000,000		<b>492,000,000</b>
9	Hospital Management	0	180,000,000	180,000,000	0	<b>180,000,000</b>
	<b>TOTAL</b>	<b>4,743,508,584</b>	<b>668,300,000</b>	<b>5,411,808,584</b>	<b>6,510,000,000</b>	<b>11,921,808,584</b>

## 2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Hospital Management	0	170,000,000	170,000,000	0	<b>170,000,000</b>
2	Sir Yahaya Memoria Hospital	520,000,000	45,000,000	565,000,000	0	<b>565,000,000</b>
3	Kebb State Health System Dev. Project II	0	0	0	0	<b>0</b>
4	Community Direct treatment	0	600,000	600,000	0	<b>600,000</b>
5	School of health Jega	136,000,000	21,610,425	157,610,425	0	<b>157,610,425</b>
6	School of nursing	155,000,000	20,000,000	175,000,000	0	<b>175,000,000</b>
7	SACA	0	0	0	100,000,000	<b>100,000,000</b>
8	Primary Agency For Health Care Dev	3,000,000	24,000,000	27,000,000	665,388,441	<b>692,388,441</b>
9	Ministry of Health	3,800,000,000	379,000,000	4,179,000,000	3,861,000,000	<b>8,040,000,000</b>
	<b>TOTAL</b>	<b>4,614,000,000</b>	<b>660,210,425</b>	<b>5,274,210,425</b>	<b>4,626,388,441</b>	<b>9,900,598,866</b>

## Annex 6: Expenditure by Health MDAs

**2013**

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Hospital Management			224,800,000	0	224,800,000
2	Sir Yahaya Memorial Hospital			399,432,729	0	399,432,729
3	Kebbi State Health System Development Project II			5,588,383	0	5,588,383
4	Community Direct Treatment Review			600,000	0	600,000
13	School of Nursing and midwifery			165,390,003	0	165,390,003
11	School of Health Jega			132,848,758	0	132,848,758
5	Kebbi State Agency for the Control of AIDS			0	0	0
6	Agency for Health Care Development			24,000,000	0	24,000,000
7	Ministry of Health	2,655,171,433	210,918,710	2,866,090,143	1,061,466,102	3,927,556,245
	<b>TOTAL</b>	<b>2,655,171,433</b>	<b>210,918,710</b>	<b>3,818,750,015</b>	<b>1,061,466,102</b>	<b>4,880,216,117</b>

**2014**

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MINISTRY OF HEALTH	2,833,599,529	270,569,314	3,104,168,843	1,356,416,636	<b>4,460,585,480</b>
2	Sir Yahaya Memorial Hospital	391,217,366	36,000,000	427,217,366	0	<b>427,217,366</b>
3	H S D P (2)	3,106,399	1,115,326	4,221,724	0	<b>4,221,724</b>
4	C D T I	0	500,000	500,000	0	<b>500,000</b>
6	School of Nursing and midwifery	137,503,328	19,023,533	156,526,861	0	<b>156,526,861</b>
8	School of Health Jega	124,912,428	18,000,000	142,912,428	0	<b>142,912,428</b>
5	S A C A	0	0	0	0	<b>0</b>
6	PRIMARY HEALTH CARE DEV	0	24,000,000	24,000,000	0	<b>24,000,000</b>
7	Hospitals Management Board	0	140,500,000	140,500,000		<b>140,500,000</b>
	<b>TOTAL</b>	<b>3,490,339,050</b>	<b>509,708,172</b>	<b>4,000,047,222</b>	<b>1,356,416,636</b>	<b>5,356,463,859</b>

## 2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	2,935,630,733	336,199,930	3,271,830,663	476,766,867	<b>3,748,597,530</b>
2	State primary Health care Development Agency	0	24,000,000	24,000,000	0	<b>24,000,000</b>
3	SACA/HIV	0	0	0	0	<b>0</b>
4	Community Direct treatment review	0	450,000	450,000	0	<b>450,000</b>
5	School of Health Jega	125,262,050	18,000,000	143,262,050	0	<b>143,262,050</b>
6	School of nursing and midwifery	146,258,771	18,000,000	164,258,771	0	<b>164,258,771</b>
5	HSDP	3,179,644	1,000,000	4,179,644	0	<b>4,179,644</b>
6	Sir Yahaya Memorial Hospital	403,624,504	36,000,000	439,624,504	0	<b>439,624,504</b>
7	Hospital Management	0	168,500,000	168,500,000	0	<b>168,500,000</b>
	<b>TOTAL</b>	<b>3,613,955,703</b>	<b>602,149,930</b>	<b>4,216,105,632</b>	<b>476,766,867</b>	<b>4,692,872,499</b>

## 2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Hospital Management	0	153,900,000	153,900,000	0	<b>153,900,000</b>
2	Sir Yahaya Memoria Hospital	421,560,803	36,000,000	457,560,803	0	<b>457,560,803</b>
3	Kebbi State Health System	0	0	0	0	<b>0</b>
4	Community Direct treatment	0	600,000	600,000	0	<b>600,000</b>
5	School of health Jega	126,442,011	18,000,000	144,442,011	0	<b>144,442,011</b>
6	School of nursing	148,556,924	18,000,000	166,556,924	0	<b>166,556,924</b>
7	SACA	0	0	0	0	<b>0</b>
8	Primary Agency For Health Care Development	0	24,000,000	24,000,000	0	<b>24,000,000</b>
9	Ministry of Health	2,741,700,882	220,555,051	2,962,255,933	364,875,603	<b>3,327,131,536</b>
	<b>TOTAL</b>	<b>3,438,260,619</b>	<b>471,055,051</b>	<b>3,909,315,671</b>	<b>364,875,603</b>	<b>4,274,191,273</b>



## Annex 7: Performance Indicators

DETAILS	2013	2014	2015	2016
<b>NUMBER OF HEALTH WORKERS</b>				
No of Nurses	295	294	294	611
No of Midwives	238	668	238	120
No of Nurses/Midwives	533	962	532	731
No of Doctors	130	81	130	93
Pharmacists	11	11	11	12
Medical Lab Technicians /Scientists	191	164	191	192
Physiotherapists	Nil	Nil	Nil	Nil
Radiographers				
X/Ray Technicians	18	6	6	24
Medical record technicians	16	16	16	130
<b>SERVICE UTILISATION</b>				
Outpatient	53,427	538,689	455,390	701,522
Inpatient/ Admissions	6,780	45,160	31,627	48,775
ANC provided by skilled Health workers	25,282	133,563	136,263	209,067
No of deliveries in health facilities	9,030	50,453	45,011	63,166
Skilled attendants at birth	1,046	10,966	9,715	18,304
<b>HEALTH INDICATORS</b>				
Infant Mortality Rate (IMR)	24.40%	142.20%	19.20%	8.20%
Under five mortality Rate (U-5MR)	43.70%	158.30%	26.20%	18.20%
Maternal mortality rate (MMR)	1519.7	1053.6	788	490
Malaria Prevalence	18,786	360,030	268,733	417,396
TB Prevalence	338/100,000			
HIV Prevalence	1.00%	0.80%	0.80%	1.40%
<b>OTHER INDICATORS</b>				
Diarrhea in children	4,944	45,928	40,658	73,251
Children under 5 with fever receiving malaria treatment	7,494	130,257	106,716	184,561
Children 12-23 months with full immunization coverage	2493	35039	42455	65,058
comprehensive knowledge of TB				
Comprehensive knowledge of HIV				
Use of FP modern method by married women 15-49	3,219	17,589	15,149	37,315



BOLD THINKERS DRIVING  
REAL-WORLD IMPACT