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NASARAWA STATE 2012-2016 PUBLIC EXPENDITURE REVIEW

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The Health Finance and Governance Project
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NASARAWA STATE 2012-2016 PUBLIC EXPENDITURE REVIEW

DISCLAIMER

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ACRONYMS

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

EXECUTIVE SUMMARY

Globally, health systems face increasing demands and responsibilities face stagnated and dwindling financial resources from both internal and external sources. Increasing population size, high level of poverty, emerging and new disease areas and costly non-communicable diseases jointly contribute to the pressure faced by the health system.

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 aim at ensuring equitable access to needed health care without suffering financial hardship1. Nasarawa State, like many other states, is in the process of embracing health financing policy reform directives 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 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:

- 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

[1] (WHO 2017) Universal Health coverage

- To make recommendations on improved public health expenditure

Methodology

The PER team was constituted with members drawn from the State Ministry of Health, Ministry of Finance, Budget and economic planning, office of the Auditor General for Local Government Areas (LGA), Nasarawa State Agency for the Control of AIDS (NASACA) 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, 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 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

- The data from the LGA was not sufficient for in-depth analysis of health financing at that level.
- Budgets were not linked to expected outputs and outcome/targets, making it challenging to assess the effectiveness of health expenditures.
- Budget and financial statements were not separated into program and intervention areas making it difficult to map out expenditure allocated based on this criteria; this problem is more pronounced for recurrent expenditure.
- Lack of adequate data on sector performance/health outcome made it difficult to measure the developmental impact of health spending. Accuracy and completeness of available data could not be confirmed.

Assumptions

- Annual population growth rate of 3.05% from 2006 population result[2]
- Foreign Exchange Rate of N150, N170, N190 and N300 for 2013, 2014, 2015 and 2016 respectively

Main Findings

Government funding remains the dominant source of health sector financing during the period under review. The major source of revenue in the state is revenue from the federal government (statutory allocation) ranging between 75% and 92%; internally generated revenue (IGR) contributed a maximum of 12% of the accrued revenue.

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

Public health sector financing ranged between 7 -11 percent over the four-year period under review (2013-2016) meaning that the share of the health budget in the total government budget remains below the 15 percent recommended under the Abuja Declaration. Although the health budget trend occasionally reflected government's commitment to achieve its health plan as highlighted in the SHDP (2010 – 2015), actual expenditure trends shows a contrary view; the health sector budget increased from N8.22 billion in 2013 to N12.09 billion in 2014, declined to N8.91 billion in 2015 and finally to N6.93 billion in 2016. The actual health expenditure experienced a decline during the years under review; it increased slightly from N4.97 billion in 2013 to N5.11billion in 2014, dropped to N4.54 billion in 2015 and then increased slightly to N4.8 billion in 2016. With expected support from other partners in the health sector, the state planned to spend at least N7.18billion for a period of six years (2010 – 2015) to achieve its desired objective.

Large share of public health sector expenditure had been allocated and spent on recurrent investment from 2013-2016. The budgetary allocation into recurrent expenditure was from N4.5 billion in 2013 to N5.0 billion in 2016 while the budgetary allocation in capital expenditure only ranged from N1.9 billion to N4.7 billion.

Per capita health budget and expenditures had declined consistently from 2013 to 2016 and falls significantly short of the recommended benchmark to address health challenges of $86 per capita[3]. The per capita health expenditure is N2,157 ($14), N2,152 ($13), N1,856 ($10) and N1,906 ($6) in 2013, 2014, 2015 and 2016 respectively.

The performance of the health sector budget implementation was not satisfactory throughout the review period, it remains vulnerable to persistent challenges in the implementation of the capital budget. The implementation rate of the recurrent budget ranged from 42% to 60 % from 2013 to 2015. The execution performance of the capital budget has been generally lower than for the recurrent budget and experienced a sharp decline into 14% in 2015.

Recommendations

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 needs. As a state with considerably high burden of disease, the state urgently needs to invest far more than 6 % 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 % 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 especially in 2016. Execution of the development budget continues to be plagued by several impediments, such as the current practice of fragmented financing systems. The efforts should be addressed to those impediments to ensure the smooth implementation of the budget.

Strengthen the capacity of local government authorities (LGA) in the areas of financial management and procurement. Although the delivery of primary health services is largely

[3] $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*

concentrated at the local government level, the largest share of health sector financing is still managed at the state level. During the review period, limited health financing information could be tracked at LGA level.

The state could 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. Routine execution of a PER and other resource tracking initiatives such as National Health Accounts (NHA) etc. is important for gathering evidence on performance, planning and advocacy for increased resources for health.

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 PER) suggest the need to conduct further studies that will produce additional evidence for decision making.

1. INTRODUCTION

1.1 Background

Nasarawa State, like many other states in Nigeria, is in the process of embracing health financing policy reform directives introduced at the national level in order to achieve more money for health and more health for the money. Nasarawa 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.

The states 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 Nasarawa State, USAID/HFG is supporting the state to conduct health financing diagnostic in a number of important areas including a PER, public financial management assessment and a fiscal space analysis. The PER analyzes government expenditures over a period of years to assess their consistency with policy priorities, and what results were achieved.

1.2 Situation Analysis

1.2.1 History

Nasarawa State is one of the 36 States of the Federal Republic of Nigeria; Nasarawa State is in the North-Central geo-Political zone of the country with Lafia as its capital. The population of the State was put at 1,869,377 by the 2006 census with a growth rate of 3.05% per annum, the State will have a projected population of 2,524,509 by the end of 2016. There are 13 LGAs in the state (and 16 semi-independent development areas). Economic activities are predominantly commerce and farming with 85 percent of the population living in the rural areas.

1.2.2 Health status of the population

The demographics in Nasarawa State show that women of child bearing age and under five children, who are considered 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 include malaria, diarrhea, pneumonia, HIV/AIDS and TB.

Table 1: Nasarawa State Health Performance Indicators

S/N	INDICATOR	North – Central	Nasarawa	National
1	Infant Mortality rate (deaths/1000 live births)	72	81	70
2	Child mortality rate (deaths/1000 children surviving to	33	43	54

	age one)			
3	Under-five mortality rate (deaths/1000 live births)	103	121	120
4	Estimated % of children 12 – 23 months with full immunization coverage by first birthday (measles by second birthday)	31	26	23
5	Use of FP modern method by married women 15-49 (%)	14	14	10.8
6	ANC provided by skilled Health workers (% of women with a live birth in the last two years)	62.5	67.9	65.8
7	No of deliveries in health facilities (% of women with a live birth in the last two years)	44.4	44.7	37.5
8	Skilled attendants at birth (% of women with a live birth in the last two years)	50.3	48.4	43

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

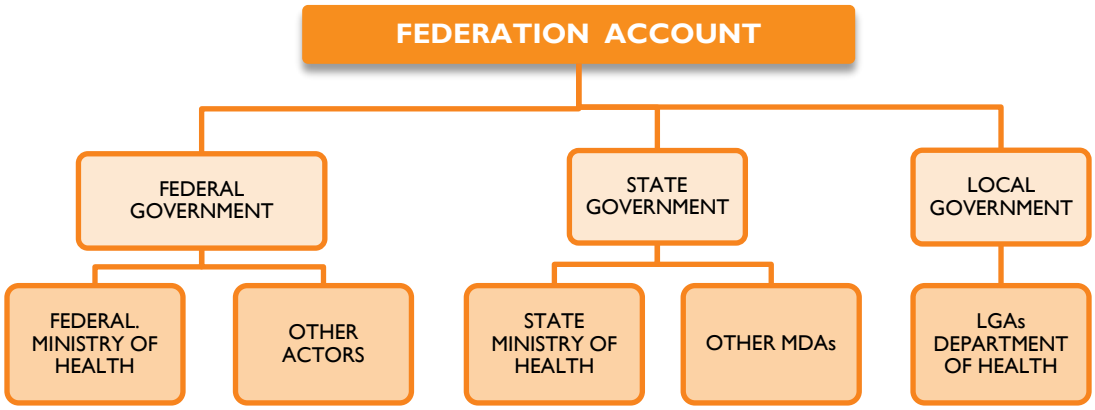
1.2.3 Overview of the State Health System

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 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 through the Federal Ministry of Health (FMoH).

It is worth noting that expenditure decisions of the three tiers of government are taken independent and the federal government has no constitutional power to compel other tiers of government to spend in accordance with its priorities and likewise, the State government cannot compel the LGAs to spend in line with its policy directives.

The Nigerian government financial system operates a structure where funds flow to the three tiers of government from what is termed the Federation Account. 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 Nasarawa State Strategic health development plan (2010 – 2015)

As contained in the SSHDP, the state is committed to becoming a state that guarantees quality health care service delivery system that drives integrated rural development; and significantly increase the life expectancy and quality of life of residents its citizens[4].

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

- Health service delivery
- Human resources for health
- Leadership and governance for health
- Finance for health
- National health management information system
- Community participation and ownership
- Partnerships for health
- Research for health

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

- Establishment of the SPHCDA and commencement of the PHCUOR structure
- Drafting of laws to establish the state supported health insurance scheme.
- Assessment and rehabilitation of health facilities
- Collaboration with development partners for health systems reform

[4] Nasarawa State Strategic health development plan 2010 - 2015

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

2. PUBLIC SECTOR EXPENDITURE REVIEW

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

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, this includes statutory allocation from the federation account, internally generated revenue (IGR), internal/external loans and other sources of revenue. The state's total revenue decreased from N67.85 billion in 2013 to N56.87 billion in 2016.

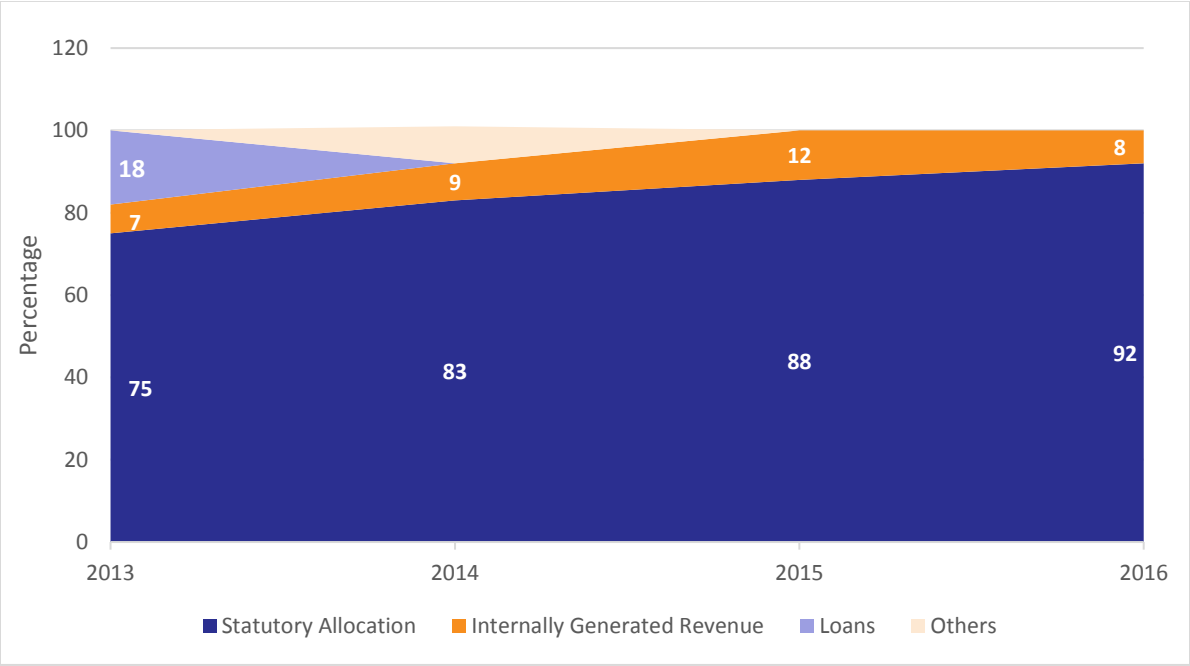
Figure 2 indicates that during the years under review, the major source of revenue in the state is revenue from the federal government (statutory allocation) accounting for between 75% and 92% of all revenue; internally generated revenue (IGR) contributed a maximum of 12% of the accrued revenue. Unlike most other states in the country, revenue from loans was only noticed during the period in 2013.

Table 2: Nasarawa State Revenue Profile 2013 – 2016

SOURCE	2013 NGN	2014 NGN	2015 NGN	2016 NGN
Loans	12,177,750,138	-	-	-
Other capital receipts	-	5,000,000,000	-	-
Statutory allocation	50,867,748,512	47,992,271,190	38,109,505,137	52,551,584,924
Internally generated revenue	4,805,624,973	5,170,242,542	5,266,118,734	4,320,569,894
Total	67,851,123,623	58,162,513,732	43,375,623,871	56,872,154,817

Source: Nasarawa State Accountant General's report

Figure 2: Nasarawa State Revenue Composition 2013-2016



2.2 State Budget and Expenditure Review

The state total budget declined during the period from N110.14 billion in 2013 to N79.3 billion in 2016 (28% decrease); analysis of the state budget shows that recurrent budget dominates the total allocation which is not in line with best practices. The share of state budget on capital expenditure decreased from 62% to 41% during the review period.

The actual expenditure decreased from N60.24 billion in 2013 to N54.43 billion in 2016; Similar to the composition of state budget, health expenditure favored the recurrent expenditure, ranging between 73% and 78% during the period under review; investment in social and economic infrastructure is required to grow the state and build its economy.

Figure 3: State Budget and Expenditure

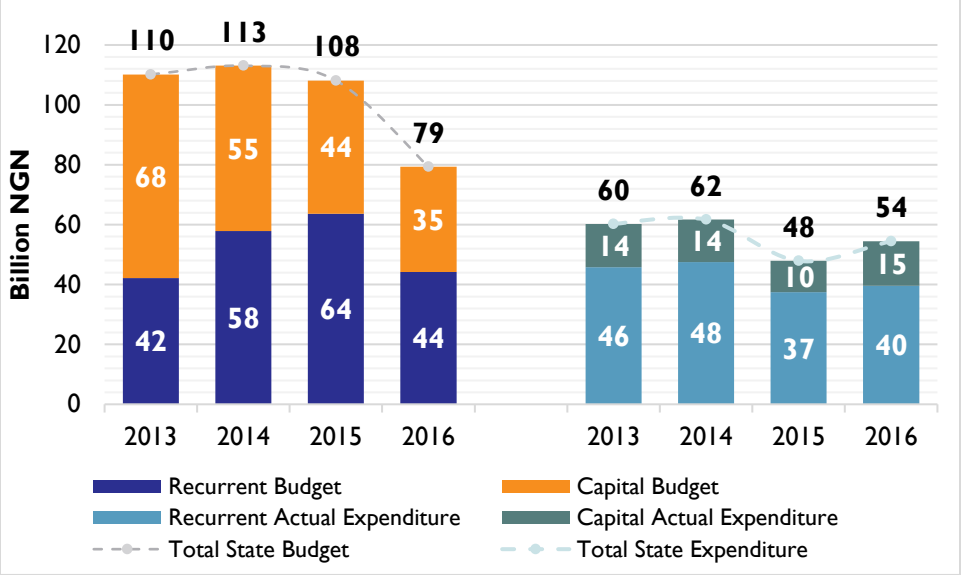
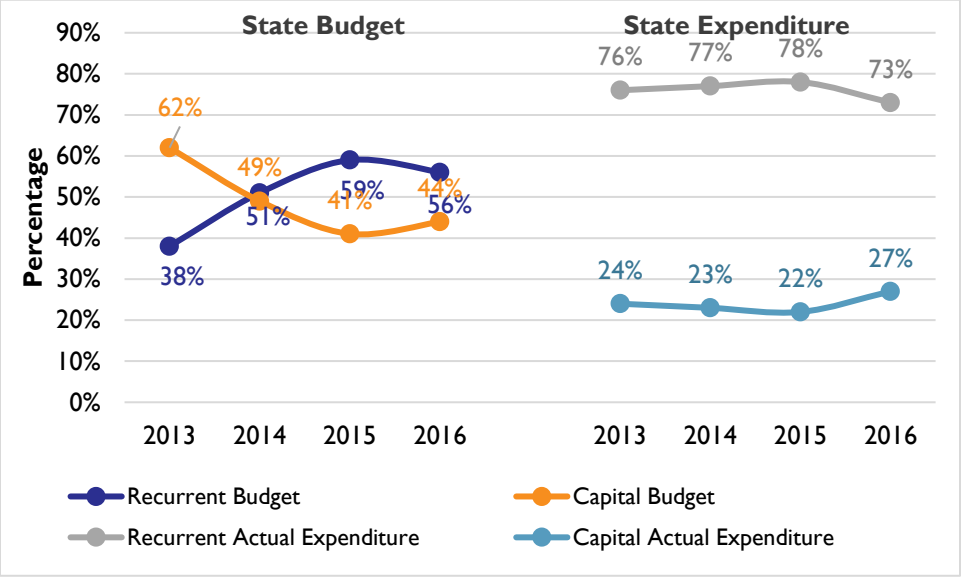


Figure 4: Composition of State Budget and Expenditure



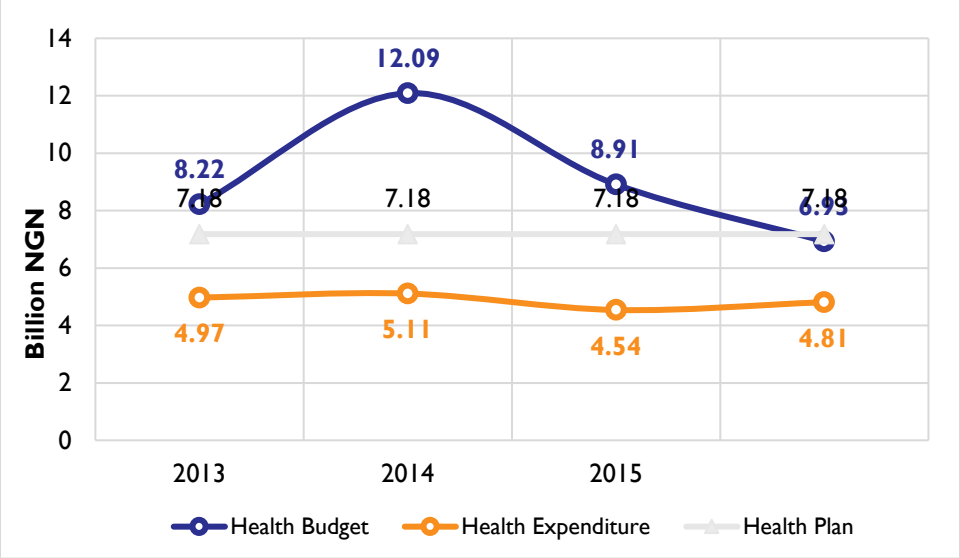
2.3 Health Sector Budget and Expenditure Review

2.3.1 Total Public Health Budget and Expenditure

Although the health budget trend sometimes reflects government's commitment to achieve its health plan as highlighted in the SHDP (2010 – 2015), actual expenditure shows a contrary view; the health sector budget increased from N8.22 billion in 2013 to N12.09 billion in 2014, declined to N8.91 billion in 2015 and finally to N6.93 billion in 2016. The actual health expenditure experienced a decline during

the years under review; it increased slightly from N4.97 billion in 2013 to N5.11 billion in 2014, dropped to N4.54 billion in 2015 and then increased slightly to N4.8 billion in 2016. Albeit expected support from other partners in the health sector, the state planned to spend at least N7.18 billion for a period of six years (2010 – 2015) in order to achieve its desired objective.

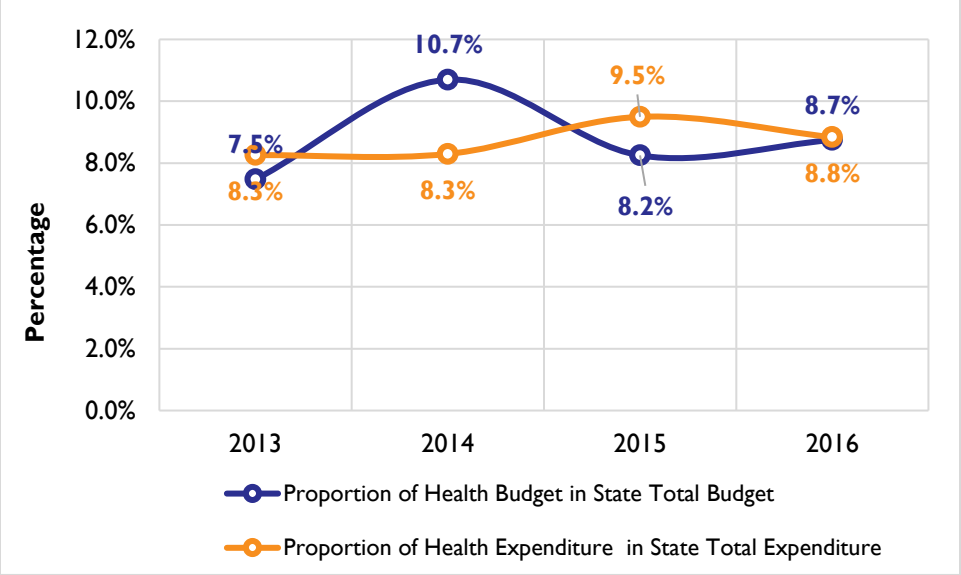
Figure 5: Health Budget and Expenditure Trend



2.3.2 Share of Health Budget and Expenditure

The share of health budget in total state government budget ranged between 7% and 11% for the period under review; the recommendation from the Abuja declaration of 2001 requires government to 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. Health expenditure as a proportion of total government expenditure fluctuated between 8% and 9%; the low investment in the health sector needs to be reversed to pave way for actualization of health objectives.

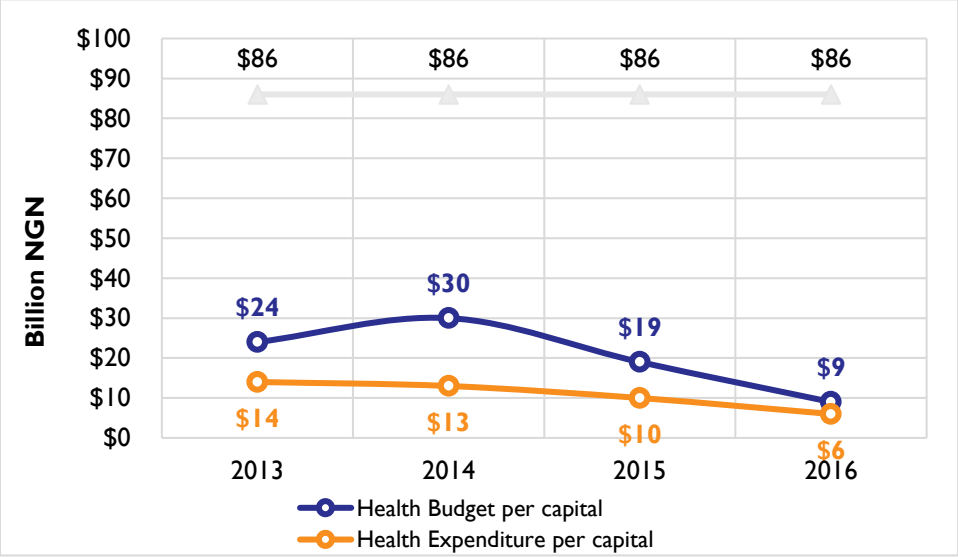
Figure 6: Share of Health in State Government Total Budget and Expenditure



2.3.3 Per capita health budget and expenditure

The per capita health budget was N3,567 ($24), N5,088 ($30), N3,641 ($19) and N2,872 ($9) respectively for each of the years under review. The per capita health expenditure is N2,157 ($14), N2,152($13), N1,856($10) and N1,906($6) in 2013, 2014, 2015 and 2016 respectively. Though higher than what is attained in some other states in the country, the per capita health expenditure is low and falls short of the WHO recommended benchmark and may therefore not guarantee a healthy and productive population.

Figure 7: : Per capita health budget and expenditure



2.3.4 Health Recurrent and Capital Budget and Expenditure

Recurrent expenditure is the major driver of the health sector budgetary allocation; analysis of the health budget shows that more funds were allocated to recurrent expenditure. The budgetary allocation into recurrent expenditure was from N4.5 billion in 2013 to N5.0 billion in 2016 while the budgetary allocation in capital expenditure only ranged from N1.9 billion to N4.7 billion.

Similarly, a huge proportion of the health spending went into recurrent expenditure; this trend is worrisome as best practice requires that a higher proportion of expenditure should be on investment activities to strengthen and sustain quality of the health sector.

Figure 8: Health Capital and Recurrent Budget Trends

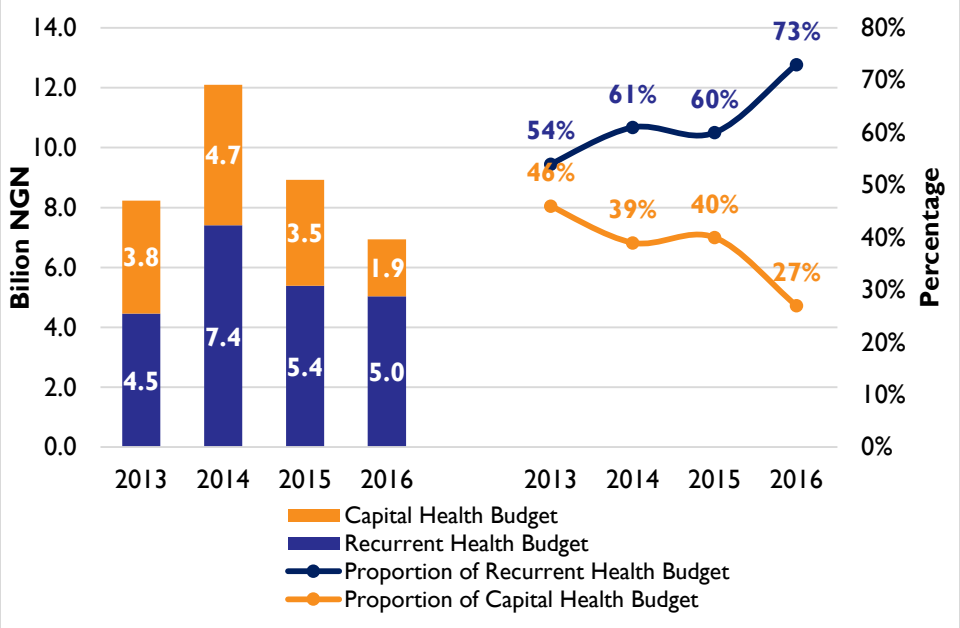
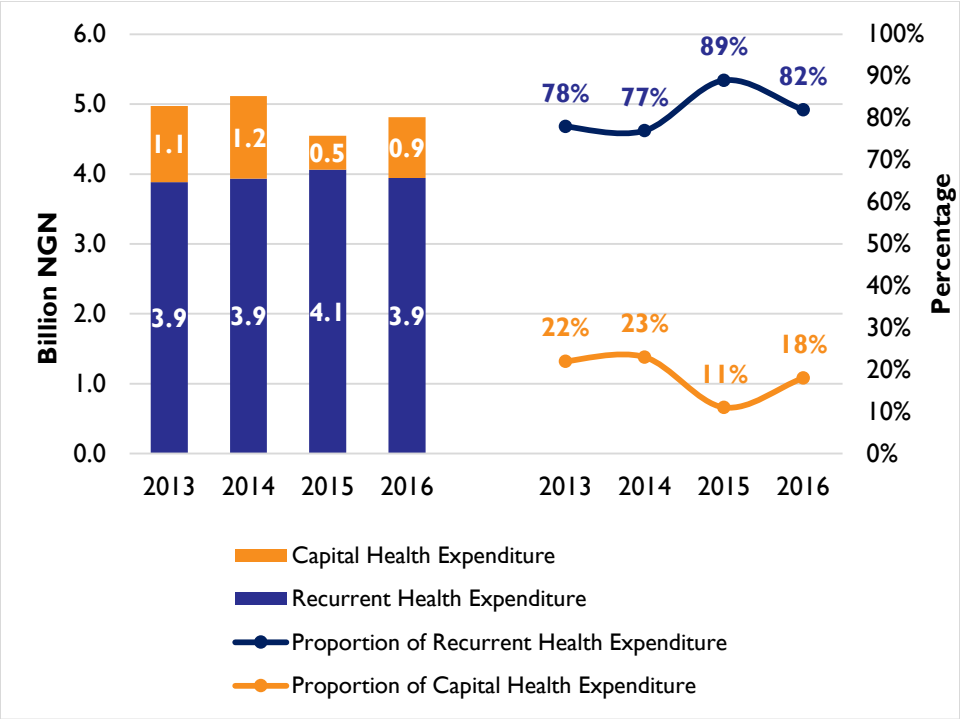


Figure 9: Capital and Recurrent Actual Expenditure Trends



2.4 Budget and Expenditure in Other Key Sectors

Allocation to health sector for the years reviewed ranged between 7% and 11% of government budget while education had 16% in 2013 and 2015 each, 19% and 21% in 2014 and 2016 respectively. The evidence therefore, suggests that health sector is not accorded the same level of priority as education sector in the state.

Actual expenditure shared similarities with the budget in terms of sectorial prioritization with the health sector again having lower expenditure figures and percentages compared to Education. Health Expenditure fluctuates between 8% and 9% throughout the period under review; Education recorded its highest proportion of 25% in 2015 and lowest of 19% in 2016. The Works and Transport sector ranked next to health sector having; both budget and expenditure data paint a revealing picture on sectorial prioritization by the state government where health does not fare badly compared to work and transport another capital resource intensive sector.

Figure 10: Budgetary Allocation to Key Sectors in Nasarawa State

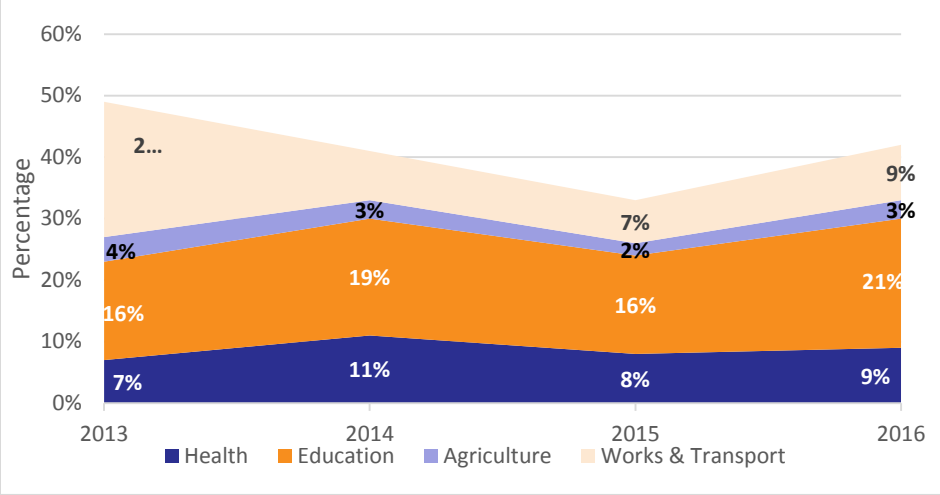
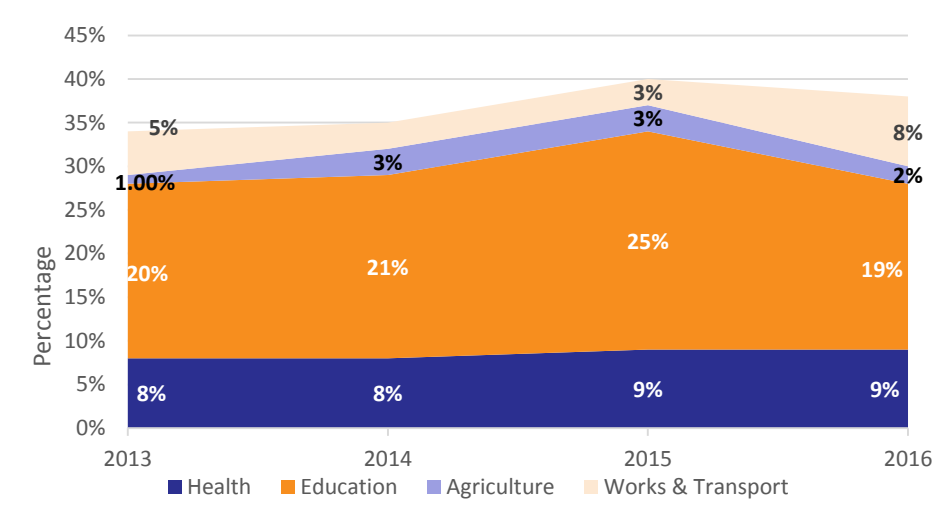


Figure 11: Key sectors' Actual Expenditure



2.5 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). For the period under review, the state budget implementation ranged between 44% and 69%; overall, recurrent budget performed better than the capital budget with highest implementation rate for the recurrent budget in 2013 at 108% (overspend) and lowest at 59% in 2015. The capital budget on the other hand had its highest in 2016 at 42%. Across the key sectors, recurrent bit of the budget also performed better than the capital.

In general, performance of the health sector budget has been lower than satisfactory throughout the review period, especially in 2014, the implementation rate was only 53%. The implementation rate of the recurrent budget ranged from 42% to 60 % from 2013 to 2015. The execution performance of the capital budget has been generally lower than for the recurrent budget and experienced a sharp decline

into 14% in 2015, where needs attention to address the causes of delays in the implementation of the health capital budget.

Table 3: Budget Performance Rates Across Different Sectors

Implementation Rates (%)	2013	2014	2015	2016
State Overall	108	82	59	90
Capital	21	26	23	42
Recurrent	55	55	44	69
Health	87	53	75	78
Capital	29	25	14	46
Recurrent	60	42	51	69
Works and Transport	40	34	66	45
Capital	11	19	21	62
Recurrent	12	20	23	62
Agriculture	49	78	75	59
Capital	0	16	0	0
Recurrent	19	49	58	22
Education	96	83	73	65
Capital	2	5	24	42
Recurrent	71	60	68	61

2.6 Health Financing at Local Government Authority Level

LGAs receive Federal allocation through the Ministry 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.

Dearth of data from the LGA precludes analysis of activities at the PHCs/LGA level; as gathered from the few financial statements made available from some LGAs, a feature of LGA health expenditure is that bulk of the expenditure is recurrent (salaries).

3. NASARAWA STATE HEALTH SYSTEM'S PERFORMANCE AND EFFICIENCY REVIEW

The efficiency of state's health system is essential in meeting its health goals with limited resources. State level efficiency of health system is concerned with understanding how well the state is using resources to accomplish the objectives of their health system. The need to develop reliable assessment of efficiency is important, given the state 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 Ebonyi 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 indictors were identified in Ebonyi and compared across all the HFG funded states. This section reviews the following three aspects of Ebonyi 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. 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 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 Nasarawa State Population Health

3.1.1 Nasarawa State Population Health Status

Overall maternal and children health status in Nasarawa state was getting better from 2013 to 2016. The infant mortality rate was decreasing from 35.7 deaths per 100,000 live births in 2013 to 3.8 deaths per 100,00 livebirths in 2016. The children under five mortality rates had similar trend, the rate decreased from to 45.1 deaths per 100,00 livebirths in 2013 to 5.3 deaths per 100,00 livebirths in 2016. The maternal mortality rate reduced 70.5 deaths per 100,00 livebirths in 2012 to 52.1 deaths per 100,00 livebirths in 2016. The infectious disease became less prevalent during the review period.

Table 4: Health Performance Indicators in Nasarawa State

Indicators	2013	2014	2015	2016
Infant Mortality Rate (MR)	35.7	9.5	4.7	3.8
Under five mortality Rate (U-5MR)	45.1	13.3	6.6	5.3
Maternal mortality Rate(MMR)	70.5	62.7	55.4	52.1
Malaria Prevalence	67.3%	66.7%	65,6%	66.9%
HIV Prevalence	11.8%	8.3%	3.4%	2.0%

Source: State Ministry of Health

3.1.2 State Population Health Status Comparison Among HFG Selected States

Comparing the health status in Nasarawa state to other HFG investigated states, in general, Nasarawa state has worse maternal and childhood conditions with lower maternal and children mortality rate. The table below shows that the infant mortality rate and children under five mortality rates was higher than the national average. Therefore, directing health financing towards child and maternal health is a reasonable strategy.

Table 5: 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[5]	HIV Prevalence (%) [6]
Nasarawa	N/A	81	121	8.1
Plateau	N/A	55	80	2.3
Zamfara	N/A	104	210	0.4
Ebonyi	576	47	62	0.9
Akwa Ibom	450	42	73	6.5
Kogi	544	92	153	1.4
Osun	165	78	101	1.6
Oyo	108.4	59	73	5.6
Kebbi	490	111	174	0.8
Sokoto	1500	51	119	6.4
Bauchi	705	39	53	0.6
Benue	1318	70	82	5.6
National Average	814	70	120	3.4

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

3.2 Nasarawa State Service Delivery

3.2.1 Nasarawa State Health Service Delivery/Provision

3.2.1.1 Maternal, Newborn and Child Health Service

Maternal and child service provision increased in some areas during the review period in Nasarawa state. Table 6 shows that, during the review period, 65.5 % of women age 15-49 years with a live birth in the last two years received antenatal care by all kinds of skilled provider during the pregnancy in 2011-

[5] Multiple Indicator Cluster Survey (MICS) 2015-2016
[6] NARHS 2012 https://naca.gov.ng/nigeria-prevalence-rate/

2012, then it increased to 67.9 percent in 2016. Similarly, the percentage of women age 15-49 years who delivered by skilled assistant was 35.1 percent in 2011-2012 and then increased to 48.4 percent in 2016. Children full immunization coverage was 14.1 percent in 2011-2012, then increased to 21.4 percent in 2016-2017.

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

Percentage	2011-2012	2016-2017
Women who received ANC by skilled health workers	65.5	67.9
Received HIV counselling During ANC	45.4	49.9
Skilled Attendant Assisted at delivery	35.1	48.4
Children 12 – 23 months with full immunization coverage	14.1	21.4

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 2013 and 2015, outpatient facility attendance increased from 144,843 to 1,039,230 although it later dropped to 738,657 in 2016; inpatient care increased from 15,412 to 160,447; 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; this is the only way to confirm if the increase in utilization is worth celebrating.

3.2.2 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 above average in Nasarawa state. In 2016, there were 67.9 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, 49.9 percent of them received HIV counselling during the antenatal care provision and 48.4 percent of them received assistance from skilled attendant during their delivery. However, there was only 21.4 percent of children age 12-23 months who received all vaccinations recommended in the national immunization schedule by their first birthday.

Table 7: State Health Service Provision Comparison Among HFG Selected States

State Name	Antenatal Care Coverage [7]	Full immunization coverage[8]	Received HIV counselling During ANC [9]	Skilled Attendant Assisted at delivery [10]
Nasarawa	67.9	21.4	49.9	48.4
Plateau	61.3	30.6	40.4	47.3
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
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
Benue	67.5	37.0	57.6	62.8
National Average	65.8	22.9	41.0	43.0

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

3.3 Nasarawa State Health Financing

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, Nasarawa state spent 8.5 percent of general government expenditure into health sectors which was lower than the benchmark while the percentage compared favorably with other states. However, the average per capita public health expenditure was $ 10.8 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.

[7] 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
[8] 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
[9] 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
[10] 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

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
Nasarawa	8.5	10.8
Plateau	4.8	6.5
Zamfara	6.0	5.0
Ebonyi	8.5	8.0
Akwa Ibom	4.3	13.0
Kogi	5.4	7.7
Osun	7.8	10.8
Oyo	9.5	6.5
Kebbi	8.0	6.3
Sokoto	11.0	8.1
Bauchi	9.0	12.5
Benue	8.5	6.3
National standard	15.0	97.0

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

4. RECOMMENDATIONS

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 described below.

4.1 Highlighted Findings

4.1.1 General trend of health financing

The share of health budget in total state government budget ranged between 7 – 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 this recommendation. Health expenditure as a proportion of total government expenditure fluctuated between 8 percent and 9 percent.

The recurrent health expenditure is the major driver of budgetary allocation and actual expenditure. The low investment in capital health expenditure needs further political attentions. The implementation rate of recurrent expenditure was generally higher than the implementation rates of capital expenditures. In general, performance of the health sector budget has been lower than satisfaction throughout the review period, especially in 2014, the implementation rate was only 53 percent.

4.1.2 Per capita health budget and expenditures

The per capita health budget was N3,567 ($24), N5,088 ($30), N3,641 ($19) and N2,872 ($9) respectively for each of the years under review. The per capita health expenditure is N2,157 ($14), N2,152 ($13), N1,85 6($10) and N1,906 ($6) in 2013, 2014, 2015 and 2016 respectively. Though higher than it is for some other states in the country, the per capita health expenditure is low and falls short of the WHO recommended benchmark and may therefore not guarantee a healthy and productive population.

4.1.3 Budget performance

In general, performance of the health sector budget has been lower than satisfaction throughout the review period, especially in 2014, the implementation rate was only 53 percent. The implementation rate of the recurrent budget ranged from 42 percent to 60 percent from 2013 to 2015. The execution performance of the capital budget has been generally lower than for the recurrent budget and experienced a sharp decline into 14 percent in 2015, where needs attention to address the causes of delays in the implementation of the health capital budget.

4.1.4 Health System Performance

The children and maternal health status was improved in Nasarawa from 2013 to 2016 with a slightly increased maternal and children service provision rate. Compare the health status in Nasarawa state to other HFG investigated states, in general, Nasarawa state has worse maternal and childhood conditions with higher infant mortality rate and children under five mortality rates and lower child immunization service provision rates. Nasarawa state spent 8.5 % of general government expenditure into health which was lower than the benchmark and the average per capita public health expenditure was $ 8 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 and sustainable impact.

4.2 Recommendations

4.2.1 Macro Fiscal Context

Overreliance on statutory allocation as a main source of revenue for the state is inimical to the growth of the financial strength of the state due to volatility of oil revenue accruable to the country. Loan on the other hand increases government's future commitment hence reduction in amount available for planned interventions. Improved IGR will go a long way to expand the fiscal space 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 N360m by the state calls for a review of the state revenue generation mechanism.

4.2.2 Increase Government expenditure on Health

Both budget and expenditure trend in the state show that health is not being accorded the priority it 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 9% 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 Prioritize preventive care at the PHCs over curative care at the secondary facilities

Public health expenditure in the state is tilted towards secondary health care; although hospital care is necessary for the minimum service package, a better balance needs to be found. 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[11]. The state will benefit more by investing more on capital projects and supervision of activities at the PHCs level in order to reduce the prevalence of preventable diseases; the current effort by the

[11] (WHO) Declaration of Alma-Ata 1978

State Government to ensure PHCUOR policy is fully operational is a right step in the right direction at achieving UHC.

4.2.4 Ramp up 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.

4.2.4.1 Coordination

Absence of strong coordination platform to monitor health resources from all sources results in wastages that may arise from duplication of efforts and inefficiencies in provision of services; 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.

4.2.4.2 Institute mechanism to track allocation, expenditure and outcome

As in many developing countries, Nasarawa state government has very limited capacity to measure the impact of public expenditure and most agencies only focus on reporting how inputs have been used rather than highlighting outcomes achieved. In view of this, the HMIS/M&E team needs to be better engaged and empowered in order to identify the most feasible way to link performance to productivity, one way to achieve this is to introduce performance-based financing.

4.2.5 Further Reviews

Some of the findings of this assessment 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 unravel 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.

ANNEX A: 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	42,187,155,717	38	57,902,835,894	51	63,660,526,713	59	44,167,697,329	56
Capital	67,959,516,910	62	55,173,556,074	49	44,473,475,091	41	35,134,153,269	44
Total State Budget	**110,146,672,627**	100	**113,076,391,968**	100	**108,134,001,804**	100	**79,301,850,598**	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	45,749,865,878	76	47,530,807,238	77	37,444,218,237	78	39,615,122,739	73
Capital	14,494,557,575	24	14,132,956,047	23	10,437,027,233	22	14,824,832,095	27
Total Health Expenditure	**60,244,423,453**	**100**	**61,663,763,285**	**100**	**47,881,245,470**	**100**	**54,439,954,834**	**100**

ANNEX B: 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	376,251,089	5	4,951,022,775	41	4,090,178,250	46	3,651,337,817	53
Overhead	4,082,900,000	50	2,454,406,251	20	1,302,019,261	15	1,388,782,000	20
Total Recurrent	4,459,151,089	54	7,405,429,026	61	5,392,197,511	60	5,040,119,817	73
Capital	3,770,000,000	46	4,690,720,000	39	3,527,566,810	40	1,896,940,000	27
Total Health Budget	8,229,151,089	100	12,096,149,026	100	8,919,764,321	100	6,937,059,817	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	3,775,724,602	76	3,819,443,328	75	3,576,857,565	79	3,730,445,587	78
Overhead	106,042,721	2	113,600,000	2	484,750,000	11	210,903,659	4
Total Recurrent	3,881,767,323	78	3,933,043,328	77	4,061,607,565	89	3,941,349,246	82

Capital	1,093,717,090	22	1,182,524,894	23	485,528,179	11	870,097,573	18
Total Health Expenditure	4,975,484,413	100	5,115,568,222	100	4,547,135,744	100	4,811,446,819	100

ANNEX C: 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	8,229,151,089	7	12,096,149,026	11	8,919,764,321	8	6,937,059,817	9
Education	17,091,738,449	16	21,602,562,033	19	17,792,305,338	16	16,485,090,734	21
Agriculture	4,424,583,683	4	3,361,557,642	3	2,130,249,499	2	2,485,284,917	3
Works and Transport	23,715,853,682	22	8,774,151,926	8	7,336,751,445	7	6,777,856,670	9
Others	56,685,345,724	51	67,241,971,341	59	71,954,931,201	67	46,616,558,460	59
Total State	110,146,672,627	100	113,076,391,968	100	108,134,001,804	100	79,301,850,598	100

Budget								
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	4,975,484,413	8	5,115,568,222	8	4,547,135,744	9	4,811,446,820	9
Education	12,129,387,202	20	12,982,537,799	21	12,178,227,118	25	10,128,940,140	19
Agriculture	820,928,994	1	1,649,753,271	3	1,225,293,966	3	992,963,098	2
Works and Transport	2,843,181,128	5	1,785,749,238	3	1,674,734,359	3	4,170,139,394	8
Others	39,475,441,716	66	40,130,154,755	65	28,255,854,283	59	34,336,465,382	63
Total State Expenditure	60,244,423,453	100	61,663,763,285	100	47,881,245,470	100	54,439,954,834	100

ANNEX D: KEY PERFORMANCE INDICATORS - STATE

DETAILS	**2013**	**2014**	**2015**	**2016**
	N	N	N	N
Health Budget	8,229,151,089	12,096,149,026	8,919,764,321	6,937,059,817

Health Expenditure	4,975,484,413	5,115,568,222	4,547,135,744	4,811,446,820
Projected Population	2,306,922	2,377,283	2,449,790	2,524,509
Exchange Rate (NGN/$)	150	170	190	300
Health budget per capita (NGN)	3,567	5,088	3,641	2,748
Health Budget per capita ($)	24	30	19	9
Health Expenditure per capita (NGN)	2,157	2,152	1,856	1,906
Health Expenditure per capita ($)	14	13	10	6

ANNEX E: RECURRENT AND CAPITAL EXPENDITURE IMPLEMENTATION REPORT

STATE

DETAIL	2013			2014			2015			2016	
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Ex
Total Recurrent	42,187,155,717	45,749,865,878	108	57,902,835,894	47,530,807,238	82	63,660,526,713	37,444,218,237	59	44,167,697,329	39
Capital Expenditure	67,959,516,910	14,494,557,575	21	55,173,556,074	14,132,956,047	26	44,473,475,091	10,437,027,233	23	35,134,153,269	14
Total	110,146,672,627	60,244,423,453	55	113,076,391,968	61,663,763,285	55	108,134,001,804	47,881,245,470	44	79,301,850,598	54

HEALTH

DETAIL	2013			2014			2015			2016	
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expend
Total Recurrent	4,459,151,089	3,881,767,323	87	7,405,429,026	3,933,043,328	53	5,392,197,511	4,061,607,565	75	5,040,119,817	3,941,3
Capital Expenditure	3,770,000,000	1,093,717,090	29	4,690,720,000	1,182,524,894	25	3,527,566,810	485,528,179	14	1,896,940,000	870,097
Total	8,229,151,089	4,975,484,413	60	12,096,149,026	5,115,568,222	42	8,919,764,321	4,547,135,744	51	6,937,059,817	4,811,4

WORKS AND TRANSPORT

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	433,386,727	171,480,113	40	766,871,727	258,459,074	34	257,221,727	170,203,146	66	327,417,861	148,555,053	45
Capital Expenditure	23,282,466,955	2,671,701,016	11	8,007,280,199	1,527,290,165	19	7,079,529,718	1,504,531,213	21	6,450,438,809	4,021,584,341	62
Total	23,715,853,682	2,843,181,129	12	8,774,151,926	1,785,749,238	20	7,336,751,445	1,674,734,359	23	6,777,856,670	4,170,139,394	62

AGRICULTURE

DETAIL	2013			2014			2015			2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	1,688,083,683	820,928,994	49	1,787,557,642	1,391,114,671	78	1,625,949,499	1,225,293,966	75	1,667,284,917	989,133,098	59
Capital Expenditure	2,736,500,000	0	0	1,574,000,000	258,638,600	16	504,300,000	0	0	818,000,000	3,830,000	0

Total	4,424,583,683	820,928,994	19	3,361,557,642	1,649,753,271	49	2,130,249,499	1,225,293,966	58	2,485,284,917	992,963,098	22

EDUCATION

DETAIL	2013	2014			2015					2016		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
Total Recurrent	12,592,738,449	12,044,892,679	96	15,200,762,033	12,690,218,222	83	16,240,980,536	11,806,771,007	73	14,042,270,734	9,106,926,705	65
Capital Expenditure	4,499,000,000	84,494,524	2	6,401,800,000	292,319,577	5	1,551,324,802	371,456,111	24	2,442,820,000	1,022,013,434	42
Total	17,091,738,449	12,129,387,203	71	21,602,562,033	12,982,537,799	60	17,792,305,338	12,178,227,118	68	16,485,090,734	10,128,940,139	61

ANNEX F: BUDGET BY HEALTH MDAS

2013

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MINISTRY OF HEALTH	376,251,089	4,082,900,000	4,459,151,089	3,770,000,000	8,229,151,089
	TOTAL	376,251,089	4,082,900,000	4,459,151,089	3,770,000,000	8,229,151,089

2014

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	509,687,313	462,391,251	972,078,564	3,540,000,000	925,036,287
2	DASH	2,001,258,548	155,950,000	2,157,208,548	161,220,000	1,624,503,855
3	Hospitals Management Board	2,331,818,044	135,550,000	2,467,368,044	126,500,000	1,824,401,442
4	Primary Health Development Agency	34,088,938	1,638,315,000	1,672,403,938	622,000,000	999,814
5	School of Nursing	34,880,000	15,000,000	49,880,000	220,000,000	269,880,000
6	School of Health Tech.	28,832,823	10,900,000	39,732,823	-	39,732,823
7	NASACA	10,457,109	36,300,000	46,757,109	21,000,000	67,757,109

	TOTAL	4,951,022,775	2,454,406,251	7,405,429,026	4,690,720,000	12,096,149,026

2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of health	375,426,270	627,870,000	1,003,296,270	2,876,500,000	3,879,796,270
2	Dalhatu araf specialist hospital	1,768,628,495	213,000,000	1,981,628,495	22,566,810	2,004,195,305
3	SPHCDA	34,088,938	307,360,000	341,448,938	420,000,000	761,448,938
4	NASACA	10,457,109	28,500,000	38,957,109	31,000,000	69,957,109
5	HMB 1	1,837,864,615	105,570,000	1,943,434,615	81,300,000	2,024,734,615
6	School of health tech keffi	28,832,823	8,950,000	37,782,823	21,200,000	58,982,823
7	School of nursing & midwifery	34,880,000	10,740,000	45,620,000	75,000,000	120,620,000
8	General hospitals	-	29,261	29,261	-	29,261
	TOTAL	4,090,178,250	1,302,019,261	5,392,197,511	3,527,566,810	8,919,764,321

2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	387,615,841	737,640,000	1,125,255,841	1,447,500,000	2,572,755,841
3	Dalhatu araf specialist hospital	1,677,592,266	213,500,000	1,891,092,266	73,740,000	1,964,832,266
4	Hospitals mgt board	1,528,809,287	84,450,000	1,613,259,287	21,500,000	1,634,759,287
6	School of Nursing & Midwifery	5,577,600	7,420,000	12,997,600	25,000,000	37,997,600
7	SOHT Keffi	5,832,823	5,020,000	10,852,823	13,500,000	24,352,823
8	SPHCDA		200,811,000	200,811,000	309,000,000	509,811,000
9	NASACA		26,020,000	26,020,000		26,020,000
10	General Hospitals	45,910,000	113,921,000	159,831,000	6,700,000	166,531,000
	TOTAL	3,651,337,817	1,388,782,000	5,040,119,817	1,896,940,000	6,937,059,817

ANNEX G: EXPENDITURE BY HEALTH MDAS

2013

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	371,194,072	106,042,721	477,236,793	1,093,717,090	1,570,953,883

2	Primary Healthcare Devlopment Agency	35,296,300		35,296,300	-	35,296,300
3	Dalhatu Araph Specialist Hospital	1,640,069,680		1,640,069,680	-	1,640,069,680
4	Hospitals Management Board	1,722,473,855		1,722,473,855	-	1,722,473,855
5	School of Nursing and Midwifery	3,850,695		3,850,695		3,850,695
6	NASACA	1,190,000		1,190,000		1,190,000
7	School of Health Tech	1,650,000		1,650,000		1,650,000
	TOTAL	3,775,724,602	106,042,721	3,881,767,323	1,093,717,090	4,975,484,413

2014

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	651,038,217	18,000,000	669,038,217	1,112,419,892	925,036,287
2	Dalatu Araf specialist hospital	1,468,553,855	62,000,000	1,530,553,855	54,658,047	1,624,503,855
3	Hospitals management board	1,698,851,442	20,400,000	1,719,251,442	15,366,955	1,824,401,442
4	Primary Health Development Agency	999,814	6,600,000	7,599,814		999,814
5	School of Nursing					

		-	4,800,000	4,800,000		4,800,000
6	School of Health Tech., Keffi	-	1,800,000	1,800,000		1,800,000
7	NASACA	-	-	-	80,000	80,000
	TOTAL	3,819,443,328	113,600,000	3,933,043,328	1,182,524,894	5,115,568,222

2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of health	346,845,190	7,500,000	354,345,190	485,528,179	839,873,369
2	Dalhatu Araf Specialist Hospital	1,630,479,176	55,000,000	1,685,479,176		1,685,479,176
3	SPHCDA	2,568,388	6,000,000	8,568,388		8,568,388
4	NASACA	-	250,000	250,000		250,000
5	Hospitals Management Board	1,596,964,811	412,700,000	2,009,664,811		2,009,664,811
6	School of Health Tech Keffi	-	900,000	900,000		900,000
7	School of Nursing & Midwifery	-	2,400,000	2,400,000		2,400,000
	TOTAL	3,576,857,565	484,750,000	4,061,607,565	485,528,17	4,547,135,74

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2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	325,577,230	102,563,659	428,140,890	870,097,573	1,298,238,463
3	Dalhatu Araf Specialist, Hospital	1,685,078,252	60,000,000	1,745,078,252		1,745,078,252
4	Hospitals Management Board	1,719,407,479	27,000,000	1,746,407,479		1,746,407,479
5	Central store		3,100,000	3,100,000		3,100,000
6	School of Nursing & Midwifery		1,800,000	1,800,000		1,800,000
7	School of Health Tech Keffi		1,440,000	1,440,000		1,440,000
8	SPHCDA	327,626	12,000,000	12,327,626		12,327,626
9	NASACA	55,000	3,000,000	3,055,000		3,055,000
	TOTAL	3,730,445,587	210,903,659	3,941,349,247	870,097,573	4,811,446,820

ANNEX H: PERFORMANCE INDICATORS

DETAILS		2013	2014	2015	2016
NUMBER OF HEALTH WORKERS					
1	No of Nurses	197	267	297	845
2	No of Midwives	8	8	36	46
3	No of Nurses/Midwives	1181	81	81	233
4	No of Doctors	392	392	392	375
5	Pharmacists	126	126	126	126
6	Medical Lab.scientists	81	79	78	79
7	Physiotherapists	5	11	11	11
8	Radiographers	15	15	15	15
9	Medical Records Technologists	145	113	100	136
SERVICE UTILIZATION					
10	Outpatient	144,843	552,866	1,239,230	738,657
11	Inpatient	15,412	36,249	39,023	160,447
12	ANC provided by skilled health work	81,511	170,826	200,966	208,187
13	No of deliveries in Health Facilities	14,546	37,972	61,159	66,245
14	No of Live Births in Health Facilities	7,104	22,318	36,105	42,246
15	No of still Births in Health Facilities	207	573	606	508
16	Skilled attendant at birth	3,667	11,584	19,501	33,150
HEALTH INDICATORS					
17	Infant Deaths	206	0	0	0
18	infant Mortality Rate (MR)	35.7	9.5	4.7	3.8
19	Under five mortality Rate (U-5MR)	45.1	13.3	6.6	5.3
20	Under 5yrs deaths	42	0	0	0
21	Maternal Deaths	13	6	5	6
22	Maternal mortality Rate(MMR)	70.5	62.7	55.4	52.1
23	Malaria Prevalence	67.3%	66.7%	65,6%	66.9%
24	TB Prevalence				33%

25	HIV Prevalence	11.8%	8.3%	3.4%	2,0%
0THER INDICATORS					
26	Diarrhea in children	2,694	2	-	-
27	Children under5 with fever receiving malaria treatment	10,460	6	-	-
33	Use of FP Modern method by married women 15-49	102,275	30,353	50,166	72,217

BOLD THINKERS DRIVING
REAL-WORLD IMPACT