



# A REVIEW OF PUBLIC EXPENDITURE MANAGEMENT IN NIGERIA

## CROSS RIVER STATE REPORT

February 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Marianne El-Khoury, Elizabeth Ohadi, Chinyere Omeogu, and Oluwaseun Adeleke for Health Systems 20/20 Project.

## Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006–2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

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### **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government



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# ACRONYMS

<b>CSO</b>	Civil Society Organization
<b>DFID</b>	Department for International Development
<b>FA</b>	Federation Account
<b>FCT</b>	Federal Capital Territory
<b>FMoH</b>	Federal Ministry of Health
<b>IGR</b>	Internally Generated Revenue
<b>LGA</b>	Local Government Authority
<b>MDAs</b>	Ministries, Departments, and Agencies
<b>MTEF</b>	Medium-Term Expenditure Framework
<b>MTSS</b>	Medium-Term Sector Strategy
<b>NGO</b>	Nongovernmental Organization
<b>PCA</b>	Principal Component Analysis
<b>PEMR</b>	Public Expenditure Management Review
<b>PHC</b>	Primary Health Care
<b>SHDP</b>	Strategic Health Development Plan
<b>SMoF</b>	State Ministry of Finance
<b>SMoH</b>	State Ministry of Health
<b>SPT</b>	Sector Planning Team
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VAT</b>	Value Added Tax
<b>WHO</b>	World Health Organization



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# EXECUTIVE SUMMARY

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

- *Budget planning and preparation:* How is the budget prepared and who is involved? Does the budget follow strategic priorities? Does civil society participate in the process?
- *Budget execution:* How much of the budgeted funds get spent? To what extent does spending follow budget planning?
- *Budget utilization:* What resources are available for service delivery? How are funds utilized at the level of the various agencies and service delivery institutions?

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

The PEMR exercise was specifically designed to engage the active participation of all country stakeholders and international partners in the process. The terms of reference for this study and the design of the exercise were developed using a consultative process involving multiple partners, namely the Nigerian government, DFID/PATHS2, the World Bank, World Health Organization, USAID, United Nations International Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA).

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

This report presents the findings of the PEMR in Cross River state, located in southern Nigeria. The state has 18 LGAs. Approximately 81 percent of health facilities in the state operate as public institutions owned by either the federal, state, or local government. More than two-thirds of PHC facilities are owned by the LGAs. All aspects and components of the state's health care system presently require improvement: infrastructure, equipment, power, water, and manpower development. The state has one of the highest maternal and infant mortality rates in the country. There is a large brain-drain of health workers, hospitals are ill-equipped, and training policies are weak. The PEMR revealed additional weaknesses that partly explain the poor state of health services in Cross River.

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

### ***Budget preparation and planning***

- As a result of low investments in health over the past two years, the share of health in the overall state budget has decreased from 7.8 of the total budget in 2008 to about 4.9 percent in 2010. This decrease in the budget is inconsistent with the strategic priorities of the Cross River state government, as highlighted by the Strategic Health Development Plan (SHDP).
- The fact that the majority of state and LGA revenues originate from statutory allocations from the Federation Account (FA) raises concerns about the state's and LGA's ability to sustain their development priorities and respond to the demand of their population. In Cross River, the state rather than the federal government determines the amount of FA funding each LGA receives.
- Political pressures drive the budget planning process at the LGA level. Although the budget preparation process in the LGAs seemingly takes into account input from health facilities, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. Per capita health budgets seem to vary significantly across LGAs.

### ***Budget execution***

- A significant amount of health funds get appropriated through other ministries, departments, and agencies (MDAs) in addition to the SMoH. It has been challenging for Cross River state to coordinate these varied and often fragmented sources of funds, so it is particularly difficult to obtain accurate and consolidated figures.
- A significant portion of the SMoH's health budget is not actually spent. Weak capital budget execution at the SMoH level, mostly attributed to a lack of political will to execute the budget and procure the resources needed, is undermining the credibility of the planning process.
- The process for releasing funds across LGAs varies. In many LGAs, health spending is largely dependent upon the priorities of the LGA chairmen. The inevitable result is large discrepancies between budgets and spending that may be attributed to changes in leadership and corresponding shifts in political priorities.

### ***Budget utilization***

- Facilities do not seem to possess much financial autonomy. They do not maintain their own budgets and thus have very little influence on actual spending. For PHC facilities, responsibility for decision making falls almost exclusively on the LGAs.
- A misallocation of health resources across LGAs reflects a system of fund allocation and budgeting that is not aligned with real demand or needs. Per capita health spending differs significantly from one LGA to another, partly due to weak budget execution in certain LGAs, and reflects the varied political priorities of LGA chairmen.
- There is evidence of a weak relationship between resources spent and facility conditions, suggesting that resources are not effectively utilized.
- Large discrepancies between recurrent spending, as reported by the state, and salary estimates in certain LGAs suggest the presence of resource leakage between the LGAs and health facilities. More accurate data are needed to confirm these claims.

The PEMR survey in Cross River is the first of its kind in the state. Although department heads at the various local governments and other key officials provided the necessary logistical support to the teams, a number of challenges were encountered during data collection. The most significant was the widespread reluctance to share financial records, especially at lower levels. In the majority of the primary and secondary facilities visited, access to financial records was very limited, and where available, data were recorded in formats that did not allow easy retrieval. Although budget numbers were made available in some cases, records on spending and actual releases were much harder to obtain. In general, the absence of accurate and detailed records on budgets and expenditures indicates that the government does not have the means to ensure that health resources are distributed equitably, efficiently, and effectively. As a result, holding government officials accountable is difficult, and leakage of funds is more likely to occur.

The following is a summary of recommendations:

- Strengthen accountability for use of public funds and financial management by reforming the current approach in budget preparation and planning at the state and local levels. A state health needs assessment would serve as an advocacy tool to guide policymakers during the budget preparation and approval process. To limit political influences, LGAs need to articulate clear outputs within the framework of the National SHDP and the state's health care policies.
- Improve transparency and understanding of the budgeting approval and funds disbursements process. The current process for budget execution and disbursement of funds is unclear and weakens the implementation of the budget and reduces its effectiveness. The current system of revenue allocation from the state government to LGAs needs to be reviewed to allow a more equitable, transparent, and fair allocation process across LGAs.
- Improve the skills of the state and local government planning officers in participatory budgeting methodologies and in the medium-term sector strategy and medium-term expenditure framework. Clear steps should be outlined and a guideline document prepared for budget planning, execution, and monitoring, including roles of various parties in the budgeting process.
- Build capacity in sound financial management processes, tools, and techniques at the federal, state, and LGA levels. Impose adequate financial management and control mechanisms that can effectively track funds at all levels and across all MDAs in Cross River. A financial reporting manual should be developed and adopted at all levels of government. Importantly, the disbursements of resources for and on behalf of PHC facilities need to be more transparent. Facilities should be endowed with the capacity (human and financial) to maintain records of all financial transactions, both cash and in-kind.



# I. INTRODUCTION AND STUDY OBJECTIVES

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

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

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

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

- *Budget planning and preparation:* How is the budget prepared and who is involved? Does the budget follow strategic priorities? Does civil society participate in the process?
- *Budget execution:* How much of the budgeted funds get spent? To what extent does spending follow budget planning?
- *Budget utilization:* What resources are available for service delivery? How are funds utilized at the level of the various agencies and service delivery institutions?

The PEMR exercise was specifically designed to engage the active participation of all country stakeholders and international partners in the process. The aim was to reach consensus over issues related to public expenditure management in Nigeria and use evidence-based approaches to improve existing systems. The terms of reference for this study and the design of the exercise were developed using a consultative process involving multiple partners, namely the Nigerian government,

DFID/PATHS2, the World Bank, the World Health Organization (WHO), USAID, UNICEF, and UNFPA.

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

## 2. OVERVIEW OF HEALTH EXPENDITURE SYSTEMS IN NIGERIA

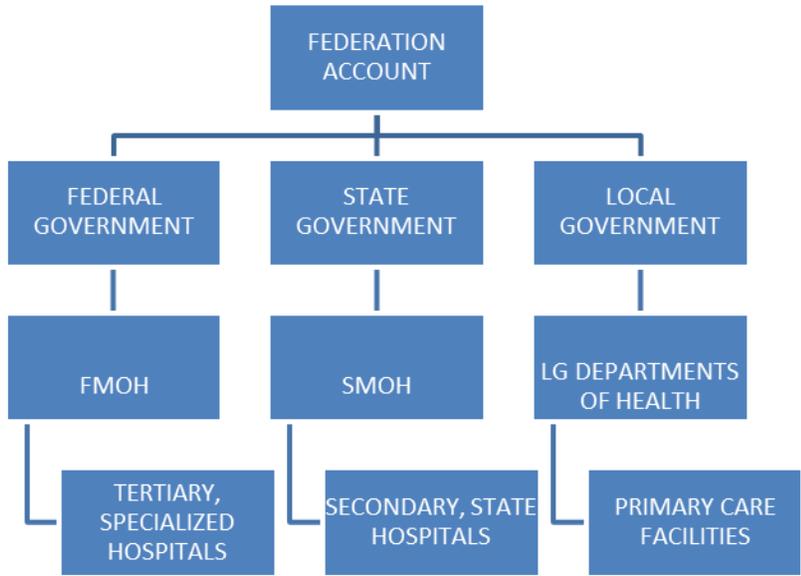
Nigeria is a federal state with three tiers of government, namely, the federal government, 36 state governments, and 774 local governments. Within the public sector, primary level health care falls under the responsibility of local government authorities (LGAs). This means that primary health care (PHC)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

The Federal Ministry of Health (FMoH), the State Ministry of Health (SMoH), and the LGA's Department of Health are each responsible for planning for and managing health spending in their respective jurisdictions. Under each of the ministries (federal and state), associated departments and agencies are referred to collectively as ministries, departments, and agencies (MDAs). The principal actors in the Nigerian public health sector are therefore the FMoH, the 36 SMoHs, the 774 LGA Departments of Health, and the authorities of the FCT, as well as various government parastatals and training and research institutions that are concerned with health matters. Figure 1 illustrates the flow of health funds through these various agencies, down to the service provision level. It is worth noting that expenditure decisions of the three tiers of government are taken independently, and the federal government has no constitutional power to compel other tiers of government to spend in accordance with its priorities.

Other important actors are the Ministry of Defense, Ministry of Education, and Ministry of Internal Affairs, which own and run extensive networks of health facilities providing treatment and care for armed forces personnel and their families, students, and prison inmates, respectively.

The private sector consists of a network of privately owned health facilities that cut across the three levels of care – primary to tertiary. They include private-for-profit as well as private-not-for-profit health care facilities, including faith-based facilities and those owned and managed by nongovernmental organizations (NGOs), as well as community-based organizations. These facilities include drug stores, pharmacies, clinics, and hospitals (FMoH 2004b). This PEMR study did not include a review of the private sector or other actors involved in the provision of health services (such as the Ministries of Defense, Education, and Internal Affairs).

**FIGURE 1: DIAGRAMMATIC REPRESENTATION OF THE FLOW OF PUBLIC EXPENDITURE IN HEALTH**



In some states (e.g., Cross River), health funds flow through other MDAs in addition to the SMOH. These include the Ministry of Education, State Agency for the Control of HIV/AIDS, Ministry of Social Welfare, Ministry of Rural Development, Department of International Donor Support under the Office of the Governor, and the Border Communities Development Agency. In other cases, the federal government funds and runs certain model primary health care centers through National Primary Health Care Development agencies. These funds are typically received for initial logistical support.

### Box I. Decentralization Arrangements and Intergovernmental Fiscal Transfers in Nigeria

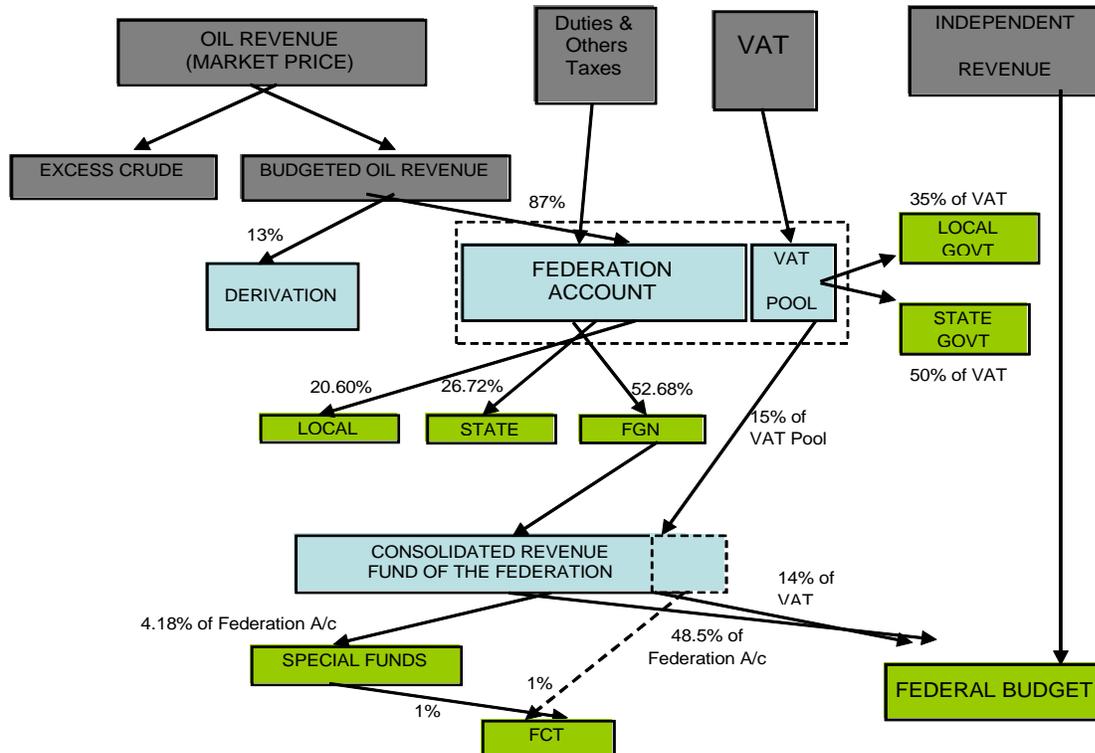
The Nigerian intergovernmental fiscal arrangement is complex, spanning a number of policies and institutional and administrative structures. These fiscal arrangements are strongly influenced by historical, political, social, and economic factors. Accordingly, the constitution assigns government functions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

Currently, 87 percent of all the budgeted oil revenues are paid to the FA and 13 percent to a Derivation Account while excess oil revenues are paid into the Excess Crude Account. Similarly, all VAT revenues net of costs of collection are paid into the VAT pool while other federally collected taxes net of costs of collection are paid into the FA.

Of funds in the FA, 48.5 percent goes to the federal government (and an additional 4.18 percent is passed through the federal government to special funds), 26.72 percent goes to the state governments, and 20.6 percent goes to the local governments. Of the funds in the VAT pool, 14 percent goes to the federal government (an additional 1 percent goes to FCT through the federal government), 50 percent goes to the state governments, and 35 percent goes to the local governments.

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

#### Distribution of Nigerian Revenues among Tiers of Government



Source: Revenue Mobilization Allocation and Fiscal Commission (RMAFC)

## 3. PEMR METHODOLOGY

### 3.1 STAKEHOLDERS' ENGAGEMENT

The effective participation and support of health sector stakeholders was considered critical to the organization of the PEMR. A committee was established to facilitate the various activities of the review. The Department of Planning, Research, and Statistics of the FMoH headed the committee, which included representatives from PATHS2/DFID, the World Bank, WHO, USAID's Health Systems 20/20 project, UNFPA, UNICEF, and the Nigerian government. The various representatives agreed on the framework, the PEMR model, and the survey questionnaires.

The committee held consultative meetings with the permanent secretaries and directors of the targeted SMOH and LGAs, as well as sensitization workshops in the selected PEMR states to engage and gain support from key stakeholders. During the workshop the stakeholders were briefed on the purpose of the PEMR and the need to cooperate with fieldworkers during data collection efforts.

### 3.2 SURVEY METHODS

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

- A survey of primary, secondary, and tertiary level facilities to collect information on facility characteristics, human resources, governance structures, and financial information using facility records when available. These surveys were administered to health facility managers.
- A survey of local- and state-level MDAs to collect information on budgeted resources and key issues related to budget preparation and execution processes. The surveys were administered to public officials at each MDA.

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

### 3.3 PREPARATORY WORK

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

Prior to the data collection process, the developed survey tools were pretested to check the respondent's level of understanding and interpretation of the questions, as well as to determine the most suitable methodology for administration, the length of the questionnaires, the number of

enumerators required, and the estimated timeline for data collection. Following the pretest, questionnaires were revised and grouped into modules for ease of data collection.

### Box 2. PEMR Survey Instruments

#### The Strategic Audit instrument –

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

- Existence of a budget and budget development
- Participatory budgeting, citizens' involvement, and issues of accountability
- Existence of strategic plans and policy documents
- Allocation of overall health resources across government agencies
- Allocation of health resources to health facilities

#### The Administrative instrument –

The Administrative instrument was designed to further inform the **budget execution** process through the collection of financial information, specifically the following:

- Government sources of funding
- IGR
- Actual government budgets released for health facilities and actual expenditures incurred by the facilities
- Capital spending on health facilities (new construction, renovation)

#### The Facility instrument –

The Facility instrument was designed to collect information on **budget utilization** at the facility level, specifically the following:

- Characteristics of the health facility (e.g., rooms, amenities, availability of basic equipment, and infrastructure)
- Human resources (e.g., professional qualifications, salary structure, official positions, gender, age, and tenure)
- Types of services provided and utilization (outpatient, inpatient)
- Facility organization and governance
- Supervision and accountability
- Facility's sources of funding
- Facility's spending
- Data sheet to calculate the value of in-kind support
- Quality of records and record keeping

## 3.4 SAMPLING AND DATA COLLECTION

The administrative and strategic audit questionnaires were administered to the relevant public offices (Planning department and Finance and Accounts) at each SMoH and within each LGA. The facility surveys were administered to six randomly selected public sector PHC facilities (three urban and three rural) in each LGA, and to all public sector secondary and tertiary level facilities in each state.

The surveys were implemented during November and December 2010. In Cross River, enumerators completed questionnaires in a total of 124 locations: 107 PHC facilities, 14 secondary health care facilities, and three tertiary facilities, along with 18 LGAs.

Field teams implemented quality control measures throughout the sampling process, as project consultants and supervisors provided logistical support for those traveling to each facility, screened

questionnaires, and sent questionnaires back to respondents when further clarification and additional data were required.

### **3.5 DATA PROCESSING AND ANALYSIS**

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

Preliminary results were validated and discussed with a number of state and LGA authorities, including representatives of the SMOH, representatives of the State Ministry of Finance (SMoF), PHC coordinators, and representatives of the State Office of the Auditor-General.

### **3.6 IMPLEMENTATION CHALLENGES**

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

## 4. MAIN RESULTS

### 4.1 OVERVIEW OF CROSS RIVER STATE

Located in southern Nigeria, Cross River state, with its capital in Calabar, was created on May 27, 1967. It shares boundaries with Benue state to the north, Enugu and Abia states to the west, Cameroon Republic to the east, and Akwa-Ibom and the Atlantic Ocean to the south. The 2005 census estimated the population of Cross River at approximately 3 million.

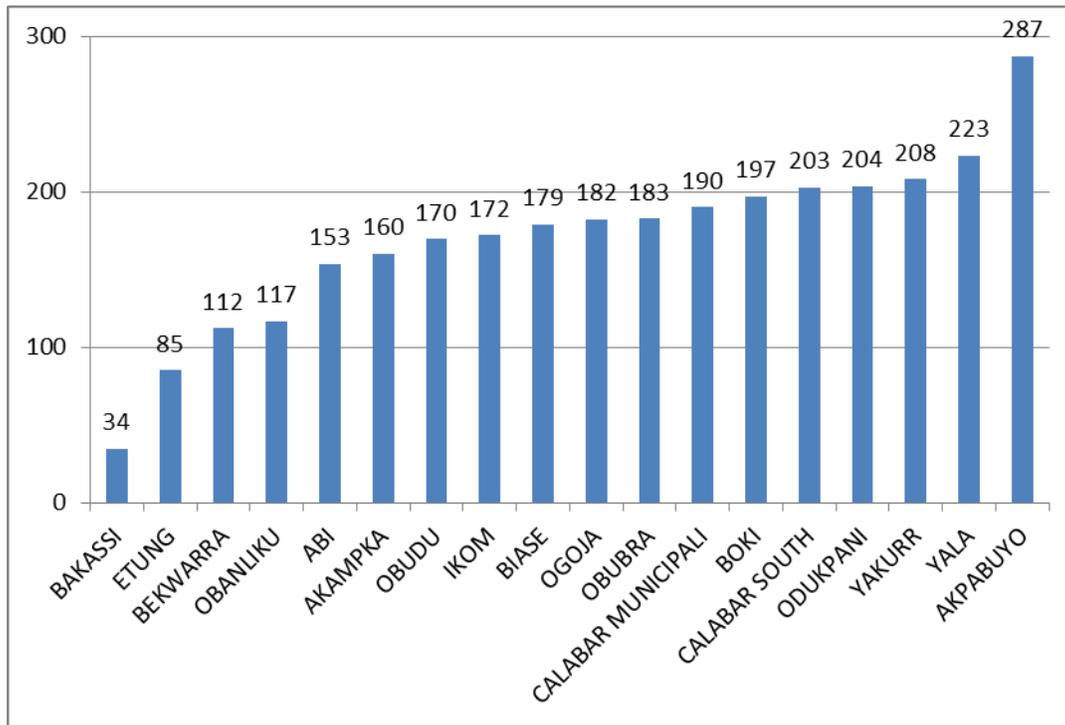
The state has 18 LGAs: Abi, Akamkpa, Akpabuyo, Bakassi, Bekwarra, Biase, Boki, Calabar Municipal, Calabar South, Etung, Ikom, Obanliku, Obubra, Obudu, Odukpani, Ogoja, Yakurr, and Yala (Figure 2).

**FIGURE 2: CROSS RIVER STATE AND LGAS**



Akpabuyo is the most populated LGA (Figure 3), with approximately 287,364 people, followed by Yala (223,249) and Yakurr (208,009). The least populated LGAs are Bakassi (34,291), Etung (84,915), and Bekwarra (112,049).

**FIGURE 3: LGA POPULATION, IN THOUSANDS (2005)**



Source: 2005 Census

The state faces a number of development challenges including a weak industrial base and a low rate of investment which has left much of the economic resources of the state largely underutilized. Socioeconomic progress is further depressed by a poor infrastructure for communication, transportation, electricity supply, water supply and sanitation, in addition to continued communal conflicts within and across state boundaries. Over 70 percent of the state’s population lives below the national poverty line, and health care service delivery is below international standards (SMoH, 2010).

Cross River state, like the rest of Nigeria, has a broad health care delivery system, comprising a wide range of service providers, including public, private for-profit, and faith-based organizations. Health care providers vary, from traditional birth attendants and medicine hawkers to specialists in teaching hospitals. The distribution of health facilities in the state by type and ownership is shown in Table I. The majority (78.4 percent) of the 735 health facilities in the state are PHC facilities, 21.4 percent are secondary, and 0.3 percent are tertiary health care facilities.

The majority (81 percent) of health facilities in the state operate as public institutions owned by either the federal, state, or local government while privately owned health facilities (19 percent) are owned by private individuals and NGOs. All PHC facilities are owned by the LGAs, with the exception of the Comprehensive Health Centre at the University of Calabar Teaching Hospital, which is owned by the federal government.

**TABLE I: HEALTH FACILITIES IN CROSS RIVER STATE**

Type of Facility	Ownership					Total
	Federal	State	LGA	Public	Private	
Tertiary	2	0	0	2	0	2
Secondary	1	16	0	17	140	157
Primary	1	0	575	576	0	576
Totals	4	16	575	595	140	735

Source: Cross River State Ministry of Health

The administrative structure of the public health system in the state is informed by the provisions of the National Health Policy (FMOH 1988, FMOH 2004a, FMOH 2004b). Within the decentralized system established by these policies, the LGAs are responsible for PHC facilities and the state government is responsible for secondary health facilities, while the responsibility for tertiary health facilities belongs to both the federal and state governments.

Apart from the SMOH and LGAs, other important actors in the state's public health sector are the Ministry of Education, State Agency for the Control HIV/AIDS, Ministry of Social Welfare, Ministry of Rural Development, Department of International Donor Support under the Office of the Governor, and the Border Communities Development Agency (a federal agency that ensures the sustainable social, economic, and infrastructural development of border communities in Nigeria). These organizations provide funding for health infrastructure and programs or serve as a channel through which donor funds are passed to the health sector. It has been challenging for Cross River state to coordinate these varied and often fragmented sources of health funding.

Health status indicators reveal the poor health status of Cross River state. Maternal and child mortality rates rank Cross River state among the worst in Nigeria. The common causes of infant mortality include preventable diseases such as malaria, measles, malnutrition, diarrhea, and pneumonia. Available data indicate a malaria prevalence of 19.8 percent and a TB prevalence of 0.07 percent. The state's HIV prevalence of 8 percent is the highest in the country (SMoH, 2010).

All aspects and components of the state's health care system presently require improvement: infrastructure, equipment, power, water, and manpower development. There is a large brain-drain of health workers, hospitals are ill-equipped, and training policies are weak. The National Health Insurance Scheme is still in its infancy and has yet to have significant impact on the health of Cross Riverians.

## 4.2 DATA COLLECTION AND VERIFICATION

The PEMR survey in Cross River state is the first of its kind in the state. Heads of the health departments at the various local governments and other key officials provided the necessary logistical support to the teams. However, a number of challenges were encountered during data collection, the most significant of which was a reluctance to share financial records, especially at lower levels (facilities and LGAs). In the majority of the primary and secondary facilities visited, access to financial records was very limited, and, where available, data were recorded in formats that did not allow easy retrieval. This was particularly the case at the LGA levels. Facilities were often unwilling to share budget or expenditure records.

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

- Rural facilities were often difficult for the field teams to reach due to poor road infrastructure.
- Securing appointments with facility heads or administrative staff to respond to the survey was challenging because most of the facilities visited were understaffed, which made it very difficult for the respondents to allocate time to complete the questionnaires.
- The time period provided for enumerators to collect data was insufficient; several visits were required to obtain the necessary information.

As a result of these challenges, the findings presented in the remainder of this report should be interpreted with caution. Nonetheless, regardless of the findings below, the lack of transparency as evidenced by the collection exercise and the absence of well-kept and easily accessible financial records are already symptomatic of a weak and fragmented financial management system. It is worth adding that similar challenges were encountered in the two other states where the project has conducted a PEMR (Nasarawa and Sokoto).

### 4.3 BUDGET PLANNING AT THE STATE LEVEL

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

***The Cross River State Strategic Health Development Plan forms the basis of the current health plan and budget of Cross River state.*** The health sector plays an important role in the development agenda of Cross River state government. Specifically, the provision of quality and affordable health services is a key priority of the health policy formulation process. The Cross River state Strategic Health Development Plan (SHDP) supports the reform agenda of the state government through eight thematic goal areas following the framework of the National SHDP. Cross River state reordered these goal areas based on the specific developmental concerns and aspirations of the state as well as a situational analysis of the state health sector's strengths and weaknesses. The priority areas in order of importance for Cross River state are health service delivery, human resources for health, finance for health, national Health Management Information System, health research, health leadership and governance, partnership for health, and community participation (SMoH, 2010).

Implementation of the Cross River state SHDP is considered the responsibility of the state, LGAs, private health care providers, health development partner agencies in the state, NGOs, and civil society organizations (CSOs), while the state and LGAs provide leadership through the coordination of the various activities of the many organizations to ensure efficiency.

***The government of Cross River state adopted a Medium-Term Sector Strategy (MTSS) in 2000 and a Medium-Term Expenditure Framework (MTEF) in 2006 as an integrated approach to budgeting and public financial management.*** The MTSS and MTEF are multiyear strategic and budget planning tools aimed at ensuring that health sector budget preparations are based on actual performance benchmarks. The adoption of an MTSS and MTEF is essential for the development of demand-driven budgets. These were embraced by Cross River state as a means to institutionalize good governance in resource mobilization, allocation, and utilization.

The SMOH prepares its budget with the assistance of its Sector Planning Team (SPT) and in consultation with relevant stakeholders. All directors within the SMOH are members of the SPT. Each secondary health facility prepares its own budget in consultation with the SMOH and with the assistance of the SPT.

**Civil society is represented in strategic planning.** According to the Strategic Audit survey, civil society participated in the development of both the SHDP and the MTEF. There is a network of CSOs in the state, including as many as 25 organizations focused on budgeting, transparency, and accountability. The special advisor on budget at the state level invites the CSOs to participate in budget preparations with the MDAs, including the SMOH. Beyond serving as members of the strategic planning committee, civil society additionally is involved in organizing public consultations and meetings.

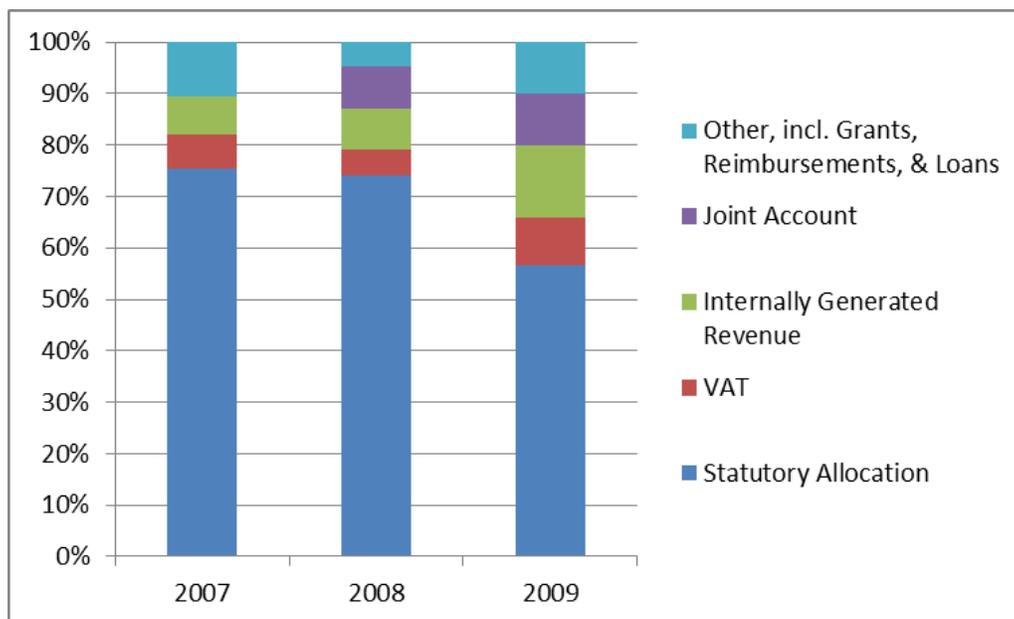
**Cross River state heavily relies on revenues received from the Federation Account.** On average, more than two-thirds of total revenues are allocations from the FA (joint state and local government accounts also derive from the FA). It should be noted that allocation to states occurs at the federal level through the Revenue Mobilization and Allocation Commission using predetermined indicators that do not take into account state input. Other revenue sources for Cross River include IGR, VAT revenue, and grants from local and international partners (Table 2). Contributions from the FA decreased from about 75 percent of total state income in 2007 and 2008 to 56 percent in 2009 (Figure 4). In contrast, IGR as a share of state income increased by 7 percentage points from 2007 to 2009. Excess crude oil revenue is a highly volatile source of income due to the potential for rapid fluctuations in international oil prices. Diminished excess crude oil revenues accounted for 24 percent of the 30.7 billion in decreased revenue from 2008 to 2009.

**TABLE 2: CROSS RIVER'S TOTAL REVENUES BY SOURCE, 2007–2009 (IN MILLION NAIRA)**

Receipts	2007	2008	2009
Statutory Allocation to State	34,780	45,683	21,548
VAT	3,055	4,108	4,677
Internally Generated Revenue	3,396	6,448	7,106
Joint State & Local Governments Account	0	6,695	5,101
Excess Crude Oil	0	14,598	7,155
Grants & Reimbursement	4,204	39	2,496
Internal & External Loans	358	1,331	2,217
Others	278	2,498	435
<b>Total Receipts</b>	<b>46,070</b>	<b>81,400</b>	<b>50,736</b>

Source: Cross River State Auditor General's Report 2010

**FIGURE 4: CROSS RIVER STATE REVENUE PROFILE 2007–2009**



Source: Cross River State Auditor General's Report 2010

**Health allocation in 2010 constituted about 4.9 percent of the total budget for the state, down from 7.8 percent in 2008** (Table 3). The increase in the health budget over the years has clearly not kept up with the pace of increase in the overall state budget. The lack of political will to support health service delivery and strengthen the health system is reflected in the limited budgetary commitments for health over the years (SMoH, 2010). The limited health budget is hence inconsistent with the strategic priorities of the government as highlighted by the SHDP.

**TABLE 3: CROSS RIVER'S STATE BUDGET, 2007–2010**

	State total budget	Health allocation	Health allocation (in % of total)
2007	42,888,255,050	3,067,603,230	7.2%
2008	104,450,087,020	8,105,415,860	7.8%
2009	107,021,984,521	4,019,630,998	3.8%
2010	78,032,669,068	3,807,510,541	4.9%

Source: Cross River State Auditor General's Report 2010

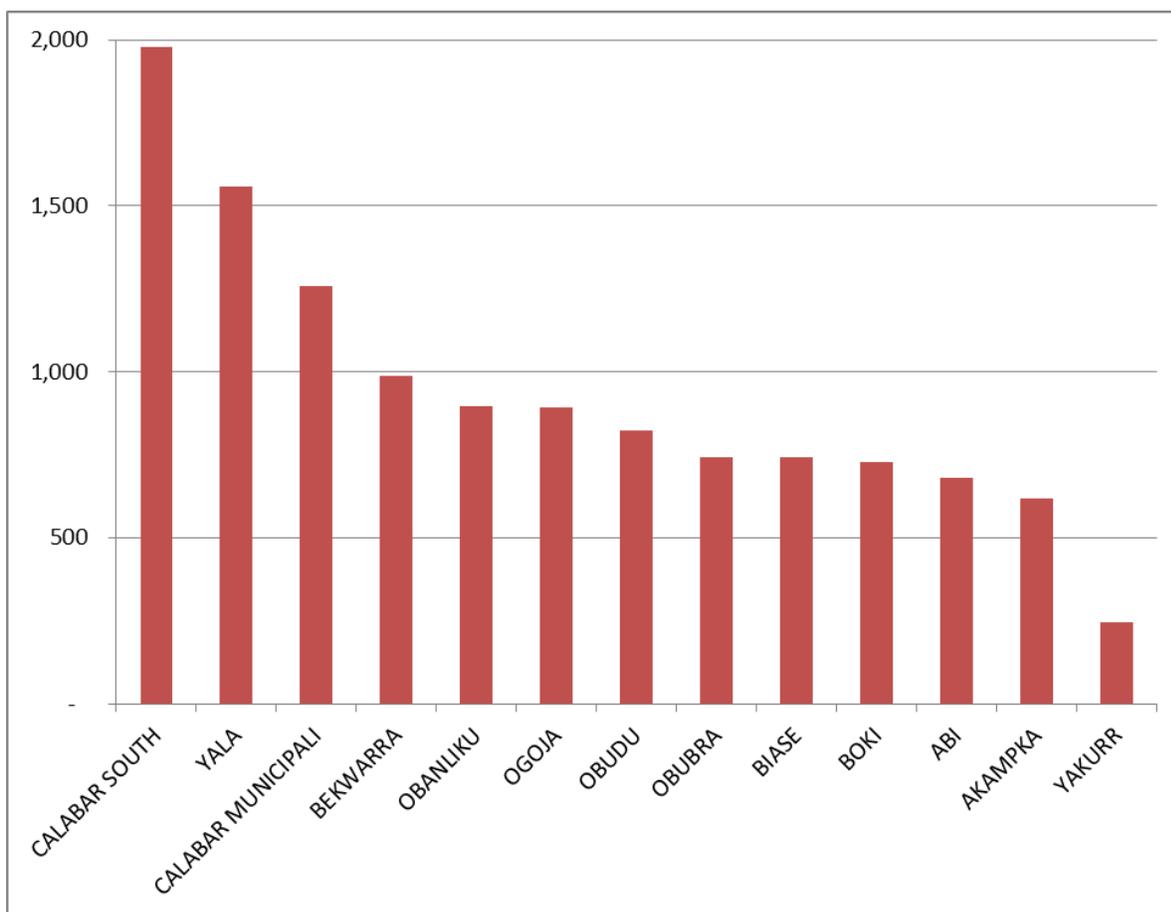
#### 4.4 BUDGET PLANNING AT THE LGA LEVEL

In Cross River state, the PHC coordinator(s) at the local government receive input from health facilities regarding their budget needs. The PHC coordinator and LGA department heads then form a budget planning committee to identify priority activities and line items to include in the draft budget sent to the chairman. Following the chairman's review, the result, at least on paper, is an approved budget. After the budget is approved, the LGA department heads and PHC coordinator send proposals to the chairman for line items in the approved budget. Upon approval from the chairman, funds are released by the LGA for spending.

**Political pressures drive the budget planning process at the LGA level.** Additional consultations with state and LGA authorities revealed that LGAs in fact do not rely on strategically informed plans. Instead, planning is primarily driven by political influences with significant interference from higher political figures at both the local and state levels. Specifically, although the heads of various LGA departments typically develop and submit budgets on an annual basis, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. Follow-ups are rare once budgets are submitted. Actual releases to health facilities are done in a discretionary manner and depend heavily upon the political priorities of the LGA chairmen.

**Per capita health budgets in 2009 varied significantly across LGAs.** Figure 5 shows the per capita health budget in 2009 by LGA. A majority (69 percent) of LGAs had a budget within 500 and 1,000 Naira per person. Yakurr is at the lower end with a total budget of less than 300 Naira per person. In contrast, a few LGAs, including Calabar Municipali, Yala, and Calabar South, have a per capita budget five to eight times as large (approximately 1,200 to 2,000 Naira).

**FIGURE 5: PER CAPITA HEALTH BUDGET IN 2009, SELECTED LGAS (IN NAIRA)**



Source: LGAs  
 Figures for Akpabuyo, Bakassi, Etung, Ikom, and Okukpani were N.A.

**Similar to the state’s revenue situation, local governments receive most of their funding from the Joint Account** (which mainly derives from the FA). In 2009, on average, 63 percent of total revenue for LGAs in Cross River was allocated from the FA. It is important to note that the process for allocating

funds from the FA to LGAs in Cross River varies from the allocation process for other states in Nigeria discussed in a previous section. The state, rather than the federal government, determines the amount of FA funding each LGA receives.

**In summary**, while the budget preparation process at the state level follows a strategic plan and CSO members are involved in setting strategic priorities, the lack of political will to support health service delivery and strengthen the health system is reflected in the limited budgetary commitment of the state. On paper the budget preparation process in the LGAs takes into account input from health facilities, however, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. This may partly explain why per capita health budgets vary significantly across LGAs. For both the state and the LGAs, the majority of revenues originate from the FA, raising concerns about the state's and LGA's ability to sustain their priorities and respond to the demand of their population. In Cross River, the state rather than the federal government determines the amount of FA funding each LGA receives.

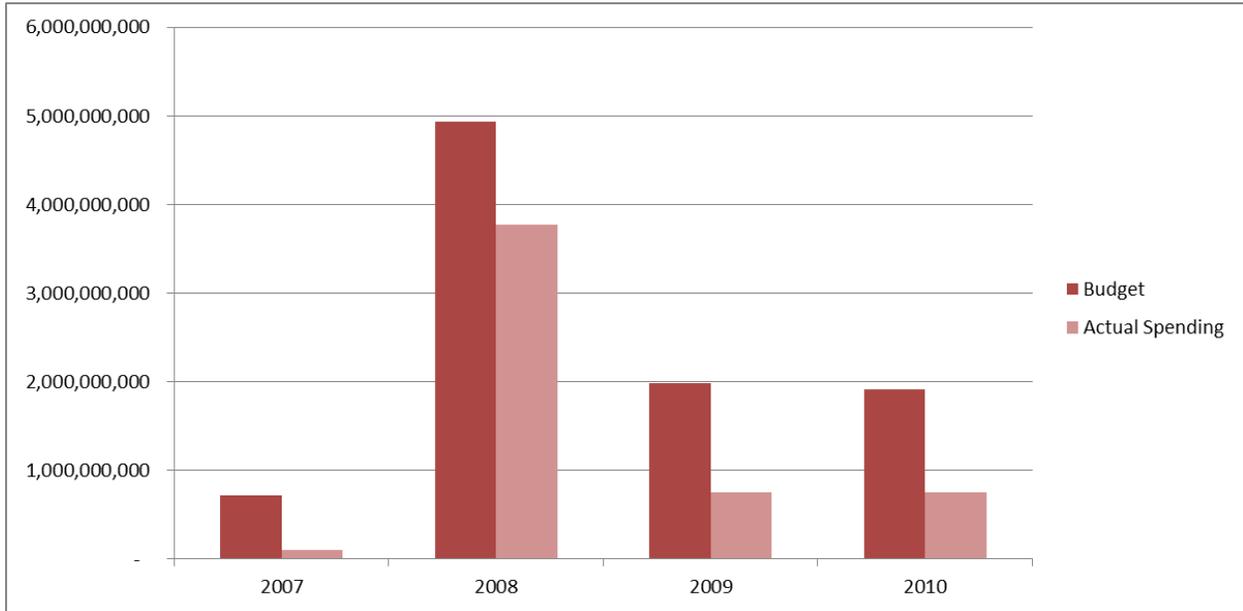
#### 4.5 BUDGET EXECUTION AT THE STATE LEVEL

**The state does not maintain consolidated records on health spending.** In addition to the SMoH, other MDAs in Cross River appropriate funds to implement health-related activities. These MDAs include the State Ministry of Education, State Agency for the Control HIV/AIDS, Ministry of Social Welfare, Ministry of Rural Development, the Department of International Donor Support under the Office of the Governor, and the Border Communities Development Agency. While these other MDAs are implementing health activities, the state does not coordinate or track all health-related spending across the MDAs. It is therefore difficult to know the actual amount of spending that goes to health.

**A significant portion of the SMoH's health budget is not actually spent.** According to data provided by the Budget Office and Office of the Accountant General in Cross River state, health spending by the SMoH ranged from 63 percent of the health budget in 2007 to 73 percent in 2010. This is not particular to the health sector – in fact, according to state figures, only 62.5 percent of the total budget of the state is actually spent. These large variances in budgetary executions may be attributed to changes in leadership at the state level and corresponding shifts in political priorities and funds disbursed.

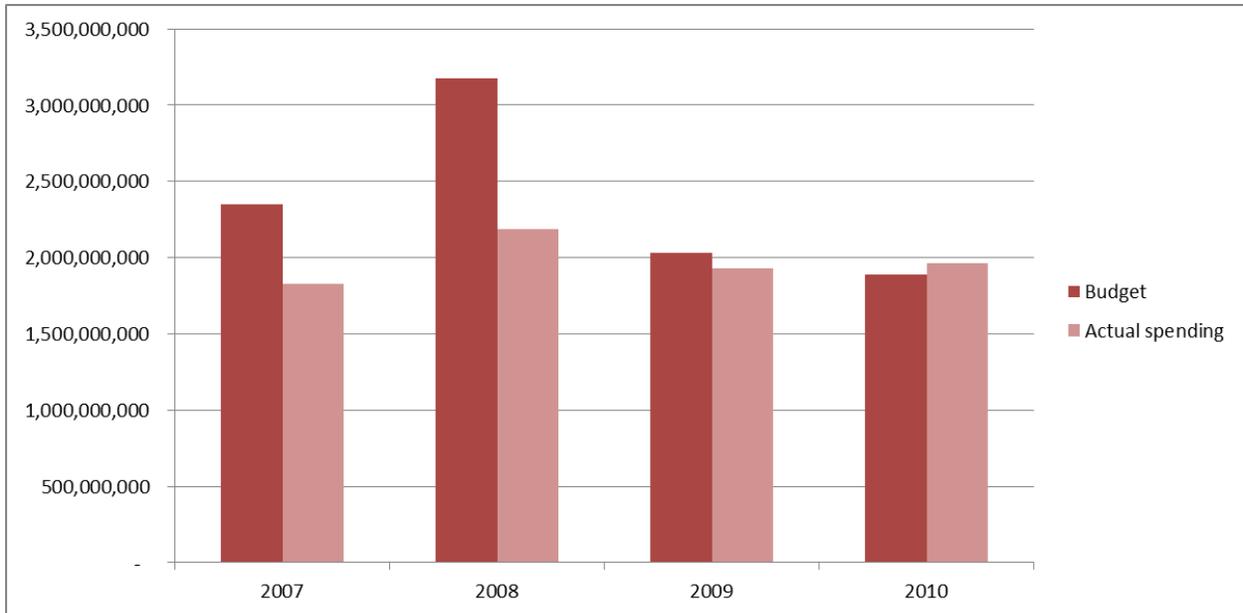
Health spending differs according to expenditure type. While recurrent spending averaged 86 percent of the budget from 2007 to 2010, capital spending averaged 42 percent (Figures 6, 7, and 8). In 2009, the health capital budget for the state was estimated around 2 billion Naira, of which less than 1 billion Naira were spent (about a 38-percent execution). The exception is 2008, in which capital spending was 76 percent.

**FIGURE 6: CAPITAL HEALTH BUDGET VERSUS ACTUAL SPENDING FOR CROSS RIVER STATE, SMOH DATA, 2007-2010**



Source: Budget Office and Office of the Accountant General, Cross River State

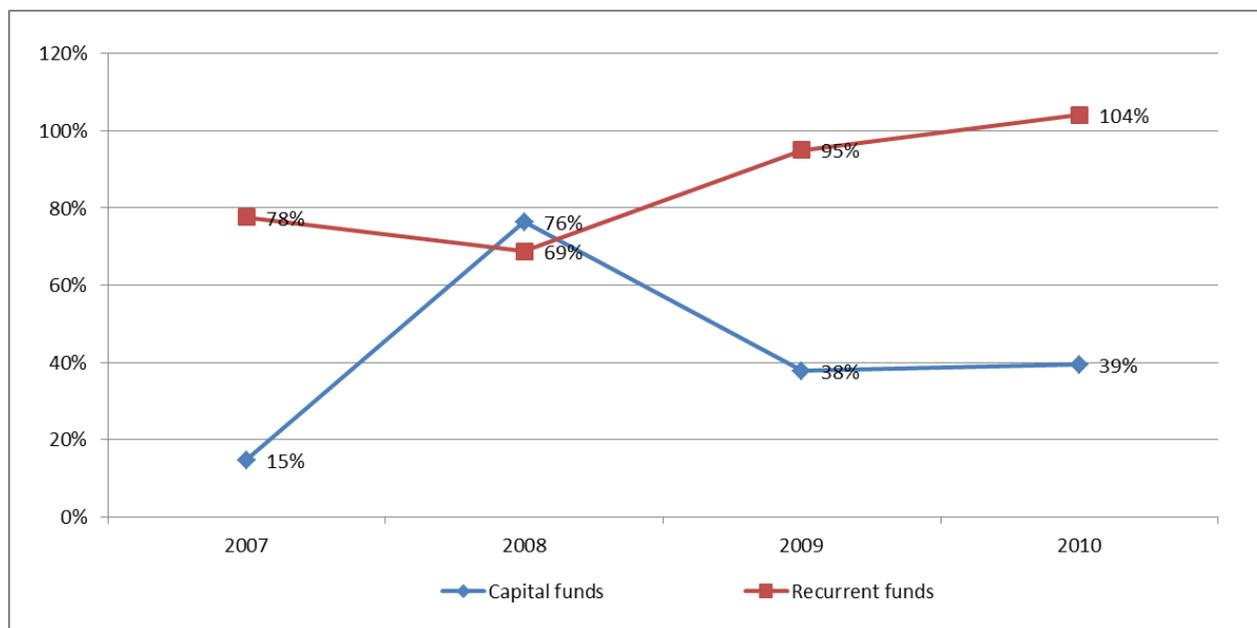
**FIGURE 7: RECURRENT HEALTH BUDGET VERSUS ACTUAL SPENDING FOR CROSS RIVER STATE, SMOH DATA, 2007-2010**



Source: Budget Office and Office of the Accountant General, Cross River State

Figure 8 shows that from 2007 to 2009, recurrent spending as a proportion of total budget averaged 84 percent while capital spending averaged only 56 percent.

**FIGURE 8: ACTUAL HEALTH SPENDING AS A PERCENTAGE OF BUDGET, CROSS RIVER STATE, SMOH DATA, 2007–2009**



Source: Budget Office and Office of the Accountant General, Cross River State

Weak budget execution is typically the result of overambitious planning, possibly driven by unrealistic political promises on spending, and/or low absorptive capacity to spend much of planned investments. In Cross River, state and LGA representatives indicated that while health budget plans were often realistic and the state had the capacity to spend resources, the lack of political will to execute the budget and procure the resources needed for health explains much of the weak budget performance (SMoH, 2010).

#### 4.6 BUDGET EXECUTION AT THE LGA LEVEL

***In many LGAs, health spending is largely dependent upon the priorities of the LGA chairmen.*** In Cross River, health facilities must submit an application to the LGA chairman when funding is needed, even when funding relates to previously identified activities in the approved LGA budget. Although some LGAs release funds to PHC facilities based on the prescription and priorities of the MTSS, in many LGAs, funds are released based on the prerogatives of the individual LGA chairmen.

***Consistent with the trends observed at the state level, health spending at the LGA level averages approximately 59 percent of the budget.*** Table 4 shows total health budget allocations and actual spending in each LGA. There is a wide variation in spending across LGAs. Actual spending in health ranges between a low of 14 percent of total budgeted funds (in Akampka) to a high of 100 percent (in Boki). This variation is seen at the level of both recurrent spending and capital spending (Figure 9). In some LGAs, such as Calabar Municipal, low budget execution is primarily driven by low capital spending, while in other LGAs, such as Yakurr and Yala, low spending is driven by the recurrent portion of the budget.

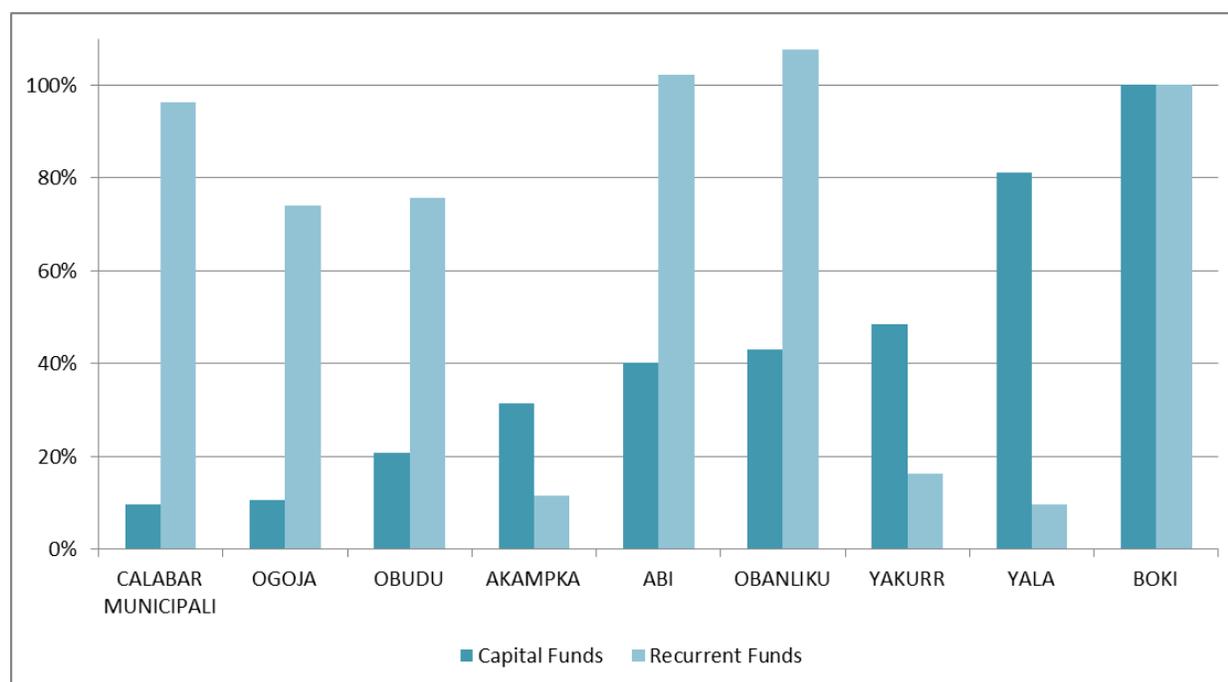
**TABLE 4: TOTAL HEALTH FUNDS IN 2009, BUDGET VERSUS ACTUAL SPENDING (IN NAIRA), SELECTED LGAS**

LGA	Budget	Actual Spending	Actual Spending as % of Health Budget
ABI	104,632,378	75,316,653	72
AKAMPKA	99,308,054	14,063,333	14
BOKI	143,774,467	143,774,467	100
CALABAR MUNICIPALI	238,984,650	211,634,160	88
OBANLIKU	104,838,972	95,804,903	91
OBUDU	139,716,198	78,521,193	56
OGOJA	162,663,592	84,818,412	52
YAKURR	51,540,000	23,872,577	46
YALA	347,743,359	80,965,797	23

Source: LGA budget documents

State and LGA authorities cited the role of LGA chairmen and their respective political priorities in releasing funds to health facilities as the main reasons for low levels of spending. These inconsistent and wide-ranging trends suggest a highly politicized process that does not respond to local needs.

**FIGURE 9: HEALTH CAPITAL AND RECURRENT BUDGET EXECUTION IN 2009, SELECTED LGAS (IN PERCENTAGES)**

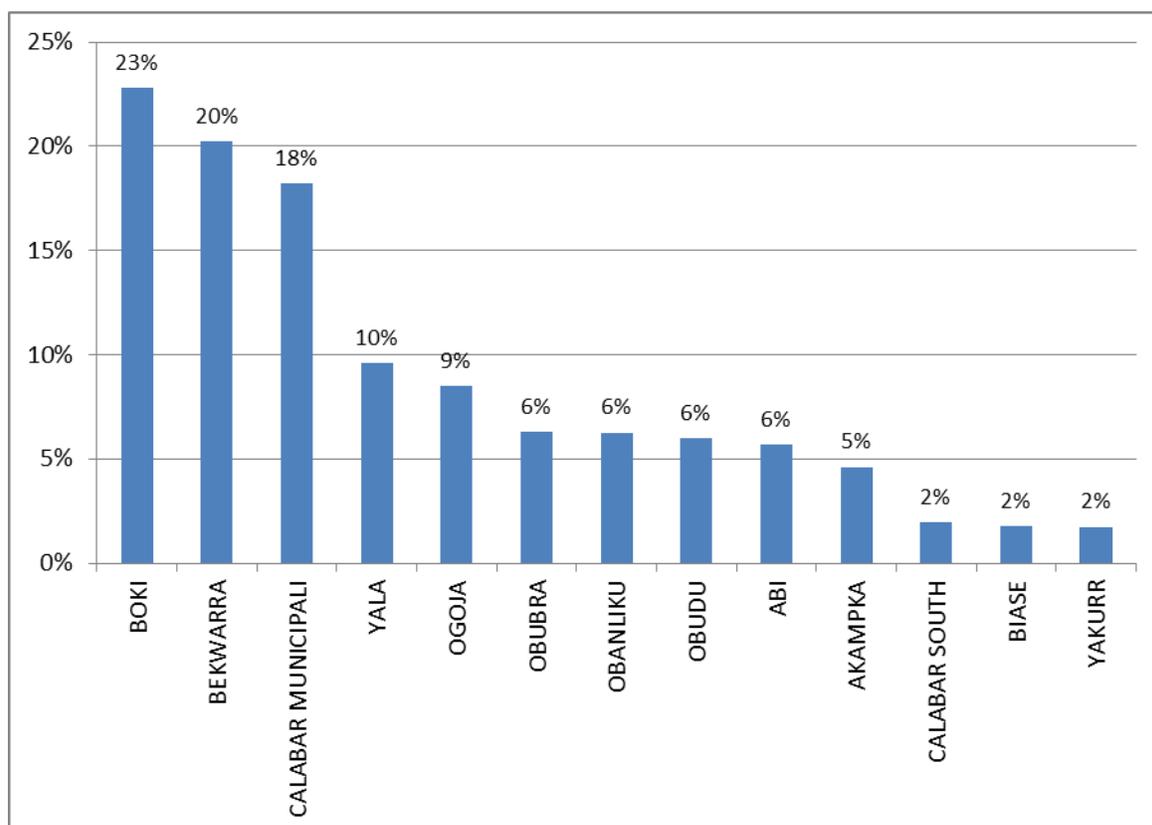


Source: LGAs

**Health spending in LGAs constitute on average about 9 percent of total spending in 2009, albeit with significant variations across LGAs.** It is also important to note that across all LGAs, health spending averaged 7 percent of the total revenues received from the FA. Figure 10 shows health spending in each LGA as a share of total spending. At the lowest end are Yakurr, Biase, Calabar South,

and Akampka, with 5 percent or less spent on health, and at the highest end are Bekwarra and Boki, with 20 and 23 percent of spending allocated to health, respectively. This wide variation could again be linked to the discretionary role that LGA chairmen play in approving the release of funds to PHC facilities.

**FIGURE 10: HEALTH SPENDING IN 2009 AS A SHARE OF TOTAL SPENDING, SELECTED LGAS IN CROSS RIVER**



Source: LGAs  
 Figures for Akpabuyo, Bakassi, Etung, and Ikrom were N.A.

**In summary**, while health funds are appropriated through other MDAs in addition to the SMoH, the state does not maintain consolidated records on health spending. Weak budget execution at the SMoH, mostly attributed to a lack of political will to execute the budget and procure the resources needed, is undermining the credibility of the planning process. Results also indicate weak budget execution at the LGA level, for both recurrent and capital spending. The process for releasing funds across all LGAs varies. In the LGAs where funds are released according to the priorities of the LGA chairmen, the large discrepancy between budgets and spending is foreseeable and inconsistent with a demand-driven budgeting process.

## 4.7 FACILITY GOVERNANCE AND FINANCES

**The majority of surveyed facilities reported having a health committee or a management board** (67 percent of tertiary facilities, 64 percent of secondary facilities, and 90 percent of PHC facilities). These committees meet regularly and discuss a variety of issues relevant to the management of the facility, such as service delivery, facility maintenance, human resources, and capital projects. On average, 11 people serve on the health committees in tertiary facilities, 25 in secondary hospitals, and 13 in PHC

facilities. Committees/boards across all facilities met an average of 15 times per year over the past two years.

Table 5 shows the composition of these committees, as reported by the facilities. Thus, 50 percent of tertiary facilities, 67 percent of secondary facilities, and 79 percent of PHC facilities reported having district or community representatives on their health committees.

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

	Tertiary (n=2)	Secondary (n=9)	Primary (n=96)
Officer in charge of facility	100.0	100.0	96.9
Other staff	50.0	77.8	75.0
District/community representatives	50.0	66.7	79.2
Parent representatives	50.0	33.3	61.5
Mosques/churches/NGOs	0.0	22.2	71.9
Local politicians	50.0	66.7	63.5

Source: Survey data

Staff meetings are held at the majority of facilities, and they occur between 4 to 10 times per year, depending on the facility. Attendance is decent: 85, 75, and 67 percent of staff attended the meeting in the last staff meeting held in tertiary facilities, regional hospitals, and primary facilities, respectively.

**Contrary to tertiary and secondary facilities that have some degree of decision-making responsibility, decision making at the PHC level falls almost exclusively on the LGA** (Table 6). At 93.5 percent, the overwhelming majority of PHC facilities reported that the primary responsibility for decision making for most of the facility-level provisions for PHC falls under the LGAs. This includes planning and preparing the budget, implementing the budget, monitoring and evaluation of the budget, setting the levels of user fees, choosing the staff to hire, and, to some extent, assessing the performance of staff and deciding on maintenance work. This probably explains why almost none of the PHC facilities reported having a budget of their own (as addressed in the next section). As seen in Table 6, the health committee/board in fact has no effective decision-making power.

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

	State	LGA	Facility Head	Health Committee / Board	Local Politician	Community
Planning and preparation of budget	8.3	91.7	0.0	0.0	0.0	0.0
Budget implementation	5.9	94.1	0.0	0.0	0.0	0.0
Designing of procedures and protocols	3.7	95.1	0.0	0.0	0.0	0.0
Budget monitoring and evaluation	7.1	90.5	0.0	1.2	0.0	0.0
Setting the level of fees at the facility	3.7	93.8	2.5	0.0	0.0	0.0
Choosing the staff to hire	7.1	92.9	0.0	0.0	0.0	0.0
Assessing staff performance	2.9	97.1	0.0	0.0	0.0	0.0
Deciding on maintenance work	4.4	94.2	1.5	0.0	0.0	0.0
<b>Overall</b>	<b>5.49</b>	<b>93.56</b>	<b>0.47</b>	<b>0.16</b>	<b>0.0</b>	<b>0.0</b>

Source: Survey data

**The survey provides evidence of some degree of accountability toward the community.** Facilities remain accountable to their clients through various ways, as listed in Table 7. Despite these mechanisms, however, LGAs remain the primary decision makers.

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

	Secondary (n=14)	Primary (n=107)
Suggestion boxes	50	24.3
Regular meetings with community	42.8	84.1
Making some citizens part of the management committee	57.1	73.8
Presentation of operations report to the community	7.1	58.9
Community participating in M&E of activities in facility	64.3	63.5

Source: Survey data

Facilities reported the number of annual supervisory visits by various government level officers. On average, facilities were visited between 4 to 5 times annually by federal-level officers (depending on the type of the facility), 2 to 9 times by LGA-level officers, 4 to 6 times by state-level officers, and 6 to 11 times by development partners. Most of these visits are routine supervision of facility management, and include monitoring and evaluation. Supervisors usually meet with the facility director, some staff, and, to a lesser extent, with patients and the community leaders. They often check facility records, and in some cases, particularly in PHC facilities, they observe consultations. A majority of facilities received written and verbal reports following supervisory visits.

**More than two-thirds of PHC facilities do not keep detailed spending records,** according to survey results. This is also true of receipts of income and subsidies from various sources (only 19 percent of PHC facilities keep such records). The lack of human resource capacity and adequate supply of material were cited as the main reasons for the absence of record keeping in the facilities. According to LGA authorities, PHC facilities actually do maintain spending records but are unwilling to share them. Further investigation is needed to understand what types of records PHC facilities do keep and the reasons for their reluctance to share them.

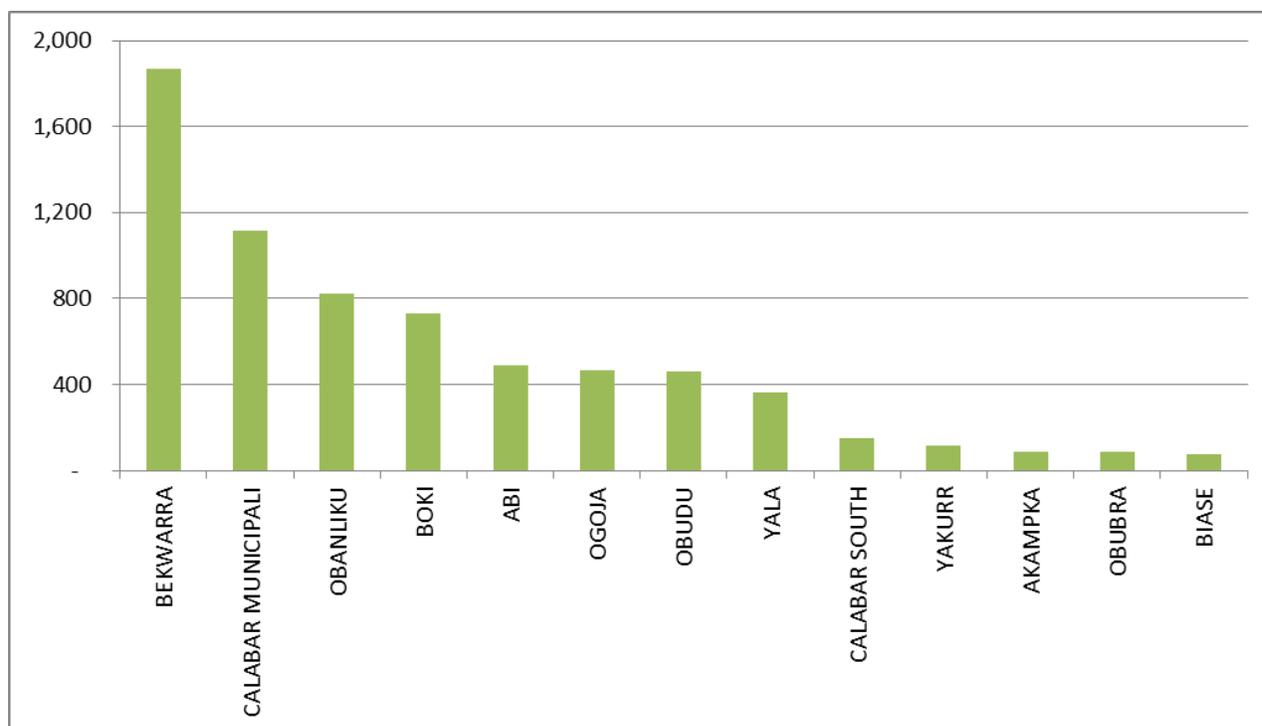
**According to the survey results, the majority of PHC facilities do not maintain a budget.** Approximately 88 percent of PHC facilities stated that they did not have a budget. For this reason, the study team was unable to obtain financial and budgetary information from most of the facilities, particularly concerning funds received and spent.

**In summary,** despite the fact that the majority of PHC facilities has a health committee or a management board and takes measures to ensure accountability toward the community, responsibility for decision making at the PHC level falls almost exclusively on the LGAs. This is compounded by the fact that almost no PHC facility maintains a budget and more than two-thirds do not keep detailed expenditure records or receipts.

## 4.8 BUDGET UTILIZATION

**Per capita health spending differs significantly from one LGA to another.** One way to look at utilization patterns across LGAs is to estimate per-capita share of health spending (Figure 11). On average, a person in Obanliku has a share in health spending that is more than 10 times as high as a person in Biase. These variations reflect the weak budget execution process at the LGA level and the discretionary and political decisions that go toward releasing funds to health facilities.

**FIGURE 11: PER CAPITA HEALTH SPENDING IN LGAS IN 2009, SELECTED LGAS (IN NAIRA)**



Source: LGAs  
 Figures for Akpabuyo, Bakassi, Etung, Odukpani, and Ikom were N.A.

## Facility conditions

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

**An estimated 51 percent of secondary facilities and 86 percent of PHC facilities reported that their consultation rooms were “poorly equipped.”** The conditions in PHC facilities are especially weak. Less than one-third of PHC facilities have a pharmacy on premise (Table 8). Basic amenities such as toilets and electricity also seem to be in real shortage: only 27 percent of PHC facilities and 57 percent of secondary facilities said they had alternative sources of electricity. More than half of secondary hospitals (57 percent) and 47 percent of PHC facilities get their water from wells or bore holes. Water is not available all year round for more than one-third of secondary facilities and more than half of primary facilities. Where provisions were initially made for these services, non-payment of utility bills often led utility service providers to cancel their services to the facilities (SMoH, 2010). Access to transport vehicles for emergencies is nonexistent at the PHC level.

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

	Secondary	Primary
	(n=14)	(n=94)
Outpatient area	85.7	73.8
Pharmacy	92.9	24.3
If yes, functional?	100.0	73.1
Facility secure at all times	71.4	33.6
Facility walled or fenced	50.0	7.5
Laboratory	100.0	19.6
If yes:		
Availability of standard of practice?	85.7	57.1
Space with temp regulator?	57.1	38.1
Reagent?	85.7	38.1
Electricity?	85.7	47.6
Lab equipment?	92.9	38.1
Water	78.6	42.9
Toilets	57.1	26.2
If yes, separate for females?	50.0	64.3
Alternative electricity source	85.7	27.1
Power shortages:		
Half of the time	14.3	6.5
Most of the time	64.3	31.8
All the time	0.0	43.0
Water available all year round?	64.3	46.7
Ambulance	78.6	0.0
Specialist doctor	28.6	1.9

	Secondary	Primary
	(n=14)	(n=94)
Kitchen/cafeteria	28.6	0.9
IEC material	21.4	32.7

Source: Survey data

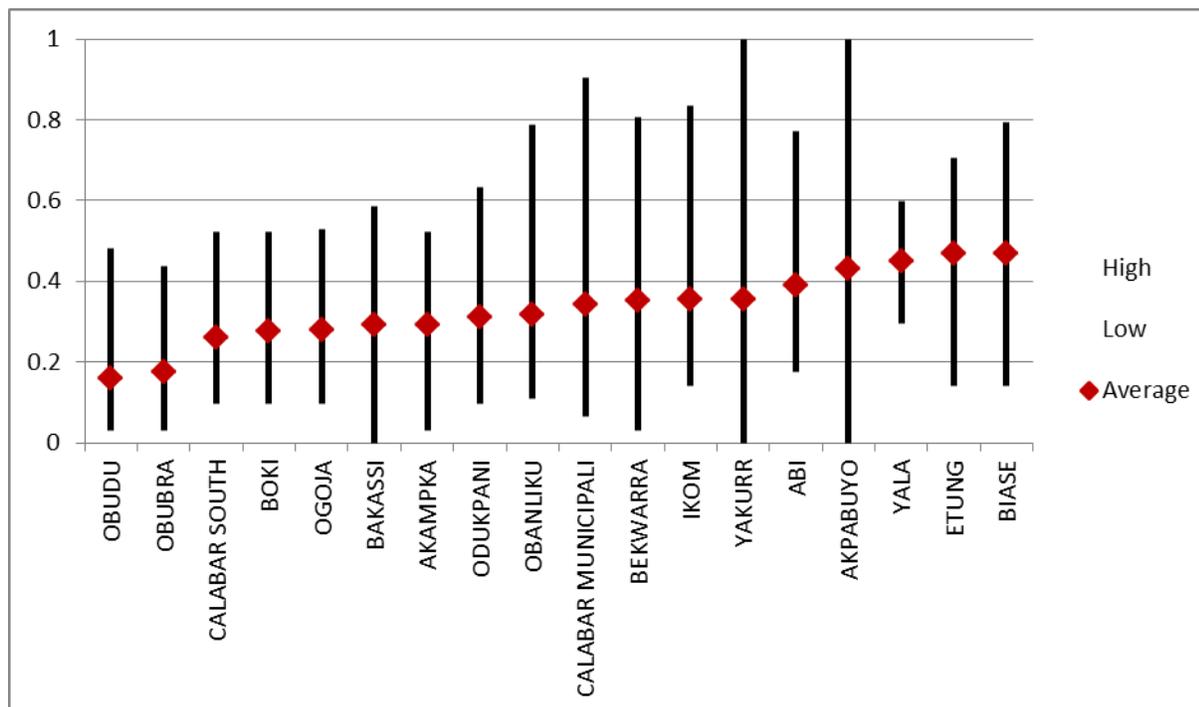
Principal Component Analysis (PCA) was used to combine 10 indicators of a facility's physical conditions into one aggregate index (thereafter, Physical Condition Index). PCA is a statistical technique that seeks a linear combination of variables such that the maximum variance is extracted from these variables. The Physical Condition Index is constructed using the following 10 indicators:

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

The Physical Condition Index can thus be considered as an aggregate indicator for the overall quality of the facility, which has a direct effect on service delivery. The PCA was done for PHC facilities only (hospitals were excluded because of the small sample size). A Physical Condition Index was computed and rescaled to vary between 0 and 1: the higher the index, the better the condition of the facility.

The average value of the Physical Condition Index for all sampled PHC facilities in Cross River is 0.33. As expected, the value is higher for urban facilities (0.46) than for rural facilities (0.26). Figure 12 plots PHC facilities according to the value of their index and calculates the average across sampled facilities in each LGA.

**FIGURE 12: PHC FACILITIES RANKED ACCORDING TO THE PHYSICAL CONDITION INDEX, BY LGA**

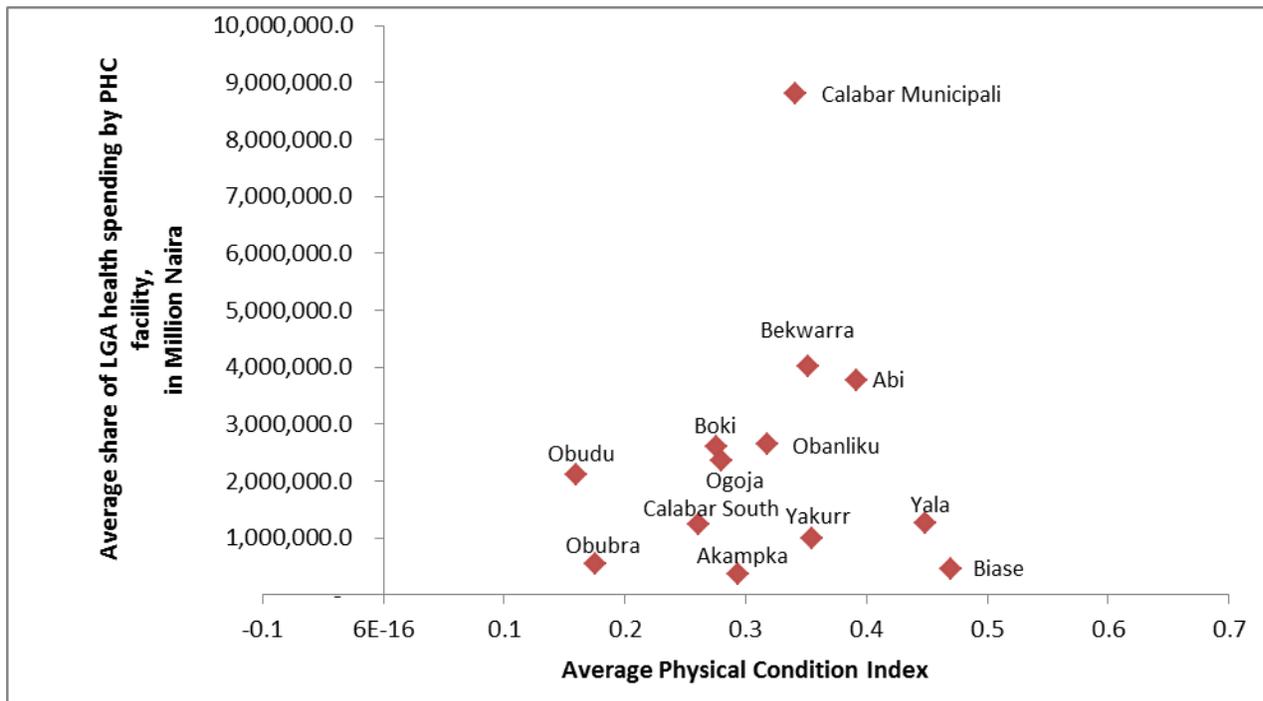


Source: Survey data and estimations

Figure 12 ranks LGAs by lowest average value of the Physical Condition Index to highest. The red diamond in the figure indicates averages, and the ranges of values (high, low) within each LGA are shown by the black bars. For instance, the sampled PHC facilities in Calabar Municipali have an average index of 0.34. The facility in Calabar Municipali with the lowest value of the index has a value of 0.07 while the highest has a value of 0.91. According to Figure 12, surveyed facilities in Biase have the highest average index, while those in Obudu have the lowest.

**There is a weak correlation between facility conditions and health spending in an LGA.** Figure 13 plots the average share of health spending per PHC facility against the average Physical Condition Index for each LGA. Facilities in Yakurr, Bekwarra, and Calabar Municipali share a similar Physical Condition Index (0.34 to 0.35); however, the average share of each PHC facility in health spending differs significantly across the three LGAs (0.9 million Naira in Yakurr versus 4 million Naira in Bekwarra and 8.8 million Naira in Calabar Municipali). Indeed, it is interesting to note that among the LGAs, Boki has the greatest share of health spending relative to total spending (Figure 11) and ranks at the lower end of the Physical Condition Index while Biase has the greatest Physical Condition Index and one of the lower shares of health spending relative to total spending.

**FIGURE 13: AVERAGE SHARE OF HEALTH SPENDING PER PHC FACILITY VERSUS AVERAGE PHYSICAL CONDITION INDEX, IN SELECTED LGAs**



Source: Survey data and estimations  
Data for some LGAs are N.A.

**Discrepancies between recurrent spending as reported by the state and salary estimates in certain LGAs may imply the presence of fund leakage.** Given the absence of budgets and accounting records at the PHC level, the team used survey data on health worker salaries in PHC facilities to estimate total spending on salaries in each LGA, and compared these data with recurrent spending by LGA as reported by the Ministry of Local Government. To estimate salary spending, the team assumed that every PHC facility has approximately three staff members with an average monthly salary of 44,653 Naira (according to survey results). Table 9 shows that for a number of LGAs, the difference between recurrent spending and salary spending is significant. For instance, in Yakurr, the LGA with the largest recurrent spending, estimated yearly salary spending represents only 4 percent of total recurrent spending in PHC facilities, when one would expect a figure closer to 80 percent (as the majority of recurrent spending is usually salary expenditures). In all but three LGAs (Akampka, Obubra, and Boki), estimated salary spending accounted for less than three-fourths of total recurrent spending.

It is important to note that the salary figures are estimates and may not accurately reflect reality. More accurate figures from the financial records of LGAs are needed to improve the reliability of these results.

**TABLE 9: RECURRENT SPENDING VERSUS ESTIMATED YEARLY SALARY SPENDING BY LGA, 2009**

LGA	# PHC facilities	Recurrent spending on health	Estimated yearly salary spending	Difference	Difference (in % of recurrent spending)
Abi	20	792,123,705	32,150,160	759,973,545	96%
Akampka	39	172,352,346	62,692,812	109,659,534	64%
Bekwarra	52	808,352,610	83,590,416	724,762,194	90%
Biase	30	711,161,276	48,225,240	662,936,036	93%
Boki	55	235,966,000	88,412,940	147,553,060	63%
Calabar Municipali	24	818,702,084	38,580,192	780,121,892	95%
Calabar South	25	977,366,996	40,187,700	937,179,296	96%
Obanliku	36	798,823,945	57,870,288	740,953,657	93%
Obubra	29	182,280,000	46,617,732	135,662,268	74%
Obudu	37	863,406,083	59,477,796	803,928,287	93%
Ogoja	36	909,676,943	57,870,288	851,806,655	94%
Yakurr	24	1,020,810,320	38,580,192	982,230,128	96%
Yala	64	749,687,612	102,880,512	646,807,100	86%

Source: Survey data and estimations  
Data for some LGAs are N.A.

*In summary*, results in this section show a misallocation of health resources across LGAs. Per capita health spending differs significantly from one LGA to another, which may be partly due to weak budget execution in certain LGAs and reflect the varied political priorities of LGA chairmen. Furthermore, there is a weak relationship between resources spent and facility conditions, suggesting that resources are not utilized most effectively. Finally, discrepancies between recurrent spending as reported by the state and salary estimates in certain LGAs may imply the presence of resource leakage between the LGAs and facilities.

## 5. CONCLUDING REMARKS

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

### ***Budget preparation and planning***

- As a result of low investments in health over the past two years, the share of health in the overall state budget has decreased from 7.8 percent of the total budget in 2008 to about 4.9 percent in 2010. This decrease in the health budget is inconsistent with the strategic priorities of the state government, as highlighted by the SHDP.
- The fact that the majority of state and LGA revenues originate from statutory allocations from the FA raises concerns about the state's and LGA's ability to sustain their development priorities and respond to the demand of their population. In Cross River, the state rather than the federal government determines the amount of FA funding each LGA receives.
- Although the budget preparation process in the LGAs seemingly takes into account input from health facilities, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. Per capita health budgets seem to vary significantly across LGAs.

### ***Budget execution***

- Health funds are appropriated through other MDAs in addition to the SMoH, and the state does not maintain consolidated records on health spending.
- Weak capital budget execution at the SMoH level, mostly attributed to a lack of political will to execute the budget and procure the resources needed, is undermining the credibility of the planning process.
- The process for releasing funds across LGAs varies. In many LGAs, health spending is largely dependent upon the priorities of the LGA chairmen. The inevitable result is large discrepancies between budgets and spending that may be attributed to changes in leadership and corresponding shifts in political priorities.

### ***Budget utilization***

- Facilities do not seem to possess much financial autonomy. They do not maintain their own budgets and thus have very little influence on actual spending. For PHC facilities, responsibility for decision making falls almost exclusively on the LGAs.
- A misallocation of health resources across LGAs reflects a system of fund allocation and budgeting that is not aligned with real demand or needs. Per capita health spending differs significantly from one LGA to another, partly due to weak budget execution in certain LGAs, and reflects the varied political priorities of LGA chairmen.
- There is evidence of a weak relationship between resources spent and facility conditions, suggesting that resources are not effectively utilized.

- Large discrepancies between recurrent spending, as reported by the state, and salary estimates in certain LGAs suggest the presence of resource leakage between the LGAs and health facilities. More accurate data are needed to confirm these claims.

It is important to note the challenges encountered during the PEMR exercise, specifically those related to the lack of accurate financial record keeping and reporting at lower levels (facilities and LGAs). In the majority of the PHC facilities visited, access to financial records was very difficult. In most cases the records did not exist. The analysis in this report largely relied on state-level financial records.

### **Recommendations**

The following recommendations address some of the weaknesses revealed by the PEMR in Cross River state:

- Strengthen accountability for use of public funds and financial management by reforming the current approach in budget preparation and planning at the state and local levels. A state health needs assessment would serve as an advocacy tool to guide policymakers during the budget preparation and approval process. To limit political influences, LGAs need to articulate clear outputs within the framework of the National SHDP and the state's health care policies. Broadening the membership of the state budget planning committee to involve members of the house of assembly (committee on health and committee on budget) in the planning process is needed.
- Improve transparency and understanding of the budgeting approval and funds disbursements process. The current process for budget execution and disbursement of funds is unclear and weakens the implementation of the budget and reduces its effectiveness. The current system of revenue allocation from the state government to LGAs needs to be reviewed to allow a more equitable, transparent, and fair allocation process across LGAs.
- Improve the skills of the state and local government planning officers in participatory budgeting methodologies and in the MTSS and MTEF. Likewise, CSOs should be trained to effectively engage in and monitor all the stages of the budget planning and implementation process. Clear steps should be outlined and a guideline document prepared for budget planning, execution, and monitoring, including roles of various parties in the budgeting process.
- Build capacity in sound financial management processes, tools, and techniques<sup>1</sup> at the federal, state, and LGA levels. Limited capacity for fiscal management among staff of PHC facilities and LGAs remains a key constraint to more effective resource allocation and use, resulting in low budget credibility. There is a need to impose adequate financial management and control mechanisms that can effectively track funds at all levels and across all MDAs in Cross River. A financial reporting manual should be developed and adopted at all levels of government. Importantly, the disbursements of resources for and on behalf of PHC facilities need to be more transparent. Facilities should be endowed with the capacity (human and financial) to maintain records of all financial transactions, both cash and in-kind.

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<sup>1</sup> For more information, see the forthcoming Health Systems 20/20 report on the health systems financial management training pilot project in select Gombe state LGAs and Abuja Federal Capital Territory Councils (Musimenta, forthcoming 2012).

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